LOYOLA UNIVERSITY NEW ORLEANS
EMPLOYEE ASSISTANCE PLAN

Summary Plan Description

Effective March 1, 2010
(Revised January 1, 2013)

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Loyola University New Orleans Employee Assistance Plan

Loyola University New Orleans sponsors an employee assistance plan (EAP) that provides you with access to confidential help for a wide range of personal (such as behavioral and substance abuse issues) and work related concerns. Through the EAP, you and/or your dependents can receive a referral to a skilled behavioral health professional for up to three face-to-face counseling sessions per problem per year and/or receive assistance in identifying appropriate community resources.

All employees and individuals who reside with the employee may use the EAP. Coverage automatically begins on your hire date. There are no election forms to complete or enrollment decisions to make. Loyola pays the full cost of this coverage.

The EAP is administered by Aetna Resources for Living (Horizon Health), an independent organization that manages a network of behavioral health specialists and also arranges consultations, assessments and referrals.

How the EAP Plan Works

As a responsible employer, Loyola recognizes and acknowledges that problems in your personal life can affect your life on the job – and vice versa. The EAP is designed to help you and your family deal with problems caused by stress and changes in life. The problems may involve you, a member of your family or your family as a whole. No matter what the reason, or who is involved, an EAP counselor or therapist can suggest solutions to your problems or direct you to other sources for help. Some of the types of problems the EAP can help you deal with include:

- Relationship problems
- Parenting issues
- Alcohol or drug abuse (by yourself or a family member)
- Emotional problems, such as feelings of anger or depression without knowing the cause
- Stress
- Grieving the loss of a loved one
- Dealing with job changes
- Legal and financial concerns
- Approaching retirement
- Marriage concerns
- Child and Elder care
- Health issues such as weight loss or managing chronic conditions
- Other concerns with your home or work life

EAP Counseling Services

When you call, an EAP counselor will discuss your problem with you, assess your individual needs and outline a plan of action for you to consider. For each problem you call about, you can get up to three sessions per year with an EAP counselor. There is no charge for EAP counseling sessions. For many people, talking to the EAP counselor through phone sessions is all the help they need. However, if you need more specialized or extensive treatment, the EAP counselor may refer you to a specialist or inpatient facility that can give you more care.

If you or a family member requires services that are beyond the scope of those provided by the EAP or need more than three counseling sessions, the counselor will recommend additional services or refer you to another provider. If you and your dependents are covered by the medical plan, the cost for these additional services may be covered under the medical plan or by your health care flexible spending account, if you participate.

EAP Referral Services

The EAP also offers a referral service. Through this service, EAP counselors will identify additional resources of health and social services available in your community such as:

- Legal assistance, including a face-to-face consultation with an attorney and supportive counseling from selected providers.
- Identity theft counseling, including preventive assistance to aid in protecting your sensitive information and assistance should your identity be stolen.
- Financial and debt counseling, ranging from individual sessions focusing on personal finances, to seminars covering such issues as saving for college and retirement planning.
- Self-help groups, such as Alcoholics Anonymous and Gamblers Anonymous.
- Dependent care and related referral services, such as resources for child care, adoption and school alternatives, to care for elderly or disabled dependents.

To receive confidential, personal counseling, contact Aetna Resources for Helath (Horizon Health) toll-free at 1-800-955-6422 anytime of day or night. An EAP specialist can provide you with the names of EAP counselors and help you set up an appointment. You may also access your EAP at www.HorizonCareLink.com. The login code is: Loyola. The Password is: eap. You will receive a wallet card with this information on it. Keep it with you for easy reference.

Confidentiality

Your use of this service is strictly confidential. The EAP does not provide Loyola with any name or other information about what you discuss with a counselor. No information regarding your participation in the EAP plan will be released to anyone without your written consent, unless otherwise required by state or federal law (for example, if you present a serious danger to yourself or others).

When EAP Coverage Ends

EAP coverage will end when the first of the following occurs:

- Your employment with Loyola ends.
- Loyola discontinues the plan.
- For a particular family member, he or she is no longer resides with you.

If you go on unpaid FMLA Leave or a Military leave of absence

If you go on an approved unpaid leave under the Family and Medical Leave Act of 1993 ("FMLA"), or a leave protected by the Uniformed Services Employment and Re-employment Rights Act of 1994 ("USERRA"), your employee assistance coverage will continue for the length of the leave.

Continuation of Coverage Under COBRA

You and your qualified dependents may be offered COBRA continuation coverage when your coverage under the plan would otherwise end because of a life event known as a "qualifying event." COBRA continuation coverage generally consists of the coverage under the plan that you and your family members had immediately before the qualifying event. This includes medical, dental and vision coverage as well as coverage under the Employee Assistance Plan and the Health Care Spending Account (HCFSA) that is in effect at the time of your qualifying event.

Each qualified beneficiary who elects COBRA continuation coverage will have the same rights under the Plan as other similarly situated individuals covered by the Plan who did not have a qualifying event. This includes the right to add dependents if they qualify for a HIPAA special enrollment period. If the plan changes, continuation coverage changes accordingly. During annual enrollment, each qualified beneficiary will have the same options under COBRA coverage as active employees covered under the Plan.

When COBRA continuation coverage is available

The specific qualifying events that trigger the right to elect COBRA continuation coverage are listed below. After a qualifying event, COBRA continuation coverage will be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

If you are an employee:

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

If you are the spouse of an employee:

- Your spouse dies,
- Your spouse's hours of employment are reduced,
- Your spouse's employment ends for any reason other than his or her gross misconduct,
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both), or
- You become divorced or legally separated from your spouse.

An employee's dependent child will become a qualified beneficiary if he or she loses coverage under the Plan because any of the following qualifying events occurs:

- The parent-employee dies,
- The parent-employee's hours of employment are reduced,
- The parent-employee's employment ends for any reason other than his or her gross misconduct,

- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B or both),
- The parents become legally divorced or separated, or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Special Rule for Retirees: Sometimes, the filing of a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If such a proceeding is filed with respect to your employer and, as a result of that filing, a retired employee loses coverage under the plan, or if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed, the bankruptcy will be a qualifying event and the retired employee will be a qualified beneficiary with respect to the bankruptcy.

The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan. In that event, the retiree will be entitled to coverage for life and the spouse and covered dependents of the retiree will be entitled to coverage for the life of the retiree. If the retiree dies while continued coverage is in effect, the other qualified beneficiaries will be entitled to continue coverage for up to 36 months from the date of the retiree's death. If the retiree is not living at the time of the qualifying event but the retiree's spouse has coverage, the surviving spouse is entitled to continued coverage for life.

Qualified beneficiaries will be offered COBRA continuation coverage only after the Human Resources Department has been notified that a qualifying event has occurred.

When the qualifying event is the end of employment or reduction of hours of employment, death of the associate, commencement of a proceeding in bankruptcy with respect to the employer, or the associate's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Human Resources Department will notify the COBRA administrator of the qualifying event.

You must give notice of some qualifying events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Human Resources Department in writing within 60 days after the qualifying event occurs. This notice should be sent to the Human Resources Department at the address specified in the section *How to contact the Human Resources Department*. A notice mailed to the Human Resources Department will be considered provided on the date of mailing.

The notice must include the employee's name, the name of the spouse and/or dependent child, the nature of the qualifying event (e.g. divorce, legal separation or a child's loss of dependent status) and the date the qualifying event occurred (date of divorce or legal separation or the date the dependent child reached the plan's limiting age, married or lost full-time student status).

If notice is not provided during this 60-day notice period, the spouse or dependent child who loses coverage will not be offered the opportunity to elect COBRA continuation coverage.

Duration of COBRA coverage

COBRA continuation coverage is a temporary continuation of coverage. The duration of the coverage depends on the nature of the qualifying event that causes the loss of coverage:

- When the loss of coverage is on account of the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage for the employee's spouse and/or dependent child may last for up to a total of 36 months.

- When the loss of coverage is on account of the employee's termination of employment or reduction of hours of employment, COBRA continuation coverage for the employee and his or her spouse and dependent children generally may last for up to a total of 18 months.

A special rule applies if the employee becomes entitled to Medicare benefits less than 18 months before the end of employment or reduction in hours. In that situation, the employee is still entitled to up to 18 months of COBRA continuation coverage under the general rule described above. However, COBRA continuation coverage for qualified beneficiaries other than the employee may last up to 36 months after the date of the employee's Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his or her spouse and children can last up to 36 months after the date of Medicare entitlement. Thus, their COBRA continuation coverage may continue for up to 28 months after the date of the qualifying event (36 months minus 8 months).

If the employee becomes entitled to Medicare more than 18 months prior to the end of employment or reduction hours, the general rules apply.

Extension of the 18-Month Period of Continuation Coverage

There are two ways in which the 18-month period of COBRA continuation coverage can be extended.

Disability extension. If the Social Security Administration (SSA) determines that you or a family member covered under the plan is disabled and the COBRA administrator receives timely notice of that determination, you and your other family members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months of COBRA coverage. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the initial 18-month period of COBRA continuation coverage.

In order for the extension to be available, you must notify the COBRA administrator in writing of the disability determination during the first 18 months of COBRA continuation coverage and no more than 60 days after the latest of: (i) the date of the SSA determination, (ii) the date of the qualifying event or (iii) the date coverage would end on account of the qualifying event.

The notice must be sent to the COBRA Administrator at the address specified in the section *How to contact the COBRA administrator*. It must include the employee's name, the name of the disabled individual as well as copy of the Social Security Administration disability determination.

A notice mailed to the COBRA administrator will be considered provided on the date of mailing.

If notice is not provided within the above timeframes, the 18-month maximum coverage period will not be extended.

The disability extension is available only for as long as the family member remains disabled. The COBRA administrator must be notified if the Social Security Administration makes a final determination that the individual is no longer disabled. Continuation coverage will end on the first day of the month that begins more than 30 days after the date of the determination.

Second qualifying event. If your family experiences a second qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family may be entitled to receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months of COBRA coverage.

This extension may be available if the employee or former employee dies, is divorced or legally separated, or if a child no longer qualifies as a dependent child under the terms of the Plan, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. Coverage will be extended only if you or your family members provide notice of the second qualifying event to the COBRA administrator no more than 60 days after the event occurs.

This notice should be sent to the COBRA administrator at the address specified in the section *How to contact the COBRA administrator*. The notice must include the employee's name, the name of the spouse and/or dependent child, the nature of the second qualifying event (e.g. divorce, legal separation or a child's loss of dependent status) and the date the qualifying event occurred (date of divorce or legal separation or the date the dependent child reached the plan's limiting age, married or lost full-time student status).

A notice mailed to the COBRA administrator will be considered provided on the date of mailing.

If notice is not provided during this 60-day notice period, COBRA continuation coverage will not be extended beyond the initial 18-month period.

Electing COBRA continuation coverage

Once the Human Resources Department receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. You and/or your spouse and dependent children will have 60 days in which to elect COBRA continuation coverage. This 60-day election period begins on the later of:

- The date coverage would end because of the qualifying event, or
- The date the COBRA administrator provides notice of the right to elect COBRA.

A COBRA election mailed to the COBRA administrator will be considered made on the date of mailing.

If COBRA continuation coverage is not elected during the 60-day election period, the right to elect continuation coverage will be lost.

You and/or your spouse and dependent children may elect COBRA continuation coverage for all qualifying family members. However, each qualified beneficiary has an independent right to elect continuation coverage.

Thus, both you and your spouse may elect continuation coverage, or only one of you may do so. You may also elect to continue coverage on behalf of your dependent children only.

Paying for COBRA continuation coverage

You must pay the full cost of COBRA continuation coverage. Your first payment must be made within 45 days of the date that the COBRA election was made. If payment is not received within this 45-day period, the COBRA administrator will terminate coverage retroactively to the beginning of the coverage period.

After the initial premium payment is made, all other premiums are due on the first day of the month to which such premium will apply, subject to a 30-day grace period. ***A premium payment that is mailed will be considered made on the date of mailing.*** If the full amount of the premium is not paid by the due date or within the 30-day grace period, COBRA continuation coverage will be canceled retroactively to the first day of the month with no possibility of reinstatement.

The amount of the premium for COBRA continuation coverage will not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage. In the case of an extension of COBRA continuation coverage due to a disability, the amount of the premium will increase to 150 percent of the cost of coverage.

When COBRA continuation coverage ends

A qualified beneficiary's COBRA continuation coverage will end before the expiration of the maximum coverage period if any of the following events occurs:

- The premium for coverage is not paid in a timely manner,
- After electing COBRA continuation coverage, the qualified beneficiary becomes covered under another group health plan that does not contain an exclusion or limitation with respect to any pre-existing condition that the individual may have,
- After electing COBRA continuation coverage, the qualified beneficiary enrolls for Medicare,
- If coverage is extended on account of disability, the Social Security Administration makes a determination that the individual is no longer disabled, or
- Loyola University no longer provides group health coverage to any of its employees.

If you have questions

Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the Human Resources Department or COBRA administrator as indicated below. For more information about your rights under ERISA including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and telephone numbers of Regional and District EBSA Offices are available through the EBSA's website.)

Keep the Human Resources Department informed of address changes

In order to protect your family's rights, you should keep the Human Resources department informed of any changes in the addresses of family members. If you have a qualifying event, you should also keep a copy of any notices you send to the Human Resources department for your records.

How to contact the Human Resources Department

All initial COBRA qualifying event notices should be mailed to the Human Resources Department at the following address:

Loyola University New Orleans
6363 St. Charles Avenue
Campus Box 16
New Orleans, LA 70118-6143

You can also call the Human Resources department at (504) 864-7757 if you have any other questions about COBRA continuation coverage.

How to contact the COBRA administrator

All correspondence, other than the initial qualifying event notice should be mailed to the COBRA administrator at the following address:

Ceridian COBRA Services Center
P.O. Box 534066
St. Petersburg, Florida 33747-4066

You may also call the COBRA administrator at 1-800-877-7994 for any questions about your COBRA coverage.

How To File A Claim

Submitting EAP claims

EAP providers will file your claim for you, and the plan will reimburse the EAP directly.

Initial claims determinations

Aetna Resources for Health (Horizon Health) will review your claim within a reasonable period of time, but not later than 30 days after the claim is received. This time period may be extended for an additional 15 days when necessary due to matters beyond Horizon Health's control or if your claim is incomplete. You will be advised in writing of the need for an extension during the initial 30-day period, and a determination will be made no more than 45 days after the date the claim was submitted. If the extension is needed because your claim is incomplete, the notice will specifically describe the information needed to complete the claim, and you will be allowed 45 days from receipt of the notice to provide the information. The timeframe for deciding the claim will be suspended from the date the notice of extension is sent until the date on which you respond to such notice. If you provide the requested information within the specified timeframe, your claim will be decided within the time specified in the extension notice. If you do not provide the requested information within the specified timeframe, your claim may be decided without that information.

If your claim is denied

If your claim is denied in whole or in part, Aetna Resources for Health (Horizon Health) will provide written notification of any adverse benefit determination. The notice will state the following:

- The specific reason or reasons for the adverse determination.

- Reference to the specific plan provisions on which the determination was based.
- A description of any additional material or information necessary to perfect the claim, and an explanation of why such material or information is necessary.
- A description of the plan's review procedures (incorporating any voluntary appeal procedures offered by the plan), the right to submit written comments and have them considered, and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an adverse benefit determination on review.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim.
- If the adverse benefit determination was based on an internal rule, guideline, protocol or other similar criterion, the specific rule, guideline, protocol or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.
- If the adverse benefit determination is based on the medical necessity or experimental or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Review of denied claims

If any part of a claim is not paid, or if you do not understand or do not agree with the handling of a claim, you have 180 days following receipt of the notification in which to appeal the decision to Loyola. Your appeal must be in writing to the following address:

EAP Plan Administrator
Loyola University New Orleans
6363 St. Charles Avenue
Campus Box 16
New Orleans, LA 70118-6143

If you do not file an appeal within this time period, you will lose the right to appeal the determination.

The appeal should include any comments, documents, records and other information relating to the claim. If you request, you will be provided free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim.

You may also request that the plan identify any medical or vocational expert from whom it received advice in connection with the benefit determination, regardless or whether it relied on such advice in making the initial benefit determination.

Determinations on appeal

Loyola will review and decide your appeal within a reasonable period of time, but in no event more than 60 days after your appeal is received. The decision by Loyola is final.

The review will take into account all comments, documents, records and other information relating to the claim that you submit, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not give deference to the initial denial. In addition, the individual who decides your appeal will not be the same individual who initially decided your claim and will not be the individual's subordinate.

A health professional may be consulted in deciding your appeal, except that any health professional consulted in connection with your appeal will not have been involved in the initial benefit determination or be a subordinate of the health professional who was involved.

You will be notified in writing of the decision on the appeal. If the decision upholds the denial of your claim, the notification will provide:

- The specific reason or reasons for the adverse determination.
- Reference to the specific plan provisions on which the determination was based.
- A statement of the claimant's right to bring a civil action under section 502 of ERISA.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim.
- If the adverse benefit determination was based on an internal rule, guideline, protocol or other similar criterion, the specific rule, guideline, protocol or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or criterion was relied upon in making the adverse benefit determination, and a copy will be provided free of charge to the claimant upon request.
- If the adverse benefit determination is based on the medical necessity or experimental or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

No suit concerning the claim may begin until the appeal process has been completed, and you have received the written decision on the appeal, or you have not been given a timely response to the appeal. You have one year from that time to file suit (unless a longer period of time is provided in accordance with ERISA). A suit may not be brought after the one-year period has passed (unless a longer period of time is provided in accordance with ERISA).

Designation of an authorized representative

You may authorize someone else to file and pursue a claim or file an appeal on your behalf. Generally, this authorization must be in writing and signed by you. Any reference in these claims procedures to "you" or "claimant" is intended to include your authorized representative.

Plan Information

The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA).

Plan name and number:	Loyola University Employee Benefit Plan (PN502)
Plan sponsor and administrator:	Loyola University New Orleans 6363 St. Charles Ave. Box 16 New Orleans, LA, 70118 504-864-7272
Employer identification number:	72-0408946
Type of plan:	This is an employee welfare benefit plan which provides medical (including prescription drug), dental, vision, life and accidental death and dismemberment, employee assistance program, long term disability, and Health Care Flexible Spending Account. The plan also includes a Dependent Care Flexible Spending Account under IRS rules. Complete rules regarding eligibility, benefits, and all other related plan information are contained in separate documents. This document describes the terms of the Employee Assistance Plan.
Type of administration:	Third Party: Aetna Resources for Health (Horizon Health) EAP Services 2941 South Lake Vista Drive Lewisville, TX 75067 1-800-955-6422
Agent for service of legal process:	Loyola University New Orleans 6363 St. Charles Ave. Campus Box 16 New Orleans, LA, 70118
Plan year ends:	December 31
Benefits provided by and disbursements from the plan made by:	Employee assistance plan coverage is funded solely by the University and is not insured. Disbursements are made by Aetna Resources for Health (Horizon Health) in accordance with the terms of the plan documents.
Termination or amendment of plan:	Loyola University New Orleans reserves the right to terminate or amend the plan completely or partially at any time, subject to the terms and provisions of the underlying plan document.

Statement of ERISA Rights

As a participant in the 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, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

- Receive a summary of the 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

In addition, if you are a participant in a group health plan, you have the right to:

- 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 and the documents governing the Plan for information concerning your COBRA continuation coverage rights.

- Receive a copy of the Plan's procedures regarding qualified medical child support orders without charge.

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 benefit or exercising your rights under ERISA.

Enforce your rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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.

Date of issue of this Summary Plan Description: March 1, 2013