

**WELFARE BENEFIT PLAN OF**

**("PLAN")**

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**("PLAN SPONSOR")**

**SUMMARY PLAN DESCRIPTION**

Effective January 1, 2005  
(or as specified)

**This document, together with the Attachments listed herein, constitute the written Summary Plan Description for the above-defined "Plan" required by ERISA Section 102.**

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## I. INTRODUCTION

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The Employer maintains the Plan for the exclusive benefit of its eligible employees and their spouses and dependents. The Plan provides you and your eligible dependents with access to medical, dental, vision, life and accidental death and dismemberment, dependent life, long term disability, and/or short term disability benefits as elected by the Employer. This Plan provides the benefits listed in Appendices E, R, or D. Other Appendices may be applicable if provided by the Employer as part of the Summary Plan Description. The Appendices as well as a copy of each booklet, summary, or other governing document of the respective benefits constitute Attachments to this Summary (all of the foregoing material as included is generically referred to in this Summary by the term "booklet"). This document and its Attachments are the Summary Plan Description for the benefits described in Appendices E, R, or D as required by ERISA Section 102.

This Summary describes the terms of the Plan as of the Plan Year starting on or after January 1, 2005.

Although this Summary will give you a general understanding of how the Plan works, it is only an overview. The detailed legal documents under which the Plan is established, including the policies, and not this Summary, control your rights and will be controlling if the documents for the Plan and this overview conflict in any respect. Copies of the legal documents will be made available for your review at the offices of the Employer.

It is intended that the Plan comply with current Federal laws. However, you should be aware that the Plan will change if the laws change or if otherwise amended by the Employer.

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## II. GENERAL PROVISIONS

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### A. GENERAL INFORMATION

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PLAN SPONSOR:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

EMPLOYER I.D. NUMBER: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

Related Employers, if any, also sponsoring the plans are attached. The Plan Sponsor and Related Employers are limited to those eligible for participation under the Trust. The term "Employer" includes the Plan Sponsor named above and will include any listed Related Employer.

PLAN ADMINISTRATOR, NAMED FIDUCIARY, AND AGENT FOR SERVICE OF LEGAL PROCESS:

NAME: Plan Sponsor

BUSINESS ADDRESS: Same as address above

TELEPHONE NUMBER: Same as telephone number above

If the Plan Sponsor is not a Plan Administrator and/or Agent for Service of Legal Process, the above information will be replaced by correct information in an attached statement. Service of Legal Process may be made upon the Trustee or Plan Administrator.

PLAN NUMBER: 50\_\_\_\_\_

TYPE OF PLAN: To the extent the Plan benefits provide medical care as defined by Federal law, these benefits may be group health plan type benefits. To the extent the Plan benefits provide medical, dental, vision, life insurance, accidental death and dismemberment, or disability coverage, they may be welfare plan type benefits subject to the provisions of ERISA.

TYPE OF ADMINISTRATION: Employer administration. The following insurers or HMOs also perform administrative functions, e.g. they make claims determinations and payments and issue Certificates of Creditable Coverage, where applicable:

- Blue Cross Blue Shield of Wisconsin ("BCBSWi") (for medical and dental benefits) or Compcare Health Services Insurance Corporation (commonly known as CompcareBlue) (for medical benefits);

- AIG Life Insurance Company through its vision benefits manager National Vision Administrations (for vision benefits); and
- Effective January 1, 2006, Jefferson Pilot Financial Insurance Company (prior to January 1, 2006, Hartford Life and Accident Insurance Company) (for life, accidental death and dismemberment, short term disability, long term disability, and dependent life benefits).

The booklets for the various benefits contain the addresses and phone numbers of the insurers/HMOs and their administrators.

**TRUSTEE:**

NAME: Marshall and Ilsley Trust Company  
ADDRESS: 401 N. Segoe Road, 2N  
Madison, Wisconsin 53705  
(608) 232-2000

**SOURCE OF CONTRIBUTIONS TO THE PLAN:** The Plan Administrator provides a schedule of the applicable premiums during the enrollment and at such time participant contributions may change and upon request for each of the benefits, as applicable. Participant and/or Employer contributions may be made as provided in Appendices, except as otherwise noted. If participants are required to make contributions and you need further information about this, please contact the Employer. If participants are required to make contributions, they may be entitled to a refund or premium reduction if applicable to the Employer under the Plan. Contact the Employer for more information.

**FUNDING MEDIUM:** The medical and dental benefits are insured under a "modified premium arrangement" with Blue Cross Blue Shield of Wisconsin ("BCBSWi") or Compcare Health Services Insurance Corporation (medical only), on a "cost plus basis." This means that if the reserves held in the Wisconsin Bankers Association Insurance Trust Fund ("Trust") would not be sufficient to pay claims of participants and beneficiaries, BCBSWi or Compcare Health Services Insurance Corporation would be obliged to pay those claims. Other benefits are fully insured. The insurers are listed under "Type of Administration." All benefits will be paid by the respective insurer; provided however, if the benefit is a medical or dental benefit, the insurer will pay any benefits not covered by the Trust as discussed in the booklets. The Employer is not responsible for paying claims with respect to any benefits.

**PLAN YEAR:** Unless otherwise provided, the Plan's financial and other records are maintained on the basis of a "Plan Year" which is the year beginning each January 1 and ending each December 31. If the Plan was adopted after January 1, 2005, the effective date was

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**FINANCING OR ADMINISTRATION BY A HEALTH INSURANCE ISSUER:** Certain benefits are guaranteed under a contract or policy of insurance issued by a health insurance company or HMO. Refer to the underlying benefit policies for more detail regarding the involvement of a health insurer or HMO in those policies.

**STATUS OF EMPLOYER AS "SMALL EMPLOYER" UNDER MEDICARE SECONDARY PAYER RULES** (*If medical benefits are offered, Plan Sponsor must choose and mark one of the two following options*):

\_\_\_\_\_ No Small Employer Election. As of the date of the completion of this Summary, the Employer did not qualify for (or qualified for, but did not elect) "small employer" status (see Questions and Answers III.5 through III.7 for important information on how this affects benefits).

\_\_\_\_\_ Small Employer Election. As of the date of the completion of this Summary, the Employer both qualified for and elected "small employer" status (see Questions and Answers III.5 through III.7 for important information on how this affects benefits).

**COBRA DESIGNATIONS** (*If medical, dental, or vision benefits are offered, Plan Sponsor should review and, if desired, complete the following*):

**PREMIUM PAYMENTS:** The Plan Sponsor does not allow payment of COBRA premiums other than by check, unless specified as follows (*Complete with other methods of payment, if allowable*): \_\_\_\_\_

**FACSIMILE (FAX) NUMBER** (*Complete only if the Plan Sponsor allows faxed COBRA notices*): \_\_\_\_\_

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### III. ELIGIBILITY, PARTICIPATION, AND BENEFITS

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#### 1. Who is eligible and when does coverage start?

Appendices E, R, and D, if applicable, provide information on the eligibility for benefits. In addition, only those persons who meet the eligibility requirements of the underlying policy, enroll, and remain insured under the policy are participants in the Plan. Benefits provided under the Plan are subject to the terms, conditions and provisions of the applicable underlying policy and will be exclusively as provided from time to time under the policy. **Please review the booklets carefully.**

Information about enrollment procedures, including when coverage begins and ends for the various benefits, is found in the materials for each benefit. Each participant will sign documents and provide the Employer and Plan Administrator with information and evidence as may reasonably be requested to administer the Plan.

The Plan Administrator will let you know the amount of premiums that apply to the benefits under the Plan (if any) and any changes in the premiums under those benefits.

**2. What are the rules for HIPAA special enrollments?**

"HIPAA," the Health Insurance Portability and Accountability Act, is a law that only applies to certain types of benefits. If you do not elect to enroll 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 policies that provide certain group health benefits (medical), 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. These benefits are subject to the provisions of the policy for the benefit. State law may provide different requirements. See the booklets. For more information on when HIPAA applies, please see the Questions and Answers on HIPAA in Section IV.E.

**3. Are there preexisting condition exclusions under the Plan?**

Certain group welfare benefits (including medical) may have preexisting condition exclusions. Please refer to those booklet policies for information as to whether those benefits are subject to any preexisting condition exclusions.

**4. What benefits are offered under the Plan?**

Each benefit has a booklet, describing eligibility, benefits, how benefits may be lost, and other important information. See the booklets for details.

**5. If I have medical benefits, do I or my family members need to enroll in Medicare when eligible?**

It depends. Sometimes Medicare is the primary payer and sometimes it is the secondary payer.

- It is especially critical for those eligible for Medicare to enroll in Medicare Parts A and B **when Medicare is primary** to avoid gaps in coverage.
- However, enrolling **when Medicare is secondary** also may be beneficial.

See Questions and Answers III.6 and III.7 which give more information on when Medicare is the primary or secondary payer of medical benefits.

**6. If an individual is Medicare eligible, when is Medicare the primary payer?**

Medicare generally will be the **primary payer** of medical benefits (and the Plan will be **secondary**) for individuals in the following categories:

- Certain individuals with end stage renal disease after 30 months of coverage;
- Certain disabled individuals who are covered, but not because of the individual's (or a family member's) current employment status;
- Certain former employees or former directors (or certain dependents of such individuals) (for information on retiree or director coverage, see Appendix R or D); or
- Certain individuals (age 65 or older) who are Medicare eligible and are working as employees or are active directors (or certain dependents of such employees or directors) (see Appendix E or D, if applicable) under a plan sponsored by an employer that has qualified for and made the Small Employer Election. See Section II to determine whether the Employer has made the Small Employer Election. This information may change from time to time so check with the Employer for current information.

Note that not every situation has been addressed and that the rules determining who falls into the above categories can be complex. For information on COBRA continuation coverage, see Appendix C. See the Employer for more information.

These are only general guidelines on coordination of Medicare with the Plan. (See also Question and Answer III.5 and III.7.) See the booklets or the Employer for more information.

**7. If an individual is Medicare eligible, when is Medicare the secondary payer?**

Medicare generally will be the **secondary payer** of medical benefits (and the Plan will be **primary**) for individuals in the following categories:

- Certain individuals with end stage renal disease prior to 30 months of coverage;
- Certain disabled individuals who are covered because of the individual's (or a family member's) current employment status; or
- Certain individuals (age 65 or older) who are Medicare eligible and are working as employees or are active directors (or certain dependents of such employees or directors) (see Appendix E or D, if applicable) under a plan sponsored by an employer that has not qualified for (or if qualified, has not made the Small Employer Election). See Section II to determine whether the Employer has made the Small Employer Election. This information may change from time to time so check with the Employer for current information.

Note that not every situation has been addressed and that the rules determining who falls into the above categories can be complex. See the Employer for more information.

These are only general guidelines on coordination of Medicare with the Plan. (See also Question and Answer III.5 and III.6.) See the booklets or the Employer for more information.

**8. Does eligibility for Medicare Part D affect benefits?**

Eligibility for Medicare Part D may affect certain benefits under the Plan. Contact the Plan Sponsor for more information.

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## IV. OTHER INFORMATION ABOUT THE PLAN

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### A. ENDING PARTICIPATION

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**1. When will my participation in the Plan or in a benefit end?**

Participation will end if:

- You no longer meet the eligibility requirements for that benefit;
- To the extent allowed by law, if you do not make contributions for that benefit required under the Plan;
- Your hours drop below any required hourly threshold;
- To the extent allowed by law (and if not otherwise limited or addressed the booklet for a benefit), you submit false claims; or
- For any other reason as set forth in the booklets for a benefit.

See Section IV.B and booklets for information about leaves of absence. See Appendices E, R, and D and booklets about termination events for more information.

Participation also will end if the Plan is terminated. Participation in a particular benefit also will end if that benefit is terminated.

You may be entitled to continue to participate in one or more of the group health benefits pursuant to any rights you have under COBRA, as explained in Appendix C. The right to convert to a personal policy, if applicable, is addressed in the booklets.

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## **B. FAMILY, MEDICAL, OR UNIFORMED SERVICES LEAVE AND COURT ORDERS**

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### **1. What happens to my benefits if I go on family and medical leave?**

If you go on a family or medical leave that is subject to the Federal Family and Medical Leave Act of 1993 ("FMLA") or, in some cases, similar state laws, you have certain rights to continue coverage of health benefits.

If an employee goes on a leave of absence that is not an FMLA leave (or uniformed services leave (see Question and Answer IV.B.2)), the employee will be treated as having terminated participation unless otherwise permitted under the policies. If an employee goes on an FMLA leave (or uniformed services leave (see also Question and Answer IV.B.2)):

- Benefits other than "group health benefits" are provided by the Employer's established policy for providing such benefits when the employee is on other forms of leave (paid or unpaid, as appropriate); and
- For group health benefits, the employee can choose to have the Employer continue to maintain the employee's health benefits coverage on the same terms and conditions as coverage would have been provided if the employee had been continuously employed during the entire leave period, subject to the employee making any required contribution.

An employee on FMLA leave will be considered to have terminated employment with the Employer on the earliest to occur of:

- The date the employee's employment relationship with the Employer would have terminated if the employee had not taken FMLA leave (e.g., if the participant's position is eliminated as part of a nondiscriminatory reduction in force and the employee would not have been transferred to another position);
- The date the employee notifies the Employer of his or her intent not to return to employment; or
- The date the employee fails to return to employment at the end of the FMLA leave or continues on leave after exhausting his or her FMLA leave entitlement in the 12-month period.

The Plan's FMLA procedures will comply with any additional requirements mandated by applicable law. Contact the Employer to determine whether FMLA applies.

**2. What happens to my benefits if I go on military leave?**

If you leave work for military duty in the uniformed services that is covered under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), then you have certain rights under the Plan.

In general, you may make the same type of elections as described in Section IV.B.1 for FMLA leave. If you are on a uniformed services leave, you and your spouse and dependents have a right to elect coverage of the lesser of: 24 months of continuation coverage of group health benefits under the Plan to the extent required by law, beginning on the date the uniformed services leave begins; or the period ending on the date you fail to apply for or return to active employment with the Employer. (24 months applies to elections for such continuation coverage made on and after December 10, 2004; see the Employer for information regarding prior elections.)

Generally, a person who elects to continue coverage under USERRA leave may be required to pay up to 102 percent of the full premium under the Plan. However, if you are on leave for less than 31 days, such person will pay only the employee share, if any, for such coverage.

While on uniformed services leave, you generally are entitled to non-health benefits on the same terms and on the same basis as those benefits are offered to other employees on a leave of absence.

The Plan will comply with any requirements under USERRA or other Federal laws relating to military service to the extent required by those laws. If you go on military duty, please see the Plan Administrator for more information.

**3. How can a Qualified Medical Child Support Order affect my benefits?**

You may be required to modify your elections under the health benefits subject to these orders, including to continue participation, in order to provide coverage for your child pursuant to an order issued by a court, or a notice issued by certain state agencies, that qualifies as a Qualified Medical Child Support Order ("QMSCO"). You will be notified if the Plan Administrator receives such an order affecting your group health benefit participation. The Plan has detailed procedures for determining whether an order qualifies as a QMSCO. Participants may obtain, without charge, a copy of such procedures from the Plan Administrator.

**C. CONTINUATION OF COVERAGE AFTER THE  
OCCURRENCE OF CERTAIN EVENTS THAT CAUSE  
LOSS OF GROUP HEALTH COVERAGE UNDER THE PLAN**

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See Appendix C for important COBRA continuation coverage information if you have health, dental, or vision coverage.

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**D. PLAN AMENDMENT OR TERMINATION**

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**1. How and when can the Plan be terminated or amended?**

The Plan Sponsor reserves the right to discontinue the Plan or any benefits at any time, subject to certain restrictions. The Plan Sponsor also has the ability to amend certain provisions of the Plan at any time. Such actions will be approved by written resolution of the Employer's governing body, or by such other person or persons authorized by the governing body to take such actions. Amendments will be signed on behalf of the Employer and will be effective as of the dates specified in the amendment. Amendments may include retroactive effective dates to the extent allowed by law. However no amendment will deprive any participant or beneficiary of any right to which he or she is entitled under the affected benefits with respect to contributions previously made or provide for use of funds or assets other than for the benefit of employees and beneficiaries except as may be allowed by law or regulation. Neither the Employer nor any of its employees will have any further financial obligations hereunder from and after termination of any of the benefits except with respect to obligations that have accrued up to the date of termination which have not been satisfied. You will be notified of any such change.

The Trust may amend this Plan on behalf of the Plan Sponsor who is maintaining the Plan at the time of the amendment. An amendment by the Trust does not require consent of the Plan Sponsor or Related Employers nor does the Plan Sponsor need to reexecute its Plan document with respect to such an amendment. The Trust will provide each Plan Sponsor a copy of the amended Plan document (either by providing substitute or additional pages, or by providing a restated document.)

**2. Are there other circumstances which may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of benefits that I might otherwise reasonably expect to receive from the Plan?**

Yes. Besides those circumstances mentioned above, some examples would be:

- If you were found to be ineligible to participate in a benefit under the Plan, you would be ineligible for that benefit (see Section III, the Appendices, and booklets for more information on participation);
- Mistakes by the Employer or Plan Administrator with respect to your eligibility, contribution, reimbursement or other aspects of the Plan, will be corrected as allowed by law; this may result, for example, in your return of an overpayment from the Plan and/or adjustment of your benefits (see Section IV.F and booklets for more information);
- If your claim for benefits is denied, your reimbursement may be affected (see Section V and booklets for claims procedures); or
- If benefits are to be paid to you, but you cannot be located after reasonable efforts, the benefits may be forfeited.

There may be other circumstances which could affect the benefits you might expect to receive. If you have any questions on the above circumstances or on a specific situation not mentioned here, please consult the booklets or see the Plan Administrator.

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## E. HIPAA

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### 1. HIPAA Notice of Preexisting Condition Exclusion

The medical benefits offered under this summary may contain direct restrictions based on preexisting conditions. The existence and terms of any preexisting condition exclusion, if any, and your right to demonstrate creditable coverage and any applicable waiting periods will be covered under the terms of the policy covering that benefit. You may request a Certificate of Creditable Coverage from a prior plan or insurer/HMO if necessary under such prior underlying health plan. The Plan (or insurer/HMO of underlying benefits) will assist in obtaining a certificate from any prior plan or insurer/HMO, if necessary.

### 2. Does HIPAA apply?

HIPAA ("Health Insurance Portability and Accountability Act of 1996") includes rights to special enrollment, preexisting condition exclusion limitations, participation due to special enrollment rights in a different health plan, and certificates of creditable coverage. References to these rights in this Summary generally apply only to medical group health benefits.

**3. What is the HIPAA procedure for requesting a Certificate of Creditable Coverage?**

If HIPAA applies and your coverage ceases, you automatically will be issued a Certificate of Creditable Coverage by the applicable health insurance insurer or HMO, as appropriate. Also, if HIPAA applies, you or someone on your behalf may request a certificate within 24 months after coverage ends. A request must be accompanied by a written authorization if not made by you personally. See Question and Answer IV.E.2 for information about which benefits may be covered. Please direct requests to the insurer or HMO.

**4. HIPAA Notice of Alternative Method**

In the event HIPAA applies, please consult the booklets for the applicable benefit documents to determine whether the "regular" method (instead of the "alternative") is used. If a booklet is silent as to the method used, the regular method is used. (The "regular" method reports creditable coverage based on all types of coverage. The "alternative" method requires reporting creditable coverage separately for mental health, dental, vision, prescription drug and substance abuse treatment coverages.)

**5. What HIPAA privacy rights apply?**

Under another provision of HIPAA, plans offering group health benefits are required to take steps to ensure that certain "protected health information" is kept confidential. You may receive a separate notice from the Employer (or insurers or the Trust) that outlines its health privacy policies. The Plan may make a HIPAA "hybrid entity" election which allows it to separate group health plan benefits and non-group health plan benefits for HIPAA privacy purposes. See the Plan Sponsor or Employer for information on whether a hybrid entity election has been made. This Question and Answer is effective as of the later of April 14, 2004, or the date of adoption of the group health benefits under the Plan.

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**F. MISCELLANEOUS PROVISIONS**

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**1. Am I guaranteed employment due to my participation in the Plan?**

No. Participation in the Plan is not a guarantee of employment. However, the Employer may not fire you or discriminate against you to prevent you from becoming eligible for the Plan or from obtaining a benefit or exercising your rights under ERISA.

**2. Can I assign my benefits?**

You cannot assign your benefits under the Plan to anyone else except as permitted in the life insurance booklet. However, your benefits and coverage under the Plan may be assigned to another person providing coverage to your child pursuant to a court order that qualifies as a **Qualified Medical Child Support Order**. See Section IV.B.

**3. What if the Plan cannot locate a payee?**

If the Plan Administrator is unable to make payment to any participant or other person to whom a payment is due under the Plan because it cannot determine the identity or whereabouts of such participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such participant or other person will be forfeited following a reasonable time (as determined by the Plan Administrator) after the date any such payment first became due.

**4. What if a mistake is made?**

The Plan Administrator will be entitled to take certain actions in the event of a mistake as to the eligibility or participation of an employee or other individual, or the amount of benefits paid or to be paid to a participant or other person. To the extent the Plan Administrator deems it administratively possible and permissible under law, it will allocate, withhold, or otherwise make adjustment or recovery of such amounts. Such action by the Plan Administrator may include, but is not limited to, withholding of any amounts due to the Plan or the Employer from compensation paid by the Employer, to the extent allowed by law.

**5. Who is the Named Fiduciary and what does that mean?**

To the extent ERISA applies, the Plan Administrator and the insurer are the "named fiduciaries" of the Plan in accordance with ERISA Section 402(a), and as such are responsible for different aspects of the operation of the Plan for the covered employees. The insurance companies for the respective benefits are responsible for (a) determining eligibility for and the amount of any benefits payable under their respective benefits, and (b) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective benefits. Except as delegated to the insurers, the Plan Administrator has full and complete authority, responsibility, discretion and control over the management, administration, and operation of the Plan, including, but not limited to, formulation, adoption, issuance and application of procedures and rules, and change, alteration or amendment of such procedures and rules in accordance with the law, interpretation and application of the provisions of the Plan, and determinations concerning eligibility for benefits.

Subject to your rights explained in Section VI, the Plan Administrator's determinations will be final, conclusive and binding on all parties as to all aspects of the Plan, including any portion of the Plan not governed by ERISA. If you have any questions regarding your eligibility for, or the

amount of, any benefit payable under the insured benefit policies, please contact the appropriate insurer/HMO.

The Wisconsin Bankers Association and Wisconsin Bankers Association Employee Benefits Corporation, Inc. are not fiduciaries with respect to the Plan.

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## V. CLAIMS AND REVIEW PROCEDURE

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### A. GENERAL INFORMATION

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The booklet for a specific benefit should be examined for the requirements as to notice and the presentation of proof of claim to the insurer and for claims and review procedures. Contact the insurer for information on how to file.

For purposes of the determination of the amount of, and entitlement to, benefits provided under the booklets, the respective insurer or HMO is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance or HMO contract.

To obtain benefits from the insurer of a particular benefit, you must follow the claims procedures under the applicable booklet, which may require you to complete, sign and submit a written claim on the insurer's form. In that case, the form is available from the insurer or HMO.

The insurer or HMO will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. The insurer or HMO has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim.

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### B. CLAIMS PROCEDURES/LEGAL ACTIONS

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#### 1. What if the procedures are not followed in processing my claim?

In case of your failure to follow claim procedures consistent with Federal requirements with respect to a benefit governed by ERISA, you would not be entitled to pursue any available remedies under an action under ERISA Section 502(a). For example, no action at law or in equity may be brought to recover benefits under the Plan until the appeal rights described in Section V.A

have been exercised and the Plan benefits requested in such appeal have been denied in whole or in part.

In case of the failure of the Plan to follow claim procedures consistent with Federal requirements in processing your claim, you may be entitled to pursue any available remedies under an action under ERISA Section 502(a).

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## **VI. STATEMENT OF ERISA RIGHTS**

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This Statement of ERISA supercedes any Statement of ERISA Rights in booklets. To the extent that ERISA applies to the Plan, participants in the Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, if applicable, all documents governing the Plan, including insurance contracts, if applicable, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, if applicable, and copies of the latest annual report (Form 5500 Series), if any, and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any. When applicable, the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### **2. Continue Group Health Plan Coverage**

- If applicable, 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 (see, e.g., Appendix C) and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions, if applicable, under your group health plan, if you have creditable coverage from another

plan. To the extent a plan benefit is subject to HIPAA requirements, you should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer (e.g., insurer or HMO) when you lose coverage under such plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion, to the extent provided for under the Plan benefit, for 12 months (18 months for late enrollees) (or such lesser periods of time as provided in the policy for the benefit) after your enrollment date in your coverage.

### **3. 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 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. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

### **4. Enforce Your Rights**

If your claim for a benefit under the Plan 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. Except as precluded by law, the Claims and Review Procedure in Section V of this Summary describes steps that must be exhausted prior to your filing suit in a court.

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, if any, from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits 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 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 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.

**5. Assistance With Your Questions**

If you have any questions about the 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 also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**ATTACHMENT TO THE  
SUMMARY PLAN DESCRIPTION OF THE WELFARE BENEFIT PLAN OF  
\_\_\_\_\_ ("PLAN SPONSOR")**

**List of Related Employers (Other Than Plan Sponsor) Maintaining the Plan**

Name:

Address

Federal Employer I.D. Number:

Telephone Number:

Name:

Address:

Federal Employer I.D. Number.

Telephone Number:

Name:

Address:

Federal Employer I.D. Number:

Telephone Number:

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