

UNDERSTANDING THE “HOLD HARMLESS” PROVISION



As you may know, the Fund will defend participants and dependents who are being pursued by a provider for payment of a claim if the reason for the Fund’s denial of the claim was that the provider was late in submitting the claim to the Fund. However, in order for the Fund to defend you, the following requirements **must be met:**

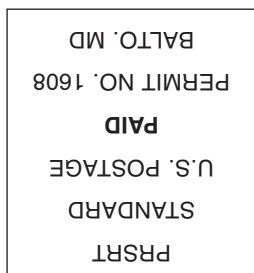
1. If you receive any bill, lawsuit or other correspondence from the

provider for services that you received, and you believe the “hold harmless” rule applies, you must contact the Fund office **within two weeks** to notify us that the provider is pursuing you, and to request that the Fund defend you against attempts by the provider to collect payment. This two-week notification requirement applies to every bill, lawsuit or other piece of correspondence you receive, even if it is a copy of a previously issued document. ***If you don’t notify us within the two-week period, the Fund cannot defend you*** and the provider can hold you responsible for the bill.

2. If you receive a bill from a provider, it may be that the Fund office has not received or paid it yet. The hold

harmless protection applies when the Fund has **denied** the claim for lateness and the provider then attempts to collect the claim amount from you. In other words, just because you receive a bill, don’t automatically apply for hold harmless protection. Contact the Fund office to make sure we’ve received it.

Finally, please note that the Fund will not defend you against a provider’s collection attempts if the reason for the provider’s late filing of the claim was your failure to inform the provider of your Fund coverage.



For Your Benefit

OPEN ENROLLMENT FOR MEDICAL COVERAGE IS JULY 15TH—SEPTEMBER 15TH

The following article applies to actively working participants in Plan I, Plan X and Plan XX.



Open Enrollment for choosing how your medical coverage will be provided is from July 15 – September 15 for coverage effective October 1, 2008 – September 30, 2009. During open enrollment, you may choose whether your medical coverage will be provided through an HMO (Kaiser Permanente) or

through the Fund under traditional medical coverage.

HOW DOES OPEN ENROLLMENT WORK?

During July, you should receive a letter from the Fund office, along with a packet of important information from the HMO (Kaiser Permanente). A Benefit Summary explaining the HMO benefits will be included, along with an enrollment form. **Please read the Kaiser Permanente information carefully.**

HOW DO I ENROLL?

If you decide you want Kaiser, complete the enrollment form for Kaiser

Continued on page 4

HEALTH COACHES ARE AVAILABLE 24/7

Health Coaches are available to actively working participants who are not in an HMO. They are also available to retirees who are not Medicare eligible and not in an HMO (whether CIGNA or Kaiser).

Health Dialog, a Health Coaching program brought to you by the FELRA & UFCW Health and Welfare Fund, can provide free information and support on a wide range of health care issues. Health Coaches are specially trained health care professionals such as nurses, respiratory therapists, and dietitians, available by phone 24 hours a day, seven days a week.

Whether you're facing an important medical decision or want to take better care of yourself and your family, call a Health Coach at 1-866-469-6331. You can also get information online at www.thedialogcenter.com/FELRA.

SPECIAL SECTION FOR RETIREES: "RETIREE CORNER"

See page 2.

To address the needs of our Retirees, a special section of this newsletter is devoted to Retiree issues. Read this section for important changes or reminders about your benefits.

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ENROLL IN MEDICARE PART B AND LET THE FUND OFFICE KNOW

As you know, Medicare is the federal health insurance program for people age 65 and over, and for certain disabled persons. Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). Medicare is available at the beginning of the month in which you turn 65 (a month sooner if your birthday is on the first of the month), whether you are retired or still working. It is also available after you have been entitled to Social Security



disability benefits for two years (sometimes sooner), and if you have end-stage renal disease (kidney failure).

ENROLLING IN MEDICARE

If you are eligible for Retiree Health and Welfare coverage through the Fund and you—or any covered dependent—become Medicare eligible at any age, for any reason, ***you must enroll in Medicare Part B*** at the earliest date you are eligible for it. Regardless of whether you or your eligible dependent enrolls in the Medicare Part B program, ***the Health and Welfare Fund will not pay any benefits that are available under the Medicare program.***

Future retirees who are Medicare eligible should call their local Social Security Administration Office at least three months before retiring to find out how to apply for Medicare.

SEND COPY OF MEDICARE CARD WHEN ENROLLED IN MEDICARE

Once you've enrolled in Medicare Part B, ***please be sure to send a copy of your Medicare card to the Fund office.*** The information shown on the card is used to update our records and to adjust your monthly co-payment. In most cases, your co-payment will be reduced to a lower rate. Sometimes participants notify us months later that they are enrolled in Medicare, resulting in a complicated process of adjustments. Once we receive your Medicare card, we will send you a letter explaining what your changes will be, if any.

RECEIVE YOUR PENSION MONEY FAST & EASY: USE EFT

Electronic Funds Transfer (EFT) is the secure, convenient and efficient way to receive your pension check. Instead of receiving your pension check in the mail and taking it to your financial institution, you'll know that your check is safely deposited into your account electronically.

SECURITY

By having EFT, you no longer have to worry about lost, stolen or misplaced checks.

CONVENIENCE

You no longer have to worry about weather conditions and getting your pension check deposited. With EFT you will have peace of mind knowing that, whatever the circumstance, your check is in your account the morning of the payment date.

RELIABILITY

You don't have to wait for your pension check to arrive in the mail. If you're on vacation, you'll know that your check is not sitting in your mailbox, but is securely in your account on time.

To take advantage of this convenient option, call the Pension Department of the Fund office at (800) 638-2972 and we'll send you an EFT enrollment form to complete. You can also download and print the form from our website at www.associated-admin.com. Once we receive your signed form, we'll contact your bank and set up the transaction. It's easy!

Join the other pensioners who enjoy this service!

NEW PLAN I SPD SENT

In January of 2008, a newly printed FELRA and UFCW **Plan I** Health and Welfare Summary Plan Description ("SPD") booklet was sent to all eligible Plan I participants. The SPD describes your benefits as well as rules regarding your eligibility, claims filing, appeal rights and much more!

If you are in Plan I and did not receive this SPD, please call the Fund office at (800) 638-2972 and we'll be glad to send one to you.

SERVICES OF CRNA OR ANESTHESIOLOGIST ARE COVERED —BUT NOT BOTH

The following article applies to non-Medicare participants whose medical coverage is provided through the Fund, not an HMO.

The Fund will cover the services of a Certified Registered Nurse Anesthetist (“CRNA”) or an anesthesiologist, **but not both for the same procedure.**

What’s the difference? A CRNA is a registered nurse who is qualified to administer anesthesia. An anesthesiologist is a medical doctor (“MD”) who specializes in administering anesthesia.

If you receive anesthesia and the Fund is billed for the services of both a CRNA and an anesthesiologist for the same operation, the Fund will pay only the anesthesiologist, not the CRNA. Services of a CRNA are only covered if an anesthesiologist has not billed the Fund.

It is a good idea to go over this with your doctor beforehand.



PLAN X PART TIMERS: OPEN ENROLLMENT FOR DEPENDENT COVERAGE IS JULY 1ST – JULY 31ST

The following article applies only to Plan X Part-Time participants.

July 1st to July 31st will be the second Open Enrollment period (there are two each year) for adding dependent (“family”) coverage to your benefits. If you are eligible for dependent coverage but did not elect it when you became first eligible, you may add the coverage in July. The coverage will be effective September 1st. The next open enrollment will be in January for coverage effective March 1, 2009.

IS THERE A COST?

Yes, there is a cost to you to add dependent coverage and it is paid by you via payroll deduction. **Do not send payment to the Fund office.** If you elect dependent coverage, your payroll deduction will begin in September. Call the Fund office to find out the rate.

WHEN WILL THE COVERAGE BEGIN?

Coverage for your dependents will begin September 1st.

HOW MANY DEPENDENTS MAY I COVER?

As long as they are eligible dependents under the Plan, you may enroll as

many dependents as you have. The cost is the same regardless of the number of dependents.

WHAT IF I WANT TO DROP DEPENDENT COVERAGE?

You may drop dependent coverage at any time throughout the year provided you notify the Fund office *in writing*. You may call us to request the proper form, which you must sign and return to us (it verifies that you wish to stop payroll deductions). However, please remember that if you **do** drop the coverage, you will not be eligible to add it again until the open enrollment period *following* a twelve-month waiting period, except in special circumstances such as a birth, adoption or marriage (see below). Open enrollment for dependent coverage occurs twice a year: in January and in July.

I WANT TO ADD COVERAGE—WHAT’S NEXT?

To add dependent coverage, simply call the Fund office at (800) 638-2972 during the open enrollment period and let us know. We’ll send you an enrollment card and begin the process for starting

your payroll deduction. We must have the completed enrollment card returned to us (along with any forms of proof which may be required, such as copies of birth certificates, etc.) before your coverage will begin.

WHAT IF I DON’T HAVE DEPENDENTS NOW, BUT I DO LATER?

If you don’t have any dependents and you then get married, have a child, adopt a child, etc., you may add dependent coverage no matter what time of year, as long as you add the dependent within 30 days from the date he/she first became your dependent (for example, within 30 days from the date of marriage, 30 days from the date of birth, etc.).

CONTACT PARTICIPANT SERVICES

If you have questions, contact Participant Services or the Eligibility Department of the Fund office at (800) 638-2972.



OPEN ENROLLMENT FOR MEDICAL COVERAGE

IS JULY 15TH—SEPTEMBER 15TH *Continued from page1*

Permanente and *send it back to the Fund office (NOT to Kaiser)! Choose*

a provider from the Kaiser directory included in your packet before you enroll. Your Plan is the “Signature” Plan. After enrolling, you will receive an ID card from Kaiser. This should arrive on or shortly after 10/1/2008.

Please note: If you are currently enrolled in Fund medical coverage and switch to Kaiser, *the change becomes effective October 1st, regardless of when your Kaiser ID card arrives.*

Starting October 1st, you must use providers in the Kaiser network.

Continue to use your white NMHC card for your prescription benefits. Participants in an HMO no longer need their green Fund ID cards. If you come back to Fund medical coverage in the future, we will send you a new Fund medical card.

WHAT IF I WANT TO CHANGE BACK TO FUND MEDICAL COVERAGE?

If you are currently in Kaiser and wish to return to traditional Fund medical coverage, call Participant Services at (800) 638-2972. Remember, you must make this change between July 15 and September 15th!

WHAT IF I WANT TO KEEP THE SAME COVERAGE I CURRENTLY HAVE?

If you wish to remain in the Plan you are in now (Kaiser or Fund medical), *don't do anything!*

FUND VS. HMO COVERAGE: WHAT'S THE DIFFERENCE?

There is *no monthly cost* for Fund medical coverage. If there is a charge for the HMO, it will be noted in your open enrollment letter.

Traditional Fund medical coverage varies by Plan. You must satisfy a deductible after which a certain percentage of the expenses are covered by the Fund with the balance payable by you. Under Fund coverage, participants in Plans I and X may use any provider they wish, although you will save money if you use a Preferred Provider Organization (“PPO”) provider. Plan XX participants must use a PPO provider.

Kaiser covers most routine services, immunizations and hospitalizations in full with a “per visit” co-payment to a physician. Under an HMO, you *must* use a participating doctor or facility. If you don't use a participating provider, services won't be covered.

WHAT IF I DIDN'T GET AN OPEN ENROLLMENT LETTER?

You will receive an open enrollment letter only if you are living in the geographic area covered by Kaiser. If you do not live in this area, your coverage will continue under the Fund automatically. If you didn't receive an Open Enrollment letter and think you should have, call the Fund office at (800) 638-2972. We will double check

If you don't do anything, you will remain in the Plan you have now, whether that is traditional Fund medical coverage or Kaiser Permanente HMO, for the next year.

whether you are in Kaiser's geographic area, and if you are, we will help you get information about the HMO.

IMPORTANT REMINDERS ABOUT OPEN ENROLLMENT

- This open enrollment period applies *ONLY* to your *medical coverage* (including mental health/substance abuse). This does not affect your optical, dental, or prescription drug coverage. Those benefits continue to be provided through United Optical/Spectera, Group Dental Service, and NMHCRx.
- Once you choose how you would like your medical coverage to be provided, you may not change again until open enrollment next year (July 15 – September 15, 2009).
- If you are a Plan X Part Timer who pays a monthly co-payment to have dependent (“family”) coverage, via payroll deduction, that will continue, regardless of which medical coverage option you choose—Fund coverage or the HMO option.
- *Open enrollment ends September 15th. Contact the Fund office on or before this date to make a change.*

If you have questions about Kaiser Permanente coverage, call Kaiser Permanente Member Services at (301) 468-6000 or toll-free at (800) 777-7902. Mention the FELRA & UFCW Health and Welfare Fund and **refer to group # 6879 if you're in Plans I or X and group # 1976 for Plan XX. This is very important.**

For questions about the enrollment process or eligibility, call the Fund office at (800) 638-2972.

GIVE COPY OF “POWER OF ATTORNEY” TO THE FUND OFFICE

If someone has “Power of Attorney” for you, or you plan to appoint someone in the future, be sure to send a copy of that document, along with his/her telephone number, to the Fund office. We need to know if someone else has the legal right to sign forms and/or make other legal decisions on your behalf.

DO YOU HAVE MEDICARE AND FUND COVERAGE? BE SURE THE FUND RECEIVES YOUR CLAIM WITHIN 180 DAYS

The following article applies to all Medicare-eligible Retirees and Medicare-eligible Dependents.

If you have Medicare as your primary medical coverage and Fund Supplemental coverage as secondary medical coverage, please be sure you file your claim with the Fund office within **180 days of the date that services were provided, whether or not you have the Medicare Explanation of Benefits (EOB) yet!**

Some providers will file the claim for you. If they do, have them file the claim with Medicare and the Fund office at the same time. Others will send you a bill. Either way, if a balance remains after Medicare has paid its portion of the claim, make sure to send

the bill, along with a copy of the Medicare EOB to:

The Fund Office
911 Ridgebrook Road
Sparks, MD 21152-9451

YOU HAVE 180 DAYS

Remember, you have 180 days from the date of service to file a claim. So if you haven't heard from Medicare within that time frame, submit your itemized bill to the Fund office ***anyway***. Your claim can then be "pended" until the Medicare information arrives. By doing this, you will have filed on time.

BE SURE TO SEND CLAIMS TO RIGHT ADDRESS!

Two years ago, the Cockeysville Fund office moved to Sparks, Maryland, and we no longer receive mail addressed to the old P.O. box.

To keep from having your claims or mail returned, ***and to be sure your claims are received on time***, send Weekly Accident & Sickness claims to:

FELRA and UFCW
Health and Welfare Fund
P.O. Box 1064
Sparks, MD 21152-1064

Some stores still have old Accident & Sickness Claim forms in stock which show our old address. ***Make sure to mail the form to our current address.***

ATTENTION SEVERANCE PARTICIPANTS: KEEP YOUR REGISTRATION UPDATED

The following article applies to participants in the UFCW & FELRA Severance Fund only. Check your Collective Bargaining Agreement ("CBA") to see if you are eligible for Severance benefits.



If you are a participant in the Severance Fund, it is very important that you complete a yellow Severance Beneficiary

Registration Card and return it to the Fund office. This card will allow you to list your beneficiary for the Severance Death Benefit. This form is ***separate***

from forms you may have completed for Life Insurance or the Pension Death Benefit. The Severance Death benefit is paid to the beneficiary named on the most recently filed card.

Because you may name different beneficiaries for different benefits (for example, your Severance beneficiary does not have to be the same person who receives your Pension death benefit), it is even more important that you keep all registrations up-to-date. ***Your enrollment card for Health and Welfare benefits is not the same as a Severance Beneficiary registration card or a Pension registration card!***

Keep all your registrations updated so your benefits are distributed the way YOU want them to be.

Every time your circumstances change (for example if you get married, divorced, or simply choose to change your beneficiary), you need to complete a Severance Beneficiary Registration benefit card. To update your card, call the Fund office toll free at (800) 638-2972 and request the Severance Department to send you one. Be sure to specify Severance.

HOW TO READ YOUR EOB (EXPLANATION OF BENEFITS)

Every time a claim is processed, the Fund office sends you and/or the provider of service an Explanation of Benefits (“EOB”). ***IT IS NOT A BILL***, but describes how your claim was processed.

The EOB gives you important information about the claim, such as:

- The amount paid and the amount for which you are responsible (if any);
- The date the claim was processed;

- The original amount billed;
- The provider of service and the date the service was performed;
- The exact service performed (determined by a special code assigned by the doctor); and,
- **VERY IMPORTANTLY**, the “**Remark Codes**” and “**Messages**” section explains how your claim was processed and gives information about deductibles, Preferred Provider Organization (“PPO”) discounts,

maximum benefit levels, allowable expenses and more.

Below is a sample of an EOB, showing different sections of the EOB and an explanation of each section. If you don’t understand your EOB or need additional information about your claim, please call Participant Services toll-free at (877) 850-0977.

EXPLANATION OF YOUR EOB

- A. Dates of Service:** The date service was performed.
- B. CPT Code:** Type of service or treatment performed.
- C. Amount Charged:** Total amount billed by the provider.
- D. Not Covered:** This amount is not necessarily an amount you owe. It could be the amount not covered by your Plan (for example, the charge above the Usual, Customary, and Reasonable or “UCR” amount) and/or it could reflect the amount discounted by the Preferred Provider Organization (“PPO”). Look at the lower part of your EOB under “Messages” for the “Code” letter/number for explanations. If the service you receive from a participating provider is not a covered service, the provider can refuse to discount the service and you would be responsible for payment of the non-covered service.
- E. Remark Codes: This is a very important part of the EOB.** These letters and numbers correspond to the lower section of your EOB under “Messages.” (See Item “O” explanation.)
- F. Allowed Amount:** The amount being considered for payment by the Fund.
- G. Deductible:** The amount, if any, which is being applied towards an annual deductible.
- H. Type:** Indicates that the service was paid under the Basic Benefit (“B”) or the Major Medical Benefit (“M”).
- I. %:** The percentage paid for that type of service.
- J. Plan Pays:** The dollar amount paid by the Fund.
- K. Medicare/Other Pymt:** Payment issued by Medicare or other insurance carrier.
- L. Patient Responsibility:** The amount that you are responsible to pay to the provider. **Please note: The Fund office does not know if you already made a payment directly to the provider. Therefore, if the “Patient Responsibility” column on your EOB shows \$45, but you know you already paid your doctor \$30, you really would only owe your doctor \$15 more.** That is between you and the provider.
- M. Total Plan Benefit:** The total benefits paid. Usually benefits are paid directly to the provider; but benefits may be paid directly to you in certain circumstances.
- N. Payment To—Amount—Check Number—Paid Date:** Indicates the name of the provider to which payment was made (hospital, physician, etc.), the amount paid to the provider, and the check number, with the date the EOB and check (if applicable) were issued by the Fund office.
- O. Line #—Code—Messages:** This section gives a detailed explanation of how expense(s) were paid, the amount (if any) that was discounted, and how much was applied to your lifetime annual major medical maximum.
- P. Appeal Rights:** This section explains the rules for appealing the Fund’s decision on your claim.

SAMPLE

Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

Explanation of Benefits - This is NOT a Bill
Please retain for Tax Purposes

200804020104



Forwarding Service Requested

FELRA & UFCW H&W FUND

If you have any questions, please call
(800) 638-2972

3-DIGIT 285



Claim #: _____
Statement Date: _____
Employee Name: _____
Employee #: _____
Patient's Name: _____
Patient Acct#: _____
Provider: _____

Line	A Dates of Service	B CPT Code	C Amount Charged	D Not Covered	E Remark Codes	F Allowed Amount	G Deductible	H Type	I %	J Plan Pays	K Medicare/ Other Pymnt	L Patient Responsibility
01	01/24/07-01/24/07	93307	1,012.00	831.08	A1	180.92	0.00	B	100	36.18	144.74	0.00
02	01/24/07-01/24/07	93320	401.00	321.42	A1	79.58	0.00	B	100	15.92	63.66	0.00
03	01/24/07-01/24/07	93325	347.00	0.00		347.00	0.00	B	100	275.01	71.99	0.00
TOTALS			1,760.00	1,152.50		607.50	0.00				280.39	0.00

TYPE	DESCRIPTION	
B	Basic Benefit	607.50
M	Major Medical Benefit	280.39
		Total Plan Benefit:
		Less COB Adjustment:
		Less Provider Discount:
		Less Provider Payment Adjustment:
		Total Benefits Paid:
		327.11

N	Payment To	Amount	Check #	Paid Date

O Line#	Code	Messages
01	A1	\$831.08 IS IN EXCESS OF MEDICARE'S ALLOWANCE.
02	A1	\$321.42 IS IN EXCESS OF MEDICARE'S ALLOWANCE.
**		*** ATTENTION PROVIDERS ***
<p>Physician or facility: HIPAA EDI regulations are effective October 16, 2003. If you are an Alliance PPO provider and would like to send your claims electronically instead of on paper, contact Alliance PPO's Professional Services Department at 800-342-6141. If you are not an Alliance PPO provider and would like to send your claims electronically to this office, please send to Payerpath, our clearinghouse. Contact support@payerpath.com and you will be contacted by a staff person to coordinate the transmission of your 837 standard transaction. We will process your electronic claim in the normal fashion, mailing an Explanation of Benefits and check to you if appropriate. If you wish to submit claims electronically but are not capable of sending the 837 transaction, contact Payerpath at sales@payerpath.com and you will be contacted about how to proceed. The Fund office will continue to process all paper claims in the usual manner. PLEASE USE PAYER ID # AA001. Participants may be held harmless from claims filed late because the provider is at fault if the participant notifies the Fund Office within two weeks of a collection attempt by the provider.</p>		

P Appeal Rights

If your claim has been wholly or partially denied (as shown in the comments section of this Explanation of Benefits, or "EOB"), you have the right to appeal this decision to the Board of Trustees. If you decide to appeal, you must do so in writing within 180 days of your receipt of this EOB. You may submit written comments, documents, and other information relating to your claim. If you so request, you will be provided with access to and copies of documents and other information that are relevant to your claim. You have the right to designate, in writing, a representative to act on your behalf. You must provide the Fund with the representative's name, address, and telephone number, and the Fund will direct all future communications to the representative.

If the Fund relied upon an internal rule, guideline, or protocol in making the decision, it will be available upon request, free of charge. If the Fund based its determination upon medical necessity, experimental treatment, or similar exclusion or limit, such explanation is available upon request and free of charge. If the Fund obtained any advice from a medical expert on the claim (even if the advice was not relied upon) the Fund will identify, upon request, the firm providing the medical expert's advice.

The Board of Trustees will review your appeal at its next scheduled meeting unless the appeal is filed within 30 days of that meeting, in which case it will be reviewed at the following meeting. If circumstances require more time for a decision, you will be notified in writing. The notice will describe the reason for the delay and the approximate date a decision will be made. The decision will be made no later than the third Board of Trustees meeting following the date the Fund receives your appeal. The review will take into account all information you submit relating to your claim. The Fund will notify you in writing of the Board of Trustees' decision within five days after the decision is made. In the event your appeal is denied, you have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA).

If your claim is denied, in whole or in part, you are not required to appeal the decision. Further, you have the right to file suit in federal or state court under Section 502(a) of ERISA on your claim for benefits. However, you must exhaust your administrative remedies by appealing the denial to the Board of Trustees before you have the right to file suit in state or federal court. Failure to exhaust these administrative remedies will result in the loss of your right to file suit, as described in the ERISA Rights statement in your Summary Plan Description.

Should you have any questions about your appeal rights, please contact Participant Services at the number shown in your SPD, or mail your appeal to "Associated Administrators, LLC., 4301 Garden City Drive, Suite 201, Landover, Maryland 20785, ATTN: Appeals Coordinator."