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 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 generally 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 <u>will not</u> 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.

Please Return Your RIF

*The following article applies to you if your pension is through the UFCW Unions and Participating Employers Pension Fund. It **<u>does not</u>** apply to participants whose pensions are through the Retail Clerks Unions and Employers Pension Plan, usually referred to as the "Atlanta Pension Fund."*

Recently, a Retiree Information Form (RIF) was sent to all retirees, asking questions about your current address, beneficiary information, whether you or your spouse have other health coverage, and information about your employment after retirement.

Please complete the form and return it to the Fund office as soon as possible. Failure to return the form may result in suspension of your benefits until we do receive it. Also, please complete all the sections. If you leave some sections blank or forget to sign the form, we must return it to you to be completed.

UFCW Unions and Participating Employers
Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451

RETURN SERVICE REQUESTED

PRESORT
FIRST CLASS
U.S. POSTAGE
PAID
PERMIT NO. 1608
BALTO. MD

FOR YOUR BENEFIT

UFCW Unions & Participating Employers Health & Welfare Fund June 2008 Vol. 24, No. 2

Plans Z and Y Part Timers: Open Enrollment for Dependent Coverage Is July 1st – July 31st

The following article applies to Part-Time Participants in Plans Z and Y.

July 1st to July 31st is the Open Enrollment period for adding dependent ("family") coverage to your benefits. During July, if you are eligible for dependent coverage, but did not elect it when you first became eligible, you may add your dependent(s) to your coverage. If you don't enroll your dependents in July, you must wait until the next open enrollment period in January, 2009.

IS THERE A COST?

Yes, you pay 20% of the cost of the coverage and your employer pays 80%. The amount you are responsible for is paid via weekly payroll deduction through your employer. ***Do not send payment to the Fund office.*** If you elect dependent coverage, your payroll deduction will begin in September. Call the Fund office toll-free at (800) 638-2972 for this year's rate (the co-pay rate changes each year).

WHEN WILL THE COVERAGE BEGIN?

Coverage for your dependents will begin September 1st.

HOW MANY DEPENDENTS MAY I ADD TO MY COVERAGE?

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 by notifying the Fund office. Call us to request the proper form, which you must sign and return to us (it verifies that you want to stop payroll deductions). But remember, 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. 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 during open enrollment, call the Fund office 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 dependent coverage can begin.

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

If you don't have any dependents now, but you later 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.

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The purpose of this newsletter is to explain your benefits in easy, uncomplicated language. It is not as specific or detailed as the formal Plan documents. Those documents always govern.

Kroger Corner

Plan K2 Employee Contributions Required Summary Material Modifications

K2 Material Modification

The Board of Trustees of the United Food and Commercial Workers Unions and Participating Employers Health and Welfare Fund ("Fund") has adopted the following changes to the eligibility and enrollment rules in the Plan K2 Summary Plan Description ("SPD"), effective September 1, 2007. Please keep this document with your SPD.

- The following is added to the end of the section entitled **"Initial Eligibility —Full Timers and Part Timers"** on page 16:

  Required Employee Contributions

  Effective September 1, 2007 and in accordance with the collective bargaining agreement, participants are required to make employee contributions to the Fund through payroll deduction in order to be eligible for Fund benefits. As part of this process, if you are enrolled in the Fund as of August 31, 2007, you must re-enroll for Fund coverage by completing and returning to the Fund Office a benefit election form and authorizing payroll deductions for coverage. Your benefits and the benefits of your dependents, if any, (only full timers are eligible for dependent coverage) will continue uninterrupted as long as the Fund Office timely receives your completed election form.

  If you fail to return the benefit election form and to authorize payroll deductions, your coverage and your dependents' coverage under the Plan will terminate effective August 31, 2007. If you do not return the forms on time, you may enroll at a later date, but your coverage will be effective the first of the month following the month in which the Fund receives the completed forms and you authorize payroll deductions. Coverage will not be retroactive. (There is an exception to this rule in limited circumstances. See page 25 of your SPD for more information.)

  When you first become eligible for benefits under the Fund, you must complete and return to the Fund Office the benefit election forms authorizing payroll deductions for coverage within thirty (30) days of your receipt of such forms. If you do not return the forms on time, you may enroll at a later date, but your coverage will be effective the first of the month following the month in which the Fund receives the completed forms and you authorize payroll deductions. Coverage will not be retroactive. (There is an exception to this rule in limited circumstances. See pg. 25 of your SPD for more information.)

  Open enrollments will occur in November of each year for coverage beginning the following January. Your election will remain in force until the next open enrollment.

- The first sentence of the section entitled **"Continued Eligibility"** on page 17 is deleted and replaced with the following:

  Once you are initially eligible, you become and remain a participant as long as you are employed by a participating employer making contributions on your behalf, you continue to authorize required payroll deductions for coverage, and you are covered by a collective bargaining agreement with a participating union.

- The following is added at the end of the section entitled **"Loss of Eligibility"** on page 18:

  #12. Your failure to authorize payroll deductions required for coverage.

- The following is added at the end of the section entitled **"Loss of Dependent Eligibility"** on page 26:

  #7. Your failure to authorize payroll deductions required for coverage.

- The following is added at the end of the section entitled **"Reinstatement of Eligibility"** on page 21:

  In order for your benefits to be reinstated as described in this section, you must authorize payroll deductions for coverage.

Plans K-2 and K-20: Open Your Mail to Prevent Delays!

The following article applies to all Kroger non-Medicare participants, both actively working and retired.

As a Kroger employee/retiree and a participant under Plan K-2 or K-20, you are covered by Anthem/Blue Cross Blue Shield PPO for medical, surgical and hospital care benefits. When you or your provider file a claim with Anthem, the Fund office may send you a letter asking for more details. It is very important that you open your mail from the Fund office and reply as soon as possible.

If we need additional information, we will hold your claim for 21 days from the date we receive it. If we do not hear back from you (either through a letter or telephone call) within 21 days, your claim may be denied. If we receive the information late, we will have to contact Anthem/Blue Cross Blue Shield to correct your claim and it may take up to 30 days to reprocess your claim.

Be sure to open your mail so your claims can be processed!

Kroger Corner

K20 Material Modification

Plan K20 Employee Contributions Required Summary Material Modifications

The Board of Trustees of the UFCW Unions and Participating Employers Health and Welfare Fund ("Fund") has made the following clarifications to the eligibility and enrollment rules for Plan K20 effective January 1, 2006. Please keep this document with your Summary Plan Description.

- The following is added to the end of the Section entitled **"Initial Eligibility—Full Timers,"** and also is added to the end of the Section entitled **"Initial Eligibility—Part Timers,"** both on page 16 of the SPD:

  Once you become eligible for benefits under the Fund, as described above, you must complete and return to the Fund Office the benefit election forms authorizing payroll deductions for coverage within thirty (30) days of your receipt of such forms. If you do not return the forms on time, you may enroll at a later date, but your coverage will be effective the first of the month following the month in which the Fund receives the completed forms and you authorize payroll deductions. Coverage will not be retroactive. (There is an exception to this rule in limited circumstances. See pg. 25 of your SPD for more information.)

  Open enrollment occurs in November of each year for coverage beginning the following January. Your enrollment will remain in force until the next open enrollment.

- The first sentence of the section entitled **"Continued Eligibility"** on page 17 is deleted and replaced with the following:

  Once you are initially eligible, you become and remain a participant as long as you are employed by a participating employer making contributions on your behalf, you continue to authorize required payroll deductions for coverage, and you are covered by a collective bargaining agreement with a participating union.

- The following is added at the end of the section entitled **"Loss of Eligibility"** on page 18:

  #12. Your failure to authorize payroll deductions required for coverage.

- The following is added at the end of the section entitled **"Loss of Dependent Eligibility"** on page 26:

  #7. Your failure to authorize payroll deductions required for coverage.

  The following is added at the end of the section entitled **"Reinstatement of Eligibility"** on page 21:

  In order for your benefits to be reinstated as described in this section, you must authorize payroll deductions for coverage.

Diabetic Coverage for Plans K-2 and K-20

*The following article applies **only** to Kroger participants in Plan K-2 or K-20.*

Your prescription plan covers the cost of the following diabetic supplies: monitors, insulin, test strips and syringes. These diabetic supplies are covered under your prescription benefits. Use your Kroger Rx ID card to purchase these supplies. If you have questions regarding this coverage, please contact Kroger Rx directly.

Other diabetic supplies such as lancets, lancing devices, calibrator solution, and alcohol wipes are covered under Major Medical, after you have satisfied the annual deductible. You must pay for these supplies up front, and then send your claim to the Fund office for reimbursement.

Send your PAID PHARMACY RECEIPT (not a cash register receipt), which shows the patient's name, item(s) purchased, and date of purchase, along with a request for reimbursement, to: UFCW Unions and Participating Employers Health and Welfare Fund, 911 Ridgebrook Road, Sparks, MD 21152-9451. Be sure to note the patient's name (CLEARLY PRINTED) and the member's Social Security Number.

Are You Taking Advantage of 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 the bank, you'll know 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 (whether you're ill, or away from home, or weather conditions are bad), 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 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, www.associated-admin.com. Once we receive your EFT form, we'll contact your bank and set up the transaction. It's easy!

Join the other pensioners who enjoy this service!

Kaiser Medicare Retirees: Send Rx Receipts to NEW Address!

If you are a Medicare Retiree covered under the Kaiser Permanente HMO option, your prescription benefits are provided through Kaiser Permanente. However, you may receive partial reimbursement from the Fund for your prescriptions if you paid more for the prescription under Kaiser than you would have paid under the Fund's prescription coverage.

Previously, you sent your prescription receipts to the Fund at a P.O. Box in Midlothian, Virginia. ***From now on, SEND THOSE RECEIPTS TO THE SPARKS, MARYLAND location of the Fund office:***

The Fund Office
Attn: UFCW Unions Fund Retiree Rx Reimbursement
911 Ridgebrook Road
Sparks, Maryland 21152-9451

You don't have to use a special blue return envelope to mail your receipts, but it does speed the process along.

Make sure you make copies of your receipts before you send them. If you don't use a blue return envelope, BE SURE to note "Attention: UFCW Unions Fund Retiree Rx Reimbursement" on your envelope so that your receipts go to the right department. Any receipts already sent to the Midlothian, VA address will be handled and processed—no need to re-send them.

Medical Coverage in Emergencies

*The following article applies only to **Plan Y20** participants.*

Using a OneNet PPO provider is mandatory for Plan Y20 participants. But, in an emergency, if you go to a non-OneNet hospital, you will be covered.

Non-OneNet claims will be covered for emergency services and admission to the hospital for ***urgent/emergency*** reasons only (not for a scheduled procedure), if you are out of the OneNet area. Emergency service is care given for the sudden onset of a medical condition with severe symptoms, such as heart attack, poisoning, severe breathing difficulties, convulsions, loss of consciousness, and other acute conditions that may be considered life threatening.

Do You Want Your Sick Pay? Be Sure to Send Claim 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 Disability claims to:

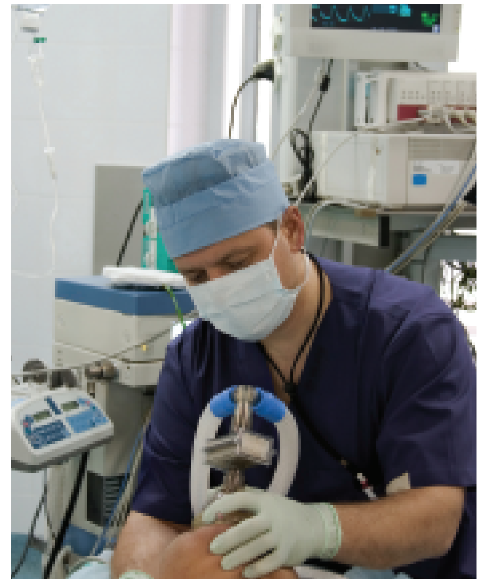
UFCW Unions & Partic. Emps.
Health and Welfare Fund
P.O. Box 1064
Sparks, MD 21152-1064

Some employers and Local Unions still have old Weekly Disability claim forms in stock, which show our old address. ***Make sure to mail the form to our current address.***

Remember, Weekly Disability claims must be filed (received by the Fund office) within 90 days from the date the disability began, so prompt delivery is very important!

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 for the same procedure.

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

Is Someone New in Your Life?

The following article applies to participants who are eligible to add dependent coverage under their Plan of benefits.

If there is someone new in your life, it is important that you notify the Fund office. Whether you get married, have a newborn baby or adopt a child, you initially have ***30 days from the date they become your dependent to enroll them in coverage.*** After that, full-time participants can still enroll their dependents, but dependent coverage will not take effect until the first of the month after the Fund receives the information. Part time participants in Plans Z and Y can add dependents only during open enrollment. See article on page one of this newsletter.

HOW DO I ENROLL MY NEW DEPENDENT?

Call the Fund office at (800) 638-2972 and ask for an enrollment card. Complete the card and return it to the Fund office along with a copy of the baby's birth certificate or adoption papers (or placement for adoption). If you have a new spouse, send a copy of your marriage certificate along with the completed enrollment card. Coverage will not begin until we receive both the enrollment card and the required proof of dependent status.

Send to:

UFCW Unions & Partic. Emps.
Health and Welfare Fund
Eligibility Department
911 Ridgebrook Road
Sparks, MD 21152-9451

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 received an Explanation of Benefits (EOB) from Medicare!***

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:

UFCW Unions & Partic. Emps.
Health and Welfare Fund
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 and the 180-day time period is almost up, send 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.

How to Read Your EOB (Explanation of Benefits)

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

When the Fund office processes a claim, you will receive an Explanation of Benefits ("EOB"). The EOB explains how your claim was processed, charge-by-charge. ***IT IS NOT A BILL,*** rather, it 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.

On page 7 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 and 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 (for example, reimbursements for vision or dental claims.)

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

Forwarding Service Requested

3-DIGIT 212
2011 0.7160 AT 0.334
9

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

UFCW **UFCW UNIONS & PART. EMP. H&W**

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

1 OF 1 F

ENV 2011

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

	A	B	C	D	E	F	G	H	I	J	K	L
Line	Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes	Allowed Amount	Deductible	Type	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
01	01/23/08-01/23/08	99284	339.00	231.40	A1	107.60	0.00	M	80	86.08	0.00	21.52
		TOTALS	339.00	231.40		107.60	0.00				0.00	21.52

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

M

Total Plan Benefit:	86.08
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	86.08

N

Payment To	Amount	Check #	Paid Date
MEDICARE	86.08	1143872	03/11/08

O

Line#	Code	Messages
01	A1	$231.40 DISCOUNTED BY ONE NET PPO (FORMERLY ALLIANCE) YOU DO NOT OWE THIS AMOUNT $24192.97 APPLIED TO LIFETIME MAXIMUM OF $400000.00.
**		*** ATTENTION PROVIDERS *** 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

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."