CVS CAREMARK
PHARMACY BENEFIT
Summary Plan Description (SPD)

The Lincoln Electric Company

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Introduction

The Prescription Drug Plan is designed to offer you quality products and dependable services. With the plan, you receive the greatest level of coverage if you use Caremark's network of participating pharmacies or Caremark's mail service pharmacy to fill your prescriptions. You can choose to have your prescriptions filled at a nonparticipating pharmacy, but you may pay more to do so.

The benefit provisions described in this booklet are effective as of January 1, 2022.

This booklet describes the basic features of the Prescription Drug Plan and how it operates. The booklet is only a summary of the key parts of the plan, and a brief description of your rights as a participant. It is not a part of the official plan documents. If there is a conflict between the official plan documents and the booklet, the plan documents will govern.

The Lincoln Electric Company has the right to modify or end the plan at any time, for any reason.

Eligibility

In order to be eligible for the prescription drug plan, you must be enrolled in the Company's medical plan. Please refer to the eligibility rules listed in the medical plan certificate.

How the Prescription Drug Plan Works

Your Prescription Drug Benefit has three parts. Note that these parts may be subject to Plan exclusions, conditions, limitations and cost sharing requirements.

The three parts are as follows:

- A retail pharmacy prescription drug program for short-term or acute prescriptions. You have the convenience of picking up short-term or acute prescriptions at your local pharmacy (subject to network requirements).

- A mail service prescription program for long-term maintenance and specialty prescriptions. With our Maintenance Choice program, you have the convenience of picking up long-term maintenance medications at your local CVS Pharmacy, Kroger and Costco (no membership needed).

- A specialty prescription program for specialty medications that require extra care, handling and/or service.
  - You will use the CVS / Specialty Pharmacy for all your Specialty medication needs.
  - You have the convenience of picking up specialty medications at a local CVS Pharmacy.
  - You have the convenience of using a network of approved specialty pharmacies. You can locate these specialty pharmacies by registering on www.Caremark.com, by downloading the CVS/Caremark app on your mobile device and registering or by calling CVS/Caremark at 800-776-1355

Your cost for a prescription drug depends on where you purchase it, whether it is a brand name or generic drug, and whether or not it is on the plan's Primary Drug List.

Under this plan you have an annual integrated deductible that applies to both medical and pharmacy claims. . When you use a network pharmacy and present your Caremark card, your purchase will be automatically reported to Caremark updating your deductible and out-of-pocket maximum.

If you are using an out-of-network pharmacy, you will be required to pay the full cost of the prescription. You will need to submit a paper claim to Caremark to update your deductible and out-of-pocket maximum, and/or to receive your 50% reimbursement. Please note: Out-of-Network purchase of Diabetic and Asthmatic medications are not covered

Where you can go for help

If you:

- Have questions about your prescription coverage;
- Need help locating a network pharmacy; or
- Want to know more about the Formulary (see the definition of Formulary).

You can conveniently register on the CVS/Caremark website at www.Caremark.com, download the CVS/Caremark App on your mobile device and register or call CVS/Caremark at 800-776-1355.

Understanding Your Prescription Drug Benefits

You should become familiar with the following terminology to better understand how your Prescription drug benefits work and to get the maximum benefit from your Plan.

Deductible

The deductible is the amount you pay during a calendar year before the Plan begins to pay benefits. The plan's deductible is a combined total of prescription and medical expenses.

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is the amount you will pay in covered expenses under the Plan during the plan year. The plan's annual out-of-pocket maximum is a combined total of prescription and medical expenses.

Formulary or Preferred Drug List

The Formulary is the list of preferred drugs that have been evaluated by CVS/Caremark and found to be clinically effective for use. CVS/Caremark has a Pharmacy and Therapeutics Committee that reviews and approves Food and Drug Administration (FDA) approved drugs for inclusion on the Formulary based on their safety and efficacy.

The drugs on this list of preferred drugs changes periodically. When a change to the Formulary is made and you are impacted, both you and your prescribing doctor will receive a notice informing you of the change and available preferred alternative medications.

To learn more about the Formulary, you can conveniently register on the CVS/Caremark website at www.Caremark.com, download the CVS/Caremark App on your mobile device and register or call CVS/Caremark at 800-776-1355.

High Deductible Health Plan (HDHP) Preventive Therapy Drug

Preventive therapy drugs are used to help avoid disease and maintain health. These drugs are not subject to the deductible. The plan allows you to buy preventive drugs at a copay. For a complete list of preventive therapy drugs, please visit www.caremark.com.

Generic Drug

This is a drug that has the same active ingredient and is chemically equivalent to the Brand Name drug and, by law, must meet the same standards for safety, purity, strength and quality as a Brand Name Drug.

Brand Name Drug

This is a drug that has one or more brand names and is protected by one or more patents.

Specialty Drug

A specialty drug is a prescription drug that can be a traditional drug, a biotech or a biological drug that is used in the management of specific chronic or genetic disease or requires special handling, distribution, administration, monitoring or patient education and counseling.

Over the Counter Drug

An over the counter drug is a drug that you can buy without a prescription. Some over the counter drugs are equivalent to a prescription drug. Your plan does not cover a prescription drug that has an over the counter equivalent.

Retail or Short Term Prescriptions

These are prescription drugs prescribed for 30 days or less.

You can have a short-term prescription filled at any Network Retail Pharmacy. Present your prescription at the pharmacy and pay your cost sharing and the Network Retail Pharmacy will electronically bill the Plan for the Plan's portion of the cost. See "Out of Network Retail Pharmacy" below for rules regarding having short term prescriptions filled at pharmacies that are not Network Retail Pharmacies.

Network Retail Pharmacy

A Network Retail Pharmacy is a member of your Plan's network of retail pharmacies. The network has been created by CVS/Caremark to provide special benefits or pricing for Plan participants. You will receive the maximum Plan retail pharmacy benefit when you have your prescription filled at a Network Retail Pharmacy. These pharmacies will electronically bill the Plan for the Plan's portion of the cost. You do not need to file a claim when you use a Network Retail Pharmacy.

Out-of-Network Retail Pharmacy

Pharmacies that are NOT part of your Retail Pharmacy Network are called Out-of-Network Retail Pharmacies. Short-term prescriptions filled at an Out-of-Network retail pharmacy are covered by the Plan. However, they require you to submit a paper claim form to CVS/Caremark for coverage consideration under the Plan. Out-of-Network Retail Pharmacies typically will not file a claim for you.

Maintenance (long-term) or Mail Order Prescriptions

Maintenance drugs are those drugs you take on a regular or long-term basis to treat chronic conditions (for example: high blood pressure, heart conditions and diabetes).

Maintenance prescriptions must be filled through the CVS/Caremark mail order service, Kroger or Costco (no membership needed). You have the convenience of picking up long-term maintenance medications at your local CVS Pharmacy. Your cost sharing will be the same as the mail order cost sharing.

If your physician prescribes a maintenance medication, it is a good idea to ask him or her to provide you with two prescriptions:

- One for a 30-day supply to be filled immediately with one or two refills at the local Retail Network Pharmacy, and
- One for up to a 90-day supply to be filled by CVS/Caremark through its mail order service program.

You may fill or refill a maintenance prescription online by registering at www.Caremark.com or by downloading the CVS/Caremark app on your mobile device and registering or you may call CVS/Caremark on a touch-tone phone at 800-776-1355.

Utilization Management

CVS/Caremark provides utilization management services. Utilization management services are special programs, guidelines, requirements of services designed to improve the quality of care you receive and to help control overall Plan costs. CVS/Caremark provides the following programs through your Plan:

Utilization Review (UR) Pharmacy: A CVS/Caremark pharmacist will evaluate patient drug utilization to identify prescription use that may lead to a severe medical condition and/or unnecessary medical costs. CVS/Caremark contacts your physician if a potential drug-induced disease or interaction is identified.

Prior Authorization (PA): This is a program designed to help ensure the appropriate use of selected prescription drug classes. The pharmacist will contact your prescribing doctor when a prescription requires a prior authorization for medical necessity.

Quantity Limits (QL): Medications with the potential for over or misuse by patients will have a limitation on the maximum quantities which may be dispensed.

Step Therapy: The Plan will cover lower cost medications such as Generic Drugs and Preferred Brand Name drugs as the first step before higher cost medications are considered.

Generic Step Therapy: Generic Drugs, when available, will always be the first step before a brand name drug is considered.

Specialty Guideline Management: Evidence based guidelines from the CVS/Caremark Pharmacy and Therapeutics Committee are applied to a specialty drug before it is dispensed. The pharmacist and CVS/Caremark will obtain permission from your physician prior to changing your prescriptions.

Specialty Preferred Drug Step Therapy: The lowest net-cost specialty drugs in select therapeutic categories must be used before other higher-cost drugs are approved

Drug Savings Review and Prescription Savings Guide: You will receive letters from CVS/Caremark showing you ways you can save money by taking alternative prescriptions.

Pharmacy Advisor Counseling: This program provides one-on-one counseling either in person or on the telephone to help you follow the prescription drug recommendations.

Opioid Utilization Management: This program is designed to reduce inappropriate use of prescription opioids WITHOUT restricting access for those that have a legitimate need. It is aligned with the Guideline for Prescribing Opioids for Chronic Pain from the Centers for Disease Control and Prevention (CDC).

For questions about Utilization Management benefits, call Caremark's specialty unit at 1-800-237-2767 or visit www.caremark.com.

Drugs and Services Not Covered

Please remember, just because a licensed medical provider prescribes a medicine does not make it medically necessary or covered by the Plan. The Plan does NOT cover drugs or services described below:

- Dispensed before the effective date of you or your dependent's participation in the Plan or after you or your dependent's participation in the Plan ends.
- That are refilled later than one year after the date of the original prescription date.
- For which Federal Law does not require a prescription (although one may be required under State Law) from an authorized provider (except insulin, insulin analogs, insulin pens and prescriptive and nonprescriptive oral agents for controlling blood sugar level); and drugs, insulin or covered devices for which no valid Prescription is obtained.
- Cosmetic drugs used primarily to enhance appearance, including, but not limited to correction of skin wrinkles and skin aging.
- Athletic performance enhancing drugs.
- That are entirely consumed or administered at the time and place the prescription order is issued (e.g. at a hospital or nursing home). See your medical

plan SPD to see whether such drugs are covered by that plan (often being considered part of the medical services).

- Associated with the administration of any drug.
- Received from a source other than a retail or mail-order pharmacy.
- For which you (or the pharmacy) do not file a claim within 12 months after the prescription or service is provided.
- That exceed the supply limitations.
- That exceed the prescribed quantity.
- That are available in the same strength without a prescription.
- That are blood derivatives that are not officially classified as drugs except blood derivative products used as an ingredient in a biotech drug.
- That are used for off-label use, except as otherwise approved by the Claims Administrator.
- Shipping, handling or delivery charges.
- Fertility drugs
- Drugs to treat erectile dysfunction

Other Drug Limits

The plan places limits on the benefits it provides for certain drugs. The following are some examples:

- Growth hormones — require a medical diagnosis with a prescription and covers them only through mail service
- Retin-A — generic only is covered
- Smoking cessation — no OTC covered

For questions on specific drugs and drug limits, please contact the customer care team at 800-776-1355 or visit www.caremark.com.

Filing Claims

If you have purchased a prescription from a network pharmacy without your Caremark account, you can submit a paper claim to Caremark for reimbursement of the difference between the purchased price and the negotiated discount.

A claim is a written, signed request to the claims administrator for benefits under the plan following the plan's procedures. The claim must be sent in a properly stamped envelope and deposited in the U.S. mail. The timeframe for processing a claim begins when the claims administrator receives it. The plan will not pay for services if a claim has not been received by the plan within 15 months of the date the services were completed.

When Coverage Ends

Coverage ends when your participation in the Anthem medical plan ends. Please refer to the medical plan document.

Situations Affecting Your Benefits

Some situations may affect your eligibility to receive prescription drug benefits.

Subrogation Rights

If you are hurt in an accident and have a third party or insurance that may be legally liable for your prescription drug bills, this plan pays its normal benefits for covered care. The plan has the right to be paid back by the responsible person or organization. If you receive payment from that third party, including payments from insurance held by you or by the third party, as the result of a judgment, or if the case is settled out of court, the plan has the right to be paid back from that payment.

This applies even if the amount you received did not compensate you in full for your losses. This right gives the plan a priority over any funds paid, including any claim for nonmedical or nondental charges, lawyers' fees or other costs. The plan may pursue any claim you have against any third party or insurer, whether or not you choose to pursue that claim. The plan's rights and priority are limited to the extent the plan has made or will make benefit payments for the injury or illness, but do extend to any costs that result from the enforcement of its rights under the plan.

You and anyone who represents you must cooperate fully with the plan when it works to collect from the person who is responsible for the injury or death. In addition, you and anyone who represents you must do nothing to prejudice the right of the plan to recover the benefits it has paid.

Right of Recovery

If a claim overpayment has been made, for whatever reason, or if you or a covered dependent owe the plan, such as for unpaid contributions, the plan administrator will work with you to determine the method by which the repayment to the plan is to be made. The plan administrator has the right to offset the amount you owe the plan against any future benefit payments to you or your covered dependent.

Coordination of Benefits

Your Prescription Drug Plan does not contain a coordination of benefits (COB) provision. This type of provision coordinates payments of benefits when you or a dependent has coverage under more than one plan.

If You Have Questions

For additional information about your rights and obligations under the plan, you should review this Summary Plan Description. If you have questions about the plan

or your COBRA continuation coverage rights, contact Lincoln Electric's U.S. Benefits Team at 216-383-2476.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

Claims Procedures and Appeals Process

The plan administrator is responsible for claim and appeal procedures and has delegated authority for claims processing to the claims administrator.

When you file a claim, the claims administrator reviews the claim and makes a decision to either approve or deny the claim. The claims administrator has the full discretionary authority to:

- Interpret the provisions of the plans — such interpretation will be final and conclusive on all persons;
- Determine eligibility for benefits;
- Provide employees with a reasonable notification of their benefits available under the plan; and
- Approve reimbursement requests and authorize the payment of benefits.

Keep in mind, the plan administrator has ultimate responsibility for final determination of all claims.

If your benefit claim is denied, in whole or in part, you'll receive written or electronic notification from the claims administrator within the timeframes noted in the following table.

Timing for Notification of Claim Decision

Type of Claim	Notice of Claim Decision	Extension
Urgent care, including urgent care that is *concurrent care* involving the extension of a course of treatment or number of treatments	As soon as possible, taking into account the medical demands, but not later than 72 hours (24 hours for concurrent care if the claim is made 24 hours before the course of treatment or number of treatments ends) after the plan receives your claim. If you fail to provide sufficient information with the claim to determine whether, or to what extent, benefits are payable from the plan, you'll be notified no later than 24 hours after the plan receives your claim about the specific information you need to submit. You will have at least 48 hours to provide this information. You'll be notified of the claim decision as soon as possible, but not later than 48 hours after the earlier of the plan's receipt of the specific information or the end of the period during which you may provide this information.	Not applicable
Concurrent care decisions involving nonurgent care for the reduction or elimination of a course of treatment before the end of the course of treatment or number of treatments	Sufficiently in advance of the reduction or termination of a course of treatment to allow time for you to appeal and get a review before the benefit is reduced or eliminated.	Initial notification may be extended up to 15 days if an extension is necessary due to matters beyond the control of the plan. If you failed to submit necessary information, the notice will specify what information is necessary, and you'll have 45 days to provide it.
Pre-service claims	Within a reasonable time appropriate to the health circumstances, but not later than 15 days after the plan receives your claim.	Initial notification may be extended up to 15 days if an extension is necessary due to matters beyond the control of the plan. You'll be notified before the end of the first 15 day period why the extension is necessary and when the plan expects to make a

Type of Claim	Notice of Claim Decision	Extension
		decision. If you failed to submit necessary information, the notice will specify what information is necessary, and you'll have at least 45 days to provide it.
Post service claims	Within a reasonable time, but not later than 30 days after the plan receives your claim.	Initial notification may be extended up to 15 days if an extension is necessary due to matters beyond the control of the plan. You'll be notified before the end of the first 30 day period why the extension is necessary and when the plan expects to make a decision. If you failed to submit necessary information, the notice will specify what information is necessary, and you'll have at least 45 days to provide it.

If Your Claim Is Denied

If your claim is denied, in whole or in part, you'll receive a written or electronic notice that contains all of the following:

- A reference to the specific reasons for the denial.
- The specific plan provisions on which the denial is based.
- If an internal guideline or other similar criterion was relied on to determine a claim, you'll receive either a copy of the actual criterion, or a statement that the criterion was used and how you can request a copy free of charge. If the denial is based on a provision such as medical necessity, experimental treatment or a similar exclusion or limit, you'll receive either an explanation of the scientific or clinical judgment for the determination based on the plan terms and your medical circumstances, or a statement that you can receive the explanation free of charge upon request.
- A description of any additional material or information needed to perfect the claim and an explanation of why it's necessary.
- An explanation of the plan's claim review procedures, applicable time limits and your rights to bring a civil action under ERISA section 502(a) following a denial on review.
- An explanation of the expedited claim review procedure for an urgent care claim. In the case of an urgent care claim, the plan may notify you by phone or fax and follow up with a written or electronic notice no later than three days after the notification.

Filing an Appeal

You, your beneficiary or your authorized representative may appeal a claim decision by writing to your claims administrator. You must make your request for appeal within the time limits shown below:

Type of Claim	**Days Limit**
Prescription drug, first appeal of a denied claim	12 months after the end of the calendar year during which the incident leading to your appeal occurred
Prescription drug, second appeal of a denied claim	60 days after receipt of the claims decision

During the applicable time period, you or your authorized representative will be given reasonable access to all documents, records and information relevant to the claim for benefits, and you may request copies free of charge. You can also submit to your claims administrator written comments, documents, records and other information relating to the claim for benefits. Review of your claim will take into account all comments, documents, records and other information, without regard to whether such information was submitted or considered in the initial benefit determination.

For an urgent care claim, all necessary information, including the decision on review, may be provided by phone, fax or any other similarly expeditious method. To request a fax number or other method of submitting information, contact the claims administrator.

Appeal Decision

The claims administrator will review the claim again and make a decision based on all comments, documents, records and other information you've submitted. For a group health plan claim:

- A person other than the original reviewer will review the claim decision.
- If the denial was based, in whole or in part, on a medical judgment, the person will consult with a health care professional who has appropriate training and experience in the field involving the medical judgment. This health care professional cannot be the same person who made the initial decision of denial, nor a subordinate of the person. Medical or vocational experts who are consulted in the claim process are identified in the final decision without regard to whether the advice was relied upon in making the claim determination.
- For an urgent care claim, there will be an expedited review process where you can submit, orally or in writing, a request for review. Necessary information may be transmitted between you and the plan by phone, fax or any other similarly expeditious method.

Notification of Appeal Decision

In most cases, you'll receive the claims administrator's written or electronic notification of the decision within the following timeframes after the claims administrator receives your request for review:

Type of Claim	Timing of Notification
Urgent care claim	As soon as possible, taking into account the medical demands, but not later than 72 hours after the plan receives the request for review.
Concurrent care claim	**For an urgent claim for ongoing care**: as soon as possible, taking into account the medical demands, but not later than 72 hours after the plan receives the request for review. **For a nonurgent claim for ongoing care:** timing of notification will be handled under pre-service or post service claim timeframes addressed below, depending on the type of claim.
Pre-service claim	A reasonable time appropriate to the health circumstances, but not later than 15 days (for each level of appeal) after the plan receives the request for review.
Post service claim	A reasonable time, but not later than 30 days (for each level of appeal) after the plan receives the request for review.

If your appeal is denied, in whole or in part, you'll receive a written or electronic notice that contains all of the following:

- The specific reasons for the denial.
- A reference to the specific plan provisions on which the denial is based.
- A statement that you are entitled to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to the claim.
- A statement describing any voluntary appeal procedures under the plan, your right to get information about the voluntary appeal procedures and your right to bring a civil action under ERISA section 502(a).
- If an internal guideline or other similar criterion was relied on to determine a claim, you'll receive either a copy of the actual criterion, or a statement that the criterion was used and how you can request a copy free of charge. If the denial is based on a provision such as medical necessity, experimental treatment, or a similar exclusion or limit, you'll receive either an explanation of the scientific or clinical judgment for the determination based on the plan terms and your medical circumstances, or a statement that you can receive the explanation free of charge upon request.

If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, you must do so no later than 180 days after the claims administrator makes a final determination to deny your claim.

External Appeals

If the plan continues to deny benefits for the service, you may request a review from another source for the following reasons:

- They are not medically necessary according to the plan and the service has not been incurred yet and non-receipt of the service would jeopardize your life or health.
- They are experimental/investigative.

To qualify for this review you must meet all of the following reasons:

- You request an external review from the administrator no later than 60 days after receipt of notice of the result of the plan's internal review.
- You have exhausted all levels of our internal review process.
- The drug, device, procedure or other therapy would be covered if it were not considered to be experimental or investigational.

The plan obtains external reviews from an independent review organization (IRO) that is not affiliated with the plan. The plan pays the cost for the IRO review.

Your request for external review must be in writing except if your physician determines that a therapy would be significantly less effective if not promptly initiated. In this case, the review may be requested orally or by electronic means. When you make an oral or electronic request for external review, you must follow up with written confirmation of the request to the administrator no later than five business days after your initial request.

The IRO must provide the administrator with a response within 30 days of your request for an external review. The IRO's decision must include:

- A description of the patient's condition;
- The principal reasons for the decision; and
- An explanation of the clinical rationale for the decision.

If the IRO determines that the service is medically necessary or not experimental/investigative, the plan must provide benefits for the service. If the IRO determines that the service is not medically necessary, the plan does not have to provide benefits for the service.

Administrative Information

This section provides you with information about how your Prescription Drug Plan is administered.

Plan Name

The Lincoln Electric Flexible Benefits Program

Prescription drug coverage described in this Summary Plan Description (SPD) is part of the Anthem Medical plans and referred to in this summary as the Prescription Drug Plan or plan. The Anthem Medical plans are group health plans subject to the Health Insurance Portability and Accountability Act (HIPAA). The

plans provide medical and prescription drug benefits. All benefits of the medical plans**,** other than prescription drug benefits, are described in a separate Summary Plan Description.

Plan Sponsor

The Lincoln Electric Company

22801 St. Clair Avenue

Cleveland, OH 44117

Plan Administrator

Caremark

800 Biermann Court

Mt Prospect, IL 60056-2173

Claims Administrator

Caremark

800 Biermann Court

Mt Prospect, IL 60056-2173

Under the terms of the plan, the claims administrator has been allocated full discretionary authority over benefit determinations.

Benefits under the plan will be paid only if the claims administrator decides in its discretion that under the terms of the plan the applicant is entitled to the benefit.

Employer Identification Number

34-0359955

Plan Number

503

Plan Funding

Unfunded welfare plan with contributions made by employees and the company.

Plan Year

January 1 through December 31

Right to Amend or Terminate the Plan

The Lincoln Electric Company reserves the right to amend or terminate the medical plan at any time for any reason, or as required to comply with applicable federal law or regulations. In such a case, you would be properly notified of any changes, and all changes would be subject to the plan's provisions and applicable laws. Keep in mind, health care benefits, such as prescription drug coverage, do not vest like retirement plan benefits. That means you do not have a guaranteed right to receive plan benefits.

No Employment Guarantee

Being a participant in the plan does not grant any current or future employment rights.

Privacy Information

During the administration of the plan, the plan and claims administrators may come into contact with what is considered "protected health information" under the Health Insurance Portability and Accountability Act (HIPAA). The Company has taken specific steps to protect and limit access to this information. For example, the company has:

- Designated a Privacy Official
- Developed privacy policies and procedures
- Implemented safeguards to protect against improper disclosure
- Provided a complaint resolution process
- Developed sanctions for employees and business partners that violate privacy policies
- Established confidentiality agreements with business associates

As part of our compliance efforts, we must provide a privacy notice to employees. If you would like to review the privacy policies and procedures, receive another copy of

the privacy notice, or just need more information, please contact the U.S. Benefits Team at 216 383-2476 or go on-line to www.lincolnconnect.com.

Your ERISA Rights

As a participant in the Prescription Drug Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the 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 for 12 months (18 months for late enrollees) after your enrollment date for coverage in your new plan.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so

prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted the claims appeals process mentioned in this SPD. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact your Human Resources Representative. 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 contact 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. When writing, please include the employer and plan numbers listed in *Administrative Information*.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.