FAIRLEIGH DICKINSON UNIVERSITY

FLEXIBLE SPENDING ACCOUNT PLAN

FOR

Fairleigh Dickinson University

CONTRACT NUMBER: 700734

EFFECTIVE DATE: January 1, 2008

Flexible Spending Account Plan

NOTICE TO EMPLOYEES

This booklet describes the Employer-sponsored Flexible Spending Account Plan ("Plan") as of January 1, 2008.

Fairleigh Dickinson University has entered into an arrangement with United HealthCare Insurance Company ("UnitedHealthcare") under which UnitedHealthcare will process reimbursements and provide certain other administrative services to the Plan.

UnitedHealthcare does not insure the benefits described in this booklet.

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PLAN HIGHLIGHTS

Under the Plan, you can elect to establish two Flexible Spending Accounts ("FSAs") which you fund with before-tax contributions from your salary, and which you then use to reimburse yourself for Eligible Expenses.

The Health Care Spending Account ("HCSA") is for reimbursement of eligible health care expenses, including certain medical and dental expenses for you, your spouse, your dependent children, and any other dependents you can claim on your federal tax return.

The Dependent Care Spending Account ("DCSA") is for reimbursement of eligible dependent care expenses, such as day care.

You can elect to participate in the HCSA, the DCSA, or both.

Each Plan Year (January 1 through December 31) you can contribute to your HCSA and DCSA, and then, during the Plan Year, you can receive reimbursement from the appropriate account for Eligible Expenses that are not otherwise reimbursed. Contribution levels are set forth below.

WHO IS ELIGIBLE AND HOW TO START YOUR FLEXIBLE SPENDING ACCOUNT

Who is Eligible

Regular full-time employees of the Plan Sponsor who are scheduled to work at his or her job at least 35 hours per week are eligible to participate in the Plan.

When You May Enroll

You may elect to participate in the Plan during your first 60 days of employment or during any subsequent annual enrollment period. If you do not elect to participate during your first 60 days of employment, you must wait until the next annual enrollment period to elect to participate in the Plan, unless you have experienced a qualified change in status. (See the ***Changing Your Contribution Amounts*** section below.) You will need to enroll each year, even if you enrolled in the Plan the year before.

How to Enroll

You elect to participate in the Plan by completing an enrollment form. You must specify the amount of before-tax dollars you wish to contribute to the HCSA, the DCSA, or both.

CONTRIBUTIONS

Each year, you must decide the amount of before-tax dollars you want to contribute to the accounts. You may contribute to the HCSA or DCSA, or both, however, amounts contributed to one account can not be used to reimburse expenses under the other account. You should carefully estimate your Eligible Health Care and Dependent Care Expenses, collectively referred to throughout this booklet as "Eligible Expenses", for the upcoming Plan Year because IRS regulations require that you forfeit any unused funds remaining in either account after the end of the Plan Year, including those unused funds remaining after a 2.5-month period following the end of the Plan Year.

For the Health Care Spending Account, you have until March 31 of the next year to request reimbursement for Eligible Expenses incurred during the Plan Year and those incurred during the first 2.5 months following the end of the Plan Year.

For the Health Care Spending Account, you may elect to contribute up to a maximum of $2,500 a year.

For the Dependent Care Spending Account, you have until March 31 of the next year to request reimbursement for Eligible Expenses incurred during the Plan Year.

For the Dependent Care Spending Account, you may elect to contribute up to a maximum of $5,000 a year, or if you are married and filing separately for federal income tax purposes, you may elect to contribute up to $2,500 a year.

CHANGING YOUR CONTRIBUTION AMOUNTS

IRS regulations do not permit you to stop or change the amount you contribute to a flexible spending account during the Plan Year, unless you meet one of the following conditions:

A. With regard to both a HCSA and a DCSA, one of the following changes in status occurs:

- An event that results in a change in your legal marital status, including your marriage, the death of your spouse, or your divorce, legal separation or annulment.
- An event that results in a change in the number of your dependents, including birth, adoption, placement for adoption or death of a dependent.
- An event that results in a change in the employment status of you, your spouse or dependent, including termination or commencement of employment, a strike or lockout, the commencement of or return from an unpaid leave of absence, and a change in work site.
- An event that causes your dependent to satisfy or cease to satisfy the eligibility requirements for dependent group health coverage or coverage under the DCSA due to the attainment of age, student status or any similar circumstances, as provided under the group health plan under which you receive coverage or under the DCSA, as applicable.
- A change in the place of residence of you, your spouse, or dependent, as allowed by IRS regulations.

B. For individuals who participate in a HCSA, the following additional events will enable you to change your election:

- If you are eligible for "special enrollment" pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). (Note: Not all types of health care spending accounts are subject to HIPAA's special enrollment rules.) See your employer to find out if you are eligible for special enrollment under HIPAA. If so, a change in election for birth, adoption or placement for adoption will be effective as of the date of the change in status event, as long as enrollment occurs within 30 days of the change in status.
- If you become entitled to Medicare or Medicaid, you may elect to revoke your HCSA coverage.
- If the FSA Plan Sponsor receives a judgment, decree or order resulting from your divorce, legal separation, annulment or change in legal custody that requires group health coverage for your dependent child then the FSA Plan Administrator may:
  - If the order requires you to provide coverage for the child under the HCSA, change your election to provide coverage for that child.
  - If the order requires your former spouse to provide coverage, permit you to cancel your child's coverage under the HCSA.

C. For individuals who participate in a DCSA, the following events, in addition to those in (A.) above will enable you to change your election:

- A change in your dependent care provider.
- If your dependent care provider significantly increases or decreases the cost of the dependent care, but only if the dependent care provider that imposes the cost change is not related to you.

The above rules are intended to be consistent with the IRS regulations under Section 125 of the Internal Revenue Code, and to the extent there is any inconsistency, those regulations shall control.

Any new election hereunder must be on account of and correspond with the change in status event. As used herein, "dependent" means a tax dependent under Section 152 of the Internal Revenue Code.

Changes in contribution amounts made during the Plan Year are effective as of the first of the month following the change in status, unless the HIPAA special enrollment rules apply (see B. above).

HEALTH CARE SPENDING ACCOUNT

Eligible Expenses

To be eligible for reimbursement from your HCSA, the health care expenses must be all of the following:

- Incurred for medical care, defined in Section 213 of the Internal Revenue Code as amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. As determined by the FSA Plan Sponsor, Eligible Expenses under the Plan do not include contraceptive devices or services, voluntary sterilization or the reversal of sterilization, or elective abortion.
- Incurred while you are participating in the Plan. If you decide to not re-enroll in the Plan, you are still eligible for reimbursement during the 2.5-month period immediately following the end of the Plan Year as long as you were enrolled in the Plan on the last day of the Plan Year.
- Incurred during the Plan Year or during the 2.5 months following the end of the Plan Year.
- Not reimbursed under any other plan covering health benefits, including a spouse's or dependent's plan.

Below is a partial list of the types of health care expenses eligible for reimbursement from your HCSA. Generally, Eligible Expenses are those for which you could have claimed a tax deduction on an itemized federal income tax return (without regard to any threshold limitation) and include any deductible and copayment amounts.

Some guidance regarding what constitutes eligible medical expenses (including additional examples) is provided in IRS Publication 502 which is available from any regional IRS office or IRS website www.irs.gov. **However, there are certain expenses which are listed as deductible in IRS Publication 502, but which can not be reimbursed by the HCSA because of IRS rules (e.g., insurance premiums).**

Eligible Medical Expenses.

Vision Expenses.

Hearing Expenses.

Dental Expenses.

Prescription Drugs.

Over-the-Counter Medications incurred for medical care.

Ineligible Expenses

The partial list below includes examples of expenses that are not eligible for reimbursement:

- As determined by the FSA Plan Sponsor, Eligible Expenses under the Plan do not include contraceptive devices or services, voluntary sterilization or the reversal of sterilization, or elective abortion.
- Expenses incurred for cosmetic surgery or other similar procedures, unless the procedure is necessary to improve deformities directly related to a congenital condition, a personal injury or a disfiguring disease.
- Expenses for custodial care in a nursing home.
- Insurance premiums, including Medicare Part B premiums, long term care premiums, and other payments or contributions for health coverage (such as contributions for coverage under an employer-sponsored group health plan or HMO or other health plan).
- Expenses incurred for general good health (such as vitamins and other dietary supplements, and toothpaste).

In addition, as with any other expense reimbursed under any other plan covering health benefits, including a spouse's or dependent's plan, health expenses reimbursed through your HCSA can not be claimed as deductions on your income tax return.

DEPENDENT CARE SPENDING ACCOUNT

Eligible Expenses

Eligible Expenses that can be reimbursed from your DCSA are expenses incurred for household and dependent care services that enable you and (if married) your spouse to be gainfully employed, which generally means working or actively looking for work.

If your spouse has no earned income, you can not use a DCSA unless your spouse is physically or mentally incapable of caring for himself or herself, or is a full-time student for at least five months during the Plan Year.

To qualify for reimbursement, Dependent Care Expenses can not exceed your earned income or, if married, the earned income of the lesser earning spouse. Earned income (including any self-employment earnings) is generally the remaining salary after all pre-tax salary reductions have been made. If married and your spouse is physically or mentally incapable of caring for himself or herself or is a full-time student, the IRS considers your spouse to have a monthly income of $250 (as adjusted from time to time) if you have one dependent, or $500 (as adjusted from time to time) if you have two or more dependents, for each month that your spouse is incapable of caring for himself or herself or is a full-time student.

Dependent Care Expenses must be incurred for a qualified dependent. Qualified dependents are:

- a dependent under federal tax law who is a child under age 13; or
- a spouse or dependent under federal tax law who is physically or mentally incapable of caring for himself or herself; provided that such spouse or dependent lives in your home for more than one-half of the year.

Eligible Expenses include, but are not limited to, the following expenses if not otherwise excluded:

- Expenses for care at a day care center that complies with all applicable state and local regulations.
- Expenses for care provided by a housekeeper, babysitter or other person in your home.
- Expenses for care provided by a relative who cares for your qualified dependents, so long as that relative is over the age of 19 and is not your dependent under federal tax law.
- Expenses for care at a day camp to which you send your children (under age 13) during school vacations so that you and your spouse, if you are married, can be gainfully employed or attend school full-time.

Dependent Care Tax Credit vs. Dependent Care Spending Account

Some employees may be eligible to claim a dependent care tax credit on their federal income tax return. This credit is available for the same types of expenses as the DCSA. However, the IRS requires that the dependent care tax credit be reduced, dollar for dollar, by the amount reimbursed under a Dependent Care Flexible Spending Account. In other words, you can not use expenses reimbursed through the DCSA to claim the tax credit.

For more information about how the dependent care tax credit works, see IRS Publication No. 503. In addition, because each employee's situation is different, you may want to consult with a tax advisor before deciding whether to use the tax credit or the DCSA.

REQUESTING A REIMBURSEMENT FROM YOUR FLEXIBLE SPENDING ACCOUNT

You will need to submit a reimbursement form, called a request for withdrawal, to be reimbursed from your account for the Eligible Expenses that have been incurred. A request for withdrawal form is available from your Employer or on the Internet at www.myuhc.com.

For reimbursement from your HCSA, you must include proof of the expenses incurred. Proof can include a bill, invoice or an Explanation of Benefits (EOB) from any plan that provides health benefits under which you are covered. An EOB will be required if the expenses are for services usually covered under group medical and dental plans, for example, charges by surgeons, doctors and hospitals. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group medical/dental plans.

For reimbursement from your DCSA, you must submit proof of the services rendered, such as a bill, receipt, or invoice and Social Security or Tax Identification Number of the care provider.

Only expenses which are incurred while you are a participant in the Plan or, for healthcare expenses only, during the 2.5-month period immediately following the end of the Plan Year, may be reimbursed from a Flexible Spending Account. In addition, expenses which are incurred during one Plan Year with the exception of expenses incurred during the 2.5-month period (healthcare expenses only) immediately following the end of the Plan Year can not be reimbursed during another Plan Year. An expense is considered incurred when services are provided, not when you are billed or when you pay for care.

You can submit a reimbursement form as often as weekly. You will be reimbursed for Eligible Expenses as long as the amount requested from either account is at least $25, except for reimbursement with respect to the last month of the Plan Year. Amounts below $25 will be accumulated and processed with future payments.

If you have established a HCSA, your total annual contribution is available immediately. You can request reimbursement for Eligible Expenses up to your annual contribution amount as soon as such Eligible Expenses have been incurred.

If you have established a DCSA, only the amounts you have actually contributed to the account are available for reimbursement. If you request reimbursement for more than what you have in your account, you will receive only the amount in your account. As additional contributions are made to your account, outstanding reimbursements will be processed automatically.

For expenses incurred during the Plan Year and during the 2.5-month period immediately following the end of the Plan Year, requests for withdrawal will be accepted and processed through March 31 of the following year.

In accordance with IRS regulations, amounts contributed to your HCSA or DCSA during the Plan Year but remaining in your account at the end of the processing period (March 31 of the following year) can not be returned to you or used to reimburse expenses incurred in a subsequent Plan Year. These amounts are forfeited and applied as directed by the Employer in accordance with the Plan.

Automatic Reimbursement

You can elect to have Eligible Expenses for claims which are not covered under your UnitedHealthcare-administered medical or dental plan automatically submitted to your HCSA for reimbursement. This eliminates extra paperwork and makes it more convenient for you to use your HCSA. To do this, you must complete an FSA Automatic Reimbursement Request form at the beginning of the Plan Year. Once this form is completed and returned to your employer, you will not be required to submit a separate withdrawal request for these expenses.

If you have medical or dental coverage through another carrier, you can not select the Automatic Reimbursement feature. In addition, the Automatic Reimbursement feature can not be selected if your domestic partner is covered under your employer's group health plan.

An FSA withdrawal request must be submitted for any other types of expenses and any health expenses not submitted to your health benefits carrier.

Extension for Incurring Expenses

If you have unused contributions in your account at the end of the current Plan Year, you can continue to incur expenses during the first 2.5 months (healthcare only) immediately following the end of the Plan Year and receive reimbursement for these expenses until such unused funds are depleted. All requests for reimbursement will be accepted and processed through March 31. After March 31 funds remaining in your account for the current Plan Year will be forfeited. Unused benefits relating to a particular qualified benefit may only be used to pay expenses incurred with respect to that particular benefit and can not be transferred to another account.

Claim Denial Process

If your claim is denied for reimbursement, you will receive a written notice from UnitedHealthcare within 30 days of receipt of the claim, as long as all needed information was provided with the claim. UnitedHealthcare will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45 day time frame and the claim is denied, UnitedHealthcare will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45 day period, your claim will be denied.

A denial notice will explain the reason for the denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Questions and Appeals

If you have a question or concern about a claim reimbursement determination, you may informally contact a UnitedHealthcare Customer Service representative before requesting a formal appeal. The Customer Service telephone number is shown on your card. If the Customer Service representative can not resolve the issue to your satisfaction, you may request a formal appeal as described below.

If you wish to request a formal appeal of a denied claim for reimbursement, you should contact Customer Service to obtain the UnitedHealthcare address where the appeal should be sent. Your appeal should be submitted in writing to that address and should include your name and identification number from the card, a description of the claim determination that you are appealing, the reason you believe your claim should be reimbursed, and any written information to support your appeal.

Your first appeal request must be submitted in writing to UnitedHealthcare within 180 days after you receive the denial.

A qualified individual who was not involved in the initial benefit decision being appealed will be designated to decide the appeal. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for reimbursement.

The first level appeal will be conducted and you will be notified by UnitedHealthcare of the decision in writing within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare. Your second level appeal request must be submitted in writing to UnitedHealthcare within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified by UnitedHealthcare of the decision in writing within 30 days from receipt of a request for a second level appeal.

UnitedHealthcare has the exclusive right to interpret and administer the Plan, and these decisions are conclusive and binding.

WHEN PARTICIPATION ENDS

You will cease to participate in the Plan as of the earlier of:

- The date on which the Plan terminates.
- The date you cease to be an eligible employee.
- The date you fail to make a required contribution under the terms of the Plan.

Health Care Spending Account

You may submit a claim for reimbursement of Eligible Expenses which were incurred during the Plan Year of termination, as long as those expenses were incurred prior to the date of your termination. Any such claims must be submitted on or before March 31 of the year after the Plan Year of termination.

The requirements of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") may apply to the Health Care Spending Account Plan. You should call your Employer to find out whether this Plan is subject to COBRA. If the Plan is subject to COBRA see "Optional Continuation Coverage under your Health Care Spending Account (COBRA)".

OPTIONAL CONTINUATION COVERAGE UNDER YOUR HEALTH CARE SPENDING ACCOUNT (COBRA)

This optional continuation coverage only applies if it has been made available by Fairleigh Dickinson University. Fairleigh Dickinson University may be required to offer this continuation coverage in certain cases as a result of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. See Fairleigh Dickinson University to find out if and how this continuation coverage applies.

In no event will UnitedHealthcare be obligated to provide continuation coverage to a participant if Fairleigh Dickinson University or its designated plan administrator fails to perform its responsibilities under federal law. These responsibilities include but are not limited to notifying the participant in a timely manner of the right to elect continuation coverage and notifying UnitedHealthcare in a timely manner of the participant's election of continuation coverage.

In general, COBRA continuation coverage must be offered with respect to a participant's HCSA if the participant has a positive balance in such account at the time of a qualifying event such as termination of employment (other than by reason of gross misconduct) or reduction in work hours. A "positive balance" for this purpose generally means that the contributions made to the account prior to the qualifying event exceed the eligible claims for reimbursement submitted prior to the qualifying event. If this COBRA continuation coverage is available to a participant who experiences a qualifying event and continuation

coverage is elected by the participant, such coverage will cease at the end of the 2.5 months immediately following the end of the Plan Year in which the qualifying event occurs and coverage cannot be continued beyond such date. Premiums for such continuation coverage (i.e., contributions to the account) will be paid by the participant on an after-tax basis unless otherwise permitted by Fairleigh Dickinson University on a uniform and consistent basis.

UnitedHealthcare is not Fairleigh Dickinson University's designated Plan Administrator and does not assume any responsibilities of a Plan Administrator pursuant to federal law.

Dependent Care Spending Account

You may submit claims for the Eligible Expenses you have incurred at any time during that Plan Year, including Eligible Expenses incurred after your termination date, against what is in your DCSA when you leave employment. Any such claims must be submitted on or before March 31 of the next Plan Year.

ERISA STATEMENT

Name of Plan: Fairleigh Dickinson University Flexible Spending Account Plan

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

Fairleigh Dickinson University
1000 River Road
Teaneck, NJ 07666
(201) 692-2705

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibilities with respect to the Plan.

Claims Administrator: United HealthCare Insurance Company

Employer Identification Number (EIN): 22-1494434

IRS Plan Number: 501

Effective Date of Plan: January 1, 2008

Type of Plan: Flexible Spending Account Plan

Name, business address, and business telephone number of Plan Administrator:

Fairleigh Dickinson University
1000 River Road
Teaneck, NJ 07666
(201) 692-2705

Type of Administration of the Plan: The Plan is administered on behalf of the Plan Administrator by United HealthCare Insurance Company. United HealthCare Insurance Company provides administrative services for the Plan including claims processing, claims payment, and handling appeals.

Person designated as agent for service of legal process:

Fairleigh Dickinson University
1000 River Road
Teaneck, NJ 07666
(201) 692-2705

Source of contributions and funding under the Plan:

The Plan is funded by general assets of the Plan Sponsor based on the salary reduction elections made by participating Employees.

Method of calculating the amount of contribution: Employee contributions to the Plan are determined by each Employee's salary reduction election based on the Plan limitations as determined by the Plan Sponsor.

Plan Year: Plan Year shall be a twelve month period ending each January 1.

Plan Amendment and Termination: Although the Plan Sponsor currently intends to continue the benefits provided by this Plan, the Plan Sponsor reserves the right, at any time and for any reason or no reason at all, to change, amend, interpret, modify, withdraw or add Benefits or terminate this Plan or this Summary Plan Description, in whole or in part and in its sole discretion, without prior notice to or approval by Plan participants and their beneficiaries. Any change or amendment to or termination of the Plan, its benefits or its terms and conditions, in whole or in part, shall be made solely in a written amendment (in the case of a change or amendment) or in a written resolution (in the case of termination), whether prospective or retroactive, to the Plan. The amendment or resolution is effective only when approved by the body or

person to whom such authority is formally granted by the terms of the Plan. No person or entity has any authority to make any oral changes or amendments to the Plan.

Benefits under the Plan are furnished in accordance with the Plan Description issued by the Plan Sponsor, including this Summary Plan Description.

Participant's rights under the Employee Retirement Income Security Act of 1974 (ERISA) and the procedures to be followed in regard to denied claims for reimbursement or other complaints relating to the Plan are set forth in the body of this Summary Plan Description.

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

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

Receive Information About Your Plan and Benefits

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

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

Continue Group Health Plan Coverage

Continue health 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 group health plan. You should be provided a certificate of creditable coverage, in writing, 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 in your coverage. You may request a certificate of creditable coverage by contacting the Plan Administrator.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon 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 is 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 Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a 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 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 the costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, United States Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.