TEAMHealth

TeamHealth

Prescription Drug
Summary Plan Description

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Notice to employees

This booklet describes Employer-sponsored health benefits under the TeamHealth Welfare Benefit Plan (called "the Plan") as of October 1, 2004.

All benefits becoming due under the Plan are funded by TeamHealth.

TeamHealth has entered into an arrangement with Caremark, which provides administrative services for TeamHealth to process benefit claims and provide certain other services under the Plan.

Caremark does not insure the benefits described in this booklet.

Schedule of Benefits

	Retail Pharmacy Program	Mail Service Program
When to use it	For immediate needs or short-term medications	For maintenance or long-term medications
You Pay	35 % ($5 min, $150 max) for each generic prescription	25% ($10 min, $150 max) for each generic prescription
	35 % ($15 min, $150 max) for each brand name* prescription on the Primary Drug List	25 % ($30 min, $150 max) for each brand name* prescription on the Primary Drug List
	35 % ($35 min, $150 max) for each brand name* prescription not on the Primary Drug List	25 % ($70 min, $150 max) for each brand name* prescription not on the Primary Drug List
Maximum Out-Of-Pocket	$1500 per individual annually $3000 per family annually	
Days' Supply Limit	30-day supply	90-day supply
Refill Limit	None	None
Caremark Customer Care	1-800-841-5550 or www.caremark.com	

**When a generic is available, but the pharmacy dispenses the brand name drug for any reason, you will pay the difference between the brand name drug and the generic plus the generic co-payment.*

Eligibility/Enrollment

All employees of TeamHealth working at least 32 hours per week are eligible on the first day of the month following 30 days of continuous employment.

Employees and their eligible dependents are automatically enrolled in the prescription plan when they enroll in the UnitedHealthcare and other medical plans specified in the medical plan SPD sponsored by TeamHealth.

Prescription Drug Co-Insurance/Co-Payment

The co-insurance/co-payment is the amount payable by you or your covered dependent for eligible prescription drug expenses. The co-insurance/co-payment must be paid each time a prescription drug is obtained.

Generic Policy

Per the Federal Drug Administration, generic drugs contain exactly the same active ingredients as the brand-name drugs and are just as safe and effective.

If your prescription is for a brand name drug, unless you accept the generic equivalent (if it is available), you will pay the generic co-pay and the difference in cost between the generic drug and the brand-name drug.

Network Retail Pharmacy

A directory of participating pharmacies can be found at www.caremark.com or by calling 800-841-5550.

Non-Network Retail Pharmacy

For prescriptions filled at a retail pharmacy that is not part of the network, you will be charged the full cost of the prescription at the time it is filled.

Network Mail Order Pharmacy

Medication that is taken regularly to treat acute or chronic health conditions may be filled through the Caremark mail order pharmacy. You may receive a 90-day supply by mail.

Non-Sedating Antihistamine Drugs
Prescriptions for all "non-sedating antihistamine prescription drugs" have been moved to the non-preferred co-pay/co-insurance, except for asthma patients.

General Limitations
No payment will be made for expenses incurred:

- to the extent that payment is unlawful where the person resides when expenses are incurred;
- for charges which the person is not legally required to pay;
- for experimental drugs or for drugs labeled: "Caution – limited by federal law to investigational use";
- for drugs obtained from a non-participating mail-order pharmacy;
- for drugs obtained from a non-participating retail pharmacy;
- for any prescription filled in excess of the number specified by the physician or dispensed more than one year from the date of the physician's order;
- for more than a 30-day supply when dispensed in any one prescription order through a retail pharmacy;
- for more than a 90-day supply when dispensed in any one prescription order through the Caremark mail order pharmacy;
- for indications not approved by the Food and Drug Administration;
- for a brand-name drug to the extent that the charge for the brand-name drug exceeds the charge for a comparable FDA "A-rated" generic, where available for immunization agents, blood or blood plasma;
- for durable medical equipment, such as therapeutic devices or appliances, support garments, and other non-medicinal substances;
- for drugs used for cosmetic purposes;
- for the administration of any drug;
- for contraceptive devices including intrauterine devices and diaphragms except as specifically approved by the plan;
- for medication which is taken or administered, in whole or in part, at the place where it is dispensed or while a person is a patient in an institution which operates, or allows to be operated on its premises, a facility dispensing pharmaceuticals;
- for prescriptions which an eligible person is entitled to receive without charges from any workers' compensation or similar law or any public program other than Medicaid;
- for nutritional or dietary supplements, except as specifically approved by the Plan;
- for any over-the-counter medications

Reimbursement/Filing a Claim
If you or your dependent purchase covered prescription drugs from a participating retail pharmacy, you pay only the portion shown in The Schedule of Benefits at the time of purchase. You do not need to file a claim form.

You may obtain the required forms from your Plan Administrator. The employee should complete all claim forms. Refills may be requested over the internet or by calling Caremark at 800-841-5550.

When Claims Must be Filed
If you have had to purchase prescription drugs at full price, you must give Caremark written proof of a claim within 15 months after the date the expenses are incurred.

Caremark will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested.

No benefits are payable for claims submitted after the 15-month period, unless it can be shown that:

- It was not reasonably possible to submit the claim during the 15-month period.
- Written proof of claim was given to Caremark as soon as was reasonably possible.

How and When Claims Are Paid

All payments will be paid to the covered employee as soon as Caremark receives satisfactory proof of a claim, except in the following cases:

- If the covered employee has financial responsibility under a court order for a dependent's medical care, Caremark will make payments directly to the pharmacy.
- If Caremark pays benefits directly to Network Providers.
- If the covered employee requests in writing that payments be made directly to a pharmacy. A covered employee does this when completing the claim form.

These payments will satisfy Caremark's obligation to the extent of the payment.

Any benefits continued for dependents after a covered employee's death will be paid to one of the following:

- The surviving spouse.
- A dependent child who is not a minor, if there is no surviving spouse.
- A provider of care who makes charges to the covered employee's dependents for covered services and supplies.
- The legal guardian of the covered employee's dependent.

Legal Actions

The covered employee may not sue on a claim before 60 days after proof of loss has been given to Caremark. The covered employee may not sue after three years from the time proof of loss is required, unless the law in the area where the covered employee lives allows for a longer period of time.

Review Procedure for Denied Claims

In cases where a claim for benefits payment is denied in whole or in part, the claimant may appeal the denial. A request for review must be directed to Caremark within 60 days after the claim payment date or the date of the notification of denial of benefits. When requesting a review, the claimant should state the reason he or she believes the claim was improperly paid or denied and submit any data or comments to support the claim.

A review of the denial will be made and Caremark will provide the claimant with a written response within 60 days of the date Caremark receives the claimant's request for review. If, because of extenuating circumstances, Caremark is unable to complete the review process within 60 days, Caremark will notify the claimant of the delay within the 60-day period and provide a final written response to the request for review within 120 days of the date Caremark received the claimants written request for review.

If the denial is upheld, Caremark's written response to the claimant will cite the specific plan provision(s) upon which the denial is based.

If Caremark continues to deny a claim after this review, the claimant may request that the Plan Administrator review the claim. The request must be in writing to the Plan Administrator. See the Section **Summary Plan Description** at the end of this booklet for more information.

Termination of Coverage

Employee Coverage

Employee coverage ends on the earliest of the following:

- The day this plan ends.
- The last day of the month in which employment stops. See **Disability** and **Leave of Absence or Temporary Layoff** below.
- The last day of the month in which contributions for the cost of coverage have been made, if the contributions for the next period are not made when due.
- The last day of a period for which contributions for the cost of coverage have been made, if the contributions for the next period are not made when due.

Disability

TeamHealth has the right to continue a person's employment and coverage under this Plan during a period in which the person is away from work due to disability. The period of continuation is determined by TeamHealth based on TeamHealth's general practice for an employee in the person's job class.

Coverage ends on the date TeamHealth notifies Caremark that the person's employment has stopped and coverage is to be ended.

Leave of Absence or Temporary Layoff

TeamHealth has the right to continue the person's employment and coverage under this Plan during period in which the person is away from work due to an approved leave of absence or temporary layoff. The period of continuation is determined by TeamHealth based on TeamHealth's general practice for an employee in the person's job class.

Coverage will end on the earlier of:

- The last day of the month following the month in which the leave or layoff begins.
- The date TeamHealth notifies Caremark that the person's employment has stopped and coverage is to be ended.

Dependent Coverage

Coverage for all of an employee's dependents end on the earlier of the following:

- The day the employee's coverage ends.
- The last day of a period for which contributions for the cost of dependent coverage have been made, if the contributions for the next period are not made when due.

Coverage for an individual dependent ends on the earlier of:

- The day the dependent becomes covered as an employee under this Plan.
- The last day of the month in which the dependent stops being an eligible dependent.

Continuation of Coverage for Incapacitated Children

A mentally or physically incapacitated child's coverage will not end due to age. It will continue as long as dependents coverage under this Plan continues and the child continues to meet the following conditions:

- The child is incapacitated.
- The child is not capable of self-support.
- The child depends mainly on the employee for support.

The employee must give Caremark proof that the child meets these conditions when requested. Caremark will not ask for proof more than once a year.

Continuation of Health Coverage (COBRA)

This optional continuation only applies to employees and their dependents if it has been made available by TeamHealth. TeamHealth is required to offer this continuation in certain cases as a result of Public Law 99-272 (COBRA). This provision is intended to comply with the law and any pertinent regulations, and they govern its interpretation. See TeamHealth to find out if and how this continuation applies to employees and their dependents.

In no event will Caremark be obligated to provide continuation to a covered person if TeamHealth or its designated Plan Administrator fails to perform its responsibilities under federal law. These responsibilities include but are not limited to notifying the covered person in a timely manner of the right to elect continuation and notifying Caremark in a timely manner of the covered person's election of continuation.

Caremark is not TeamHealth's designated Plan Administrator and does not assume any responsibilities of a Plan Administrator pursuant to federal law.

If covered under this Plan would have stopped due to a qualifying event, a qualified beneficiary may elect to continue coverage subject to the provisions below.

The qualified beneficiary may continue only the coverage in force immediately before the qualifying event.

The coverage being continued will be the same as the coverage provided to similarly situated individuals to whom a qualifying event has not occurred.

Coverage will continue until the earliest of the following dates:

- 18 months from the date the qualifying beneficiary's health coverage would have stopped due to a qualifying event based on employment stopping or work hours being reduced.
- If a qualified beneficiary is determined to be disabled under the Social Security Act at any time during the first 60 days of continued coverage due to the employee's employment stopping or work hours being reduced, that qualified beneficiary may elect an additional 11 months of coverage under this Plan, subject to the following conditions:
    - The qualified beneficiary must provide TeamHealth with the Social Security Administration's determination of disability within 60 days of the time the determination is made and within the initial 18-month continuation period.
    - The qualified beneficiary must agree to pay any increase in the required payment necessary to continue the coverage for the additional 11 months.
    - If the qualified beneficiary entitled to the additional 11 months of coverage has non-disabled family members who are entitled to continuation coverage, those non-disabled family members are also entitled to the additional 11 months of continuation coverage.
- 36 months from the date the health coverage would have stopped due to the qualifying event other than those described above.
- For the spouse or dependent of an employee who was entitled to Medicare prior to a qualifying event that is either the termination of employment or work hours being reduced, 18 months from the date of the qualifying event or if later, 36 months from the date of the employee's Medicare entitlement.

- The date this Plan stops being in force.
- The date the qualified beneficiary fails to make the required payment for the coverage.
- The date the qualified beneficiary, after electing this continuation, becomes covered under Medicare or any other group health plan. (This does not apply if the other group health plan excludes or limits coverage for a qualified beneficiary's preexisting condition.)

If within the original 18- month period, another qualifying event occurs, coverage can be continued for an additional period, for a total of 36 months from the date of the first qualifying event. Coverage will stop for the same reasons as coverage would have stopped for the first qualifying event.

Election Period

A qualified beneficiary has at least 60 days to elect to continue coverage. The election period ends on the later of:

- 60 days after the date coverage would have stopped due to the qualifying event
- 60 days after the date the person receives notice of the right to continue coverage.

Unless otherwise specified, an employee or spouse's election to continue coverage will be considered an election on behalf of all other qualified beneficiaries who would also lose coverage because of the same qualifying event.

Required Payments

A qualified beneficiary has 45 days from the date of election to make the first required payment for the coverage. The first payment will include any required payment for the continued coverage before the date of the election.

Notification Requirements

A qualified beneficiary must notify TeamHealth within 60 days when any of the following qualifying events happen:

- The qualified beneficiary's marriage is dissolved.
- The qualified beneficiary becomes legally separated from his or her spouse.
- A child stops being an eligible dependent.

TeamHealth will send the appropriate election form to the qualifying beneficiary within 14 days after receiving this notice.

Conversion

This plan does not offer a conversion option.

Claims

File a claim by completing a medical claim form and attaching your bills to the form. "COBRA" should be written on the claim form and on each of the bills.

Special Terms that apply to this Continuation Provision

Qualifying event

A qualifying event is any of the following, which results in loss of coverage for a qualified beneficiary:

- The employee's or dependent's employment ends (except in the case of gross misconduct).
- The employee's or dependent's work hours are reduced.
- The employee or dependent becomes entitled to benefits under Medicare.
- The employee's or dependent's death.
- The employee's marriage is dissolved.
- The employee becomes legally separated from his/her spouse.
- The employee's dependent child stops being an eligible dependent.

A bankruptcy is a qualifying event for certain retired employees and their dependents under certain conditions. If there is a bankruptcy, retired employees should contact TeamHealth or Caremark for more information.

Qualified beneficiary

Any of the following persons who are covered under the plan on the day before a qualifying event:

- The employee.
- An employee's spouse.
- An employee's former spouse (or legally separated spouse).
- A dependent child, including a child born to or placed for adoption with the employee during a period of continued coverage.

Continuation of Prescription Coverage During Family and Medical Leave (FMLA)

The family and Medical Leave Act of 1993 (FMLA) required Employers to provide up to a total 12 weeks of unpaid, job-protected leave during any 12-month period to be eligible employees for certain family and medical reasons. This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. See TeamHealth to find out details about how this continuation applies to you.

Reasons for Taking Leave

FMLA Leave must be granted for any of the following reasons:

- Care of child after birth.
- Care of child after placement of that child with the employee for adoption or foster care.
- Care of the employee's spouse, child or parent (but not a parent-in-law) who has a serious health condition.
- A serious health condition that makes the employee unable to work.

Employee Eligibility

To be eligible for FMLA benefits, all of the following must be true:

- The employee must work for a covered Employer.
- The employee must have worked for TeamHealth for at least 12 months.
- The employee must have worked at least 1,250 hours over the previous 12 months.
- The employee must work at a location where at least 50 employees are employed by TeamHealth within 75 miles.

Advance Notice and Medical Certification

The employee must provide advance notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable".
- If the need for the leave is unforeseen, notice must be given as soon as practicable.
  - TeamHealth may require medical certification to support a request for leave because of a serious health condition, and may require a second or third opinion (at TeamHealth's expense) and a fitness for duty report to return to work.

Continuation of Health Coverage, Job Benefits and Protection

For the duration of a FMLA leave, TeamHealth must maintain the employee's health coverage. The employee may continue the Plan benefits for himself or herself and his or her dependents on the same terms as if the employee had continued to work. The employee must pay the same contribution toward the cost of the coverage that he or she made while working.

If the employee fails to make the payments on a timely basis, TeamHealth, after giving you written notice, can end the coverage during the leave if payment is more than 30 days late.

- Upon return from a FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms.
- The use of a FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

See TeamHealth for detail about continuing group coverage other than the Plan benefits.

Intermittent Leave

Under some circumstances, an employee may take a FMLA leave intermittently which means taking a leave in blocks of time, or by reducing his or her normal weekly or daily work schedule.

- Where a FMLA leave is for birth or placement for adoption or foster care, use of intermittent leave is subject to TeamHealth's approval
- A FMLA leave may be taken intermittently whenever it is Medically Necessary to care for a seriously ill family member, or because the employee is seriously ill and unable to work.

Substitution of Paid Leave

Subject to certain conditions, employees or employers may choose to use accrued paid leave (such as sick or vacation leave) to cover some or all of the FMLA leave. TeamHealth is responsible for designating if paid leave used by the employee counts as FMLA leave, based on information provided by the employee. In no case can an employee's paid leave be credited as a FMLA leave after the leave has been completed.

Spouses Who Work for the Same Employer

Spouses employed by the same employer are jointly entitled to a combined total of 12 work weeks of family leave for the birth of a child or placement of a child for adoption or foster care, and to care for such child or to care for a parent who has a serious health condition.

Reenrollment after a FMLA leave

If any or all of an employee's coverage end while the employee is on a FMLA leave, the employee can reenroll for coverage when her or she returns to work from the FMLA leave.

The employee and any dependents will be considered timely enrollees if the employee reenrolls within thirty-one days from the date he or she returns to work. Any waiting period will be applied as if there had been no break in coverage.

Disclosure of Protected Health Information to TeamHealth

Caremark may disclose Summary Health Information to TeamHealth for the purpose of obtaining premium bids for providing coverage under the Plan or for modifying, amending, or terminating the Plan.

The Plan will disclose Personal Health Information (PHI) to TeamHealth only in accordance with the established HIPAA guidelines. PHI disclosed to TeamHealth may only be used for permitted and required uses and disclosures.

Additionally, the Plan agrees:

- Not to use or further disclose PHI other than as permitted or as required by law;
- To ensure that any of its agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions;
- Not to use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan;
- To report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses and disclosures.
- To make PHI available to individuals in accordance with HIPAA regulations
- To make PHI available for individuals' amendment and incorporate any amendments in accordance with HIPAA regulations.
- To make the information available that will provide individuals with an accounting of disclosures in accordance with HIPAA regulations.
- To make its internal practices, books, and records relating to the use and dislosure of PHI received from the Plan available to the Department of Health and Human Services upon request;
- If feasible, to return or destroy all PHI received from the Plan that TeamHealth maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, TeamHealth will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction of the information infeasible.
- To ensure that adequate separation between the Plan and TeamHealth, as required by HIPAA regulations

Access to and use of PHI will be restricted to Plan Administration Functions that TeamHealth performs for the Plan. Such access or use shall be permitted only to the extent necessary for these individuals to perform their respective duties for the Plan.

Summary Plan Description

This booklet is a covered person's Summary Plan Description for the purposes of the employee Retirement Income Security Act of 1974 (ERISA). It describes the highlights of a covered person's rights and obligations under the employee welfare benefit plan established by the Plan Sponsor, provided that the covered person is a participant of the Plan. All of the details of this Plan are not provided. The operation of this Plan is governed by the Plan Documents. For more information about the Plan Documents, refer to the section, "A covered person's Rights Under ERISA."

The Plan Sponsor reserves the right to change or discontinue this Plan at any time. This Summary Plan Description does not create a contract of employment.

Name of Plan

TeamHealth Welfare Benefit Plan

Name and Address of Employer who is the Plan Sponsor

TeamHealth

1900 Winston Road

Knoxville, TN 37919

Employer Identification Number (EIN)

62-1562558

Agent for Service of Legal Process

The Plan Sponsor named above.

Plan Number (PN):

504

Plan Type:

The Plan described in this Summary Plan Description is a "Welfare Benefit Plan" for purposes of ERISA.

Plan Years:

The financial records of this Plan are kept on a Plan Year basis. The Plan year ends on each September 30.

Plan Administrator:

The Plan Sponsor named above.

Telephone Number of Plan Administrator:

(877) 516-7492

Type of Administration:

The Plan is administered on behalf of the Plan Administrator by the TeamHealth Benefits Center. The benefits are paid from funds provided by TeamHealth on behalf of the Plan in accordance with a contract with Caremark.

Source of Contributions and Funding:

This Plan is funded by direct payments from the general assets of TeamHealth.

The employee's contribution toward the cost of this Plan is at a rate determined by TeamHealth.

Plan Details:

This Plan's provisions relating to eligibility to participate and termination of eligibility as well as a description of the benefits provided by this Plan are described in detail in the covered person's health benefits booklet which directly precedes this ERISA information.

Plan Amendment and Termination:

The Plan Sponsor reserves the right to modify, suspend or terminate this Plan at anytime. TeamHealth does not promise the continuation of any benefits nor does it promise any specific level of benefits at or during retirement. Any benefits, rights or obligations of participants and beneficiaries under this Plan following termination are described in detail in the covered person's health benefits booklet, which directly precedes this ERISA information.

How to Appeal a Claim:

The covered person will be notified in writing by Caremark if a claim or any part of a claim is denied. The notice will include the specific reason or reasons for the denial and the reference to the pertinent Plan provisions on which the denial was based. The notice will also give the telephone number a covered person can call if they need further information and a description of any additional material or information necessary to make a claim.

If a covered person is not satisfied with the explanation of why the claim was denied, the person may request to have the claim reviewed. The request must be in writing to Caremark and must be given within 60 days after the date the covered person receives the notice denying the claim.

If a covered person does not hear from Caremark within 90 days after Caremark receives the claim, the covered person may consider the claim denied and request to have the claim reviewed.

A decision will be made within 60 days after the receipt of a request for review or the date all information required from the covered person is given. If, because of extenuating circumstances, Caremark is unable to complete the review process within 60 days, Caremark will notify the covered person of the delay within the 60-day period and will provide a final written response to the request for review within 120 days of the date Caremark received the written request for review.

If Caremark continues to deny a claim after this review, a covered person may request that the Plan Administrator review the claim. The request must be in writing to the Plan Administrator and must be made within 60 days after the date the covered person receives the notice from Caremark that Caremark has denied the claim on review

The Plan Administrator will serve as the final review committee under this Plan to determine for all parties all questions relating to the payment of claims for benefits under this Plan and shall notify the covered person in writing about the decision on a review. The Plan Administrator has the discretion to continue and interpret the terms of this Plan and the authority and responsibility to make factual determinations.

The provisions of this Plan require a covered person to appeal any claim denial as described above before seeking other legal means.

A covered person's Rights under ERISA

As a participant in this Plan, a covered person is 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:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all Plan documents including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor and the Internal Revenue Service, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
- Receive a summary of this Plan's annual financial report. The Plan Administrator is required by law to furnish each participant a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan.

The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of covered persons and other Plan participants and beneficiaries.

No one, including TeamHealth or any other person, may fire a covered person or otherwise discriminate against a covered person in any way to prevent that person from obtaining a benefit or exercising their rights under ERISA.

If a claim for a benefit is denied in whole or in part, a covered person must receive a written explanation of the reason for the denial. The covered person has the right to have the Plan review and reconsider the claim.

Under ERISA, there are steps a covered person can take to enforce the above rights. For instance, if a covered person requests materials from the Plan and does not receive them within 30 days, the covered person may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the covered person up to $110 a day until the person receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If a covered person has a claim for benefits, which is denied or ignored, in whole or in part, the covered person may file sit in a state of federal court. If it should happen that Plan fiduciaries misuse this Plan's money, or if a covered person is discriminated against for asserting his or her rights, the covered person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the covered person is successful, the court may order the person who was sued to pay these costs and fees. If the covered person loses, the court may order the covered person to pay these costs and fees (for example, if it finds the person's claim is frivolous).

If a covered person has any questions about this Plan, the person should contact the Plan Administrator at 877-516-7492.

If a covered person has any questions about this statement or about their rights under ERISA, that person should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.03741895 (11/02)