Summary Plan Description

Medical
(California and Hawaii)

Prescription
(CaremarkPCS Health)

Dental
(Aetna DMO)

Vision Benefits
(Vision Service Plan)

Employee Assistance Plan
(LifeScope)

Legal
(Hyatt Legal Plans)

Long Term Care
(Genworth Financial)

Effective June 1, 2012
NOPR

Introduction

CVS Pharmacy, Inc. ("CVS") maintains The CVS Caremark Welfare Benefit Plan (the "Plan") for the exclusive benefit of, and to provide welfare benefits to, its eligible employees, their spouses, and eligible dependents.

The welfare benefits under the Plan include medical insurance, dental insurance, vision insurance, long term care insurance, and pre-paid legal benefits (the "Insured Benefits"). This Summary contains the eligibility and enrollment rules for the Insured Benefits, and is intended to supplement any insurance certificates, booklets and/or policies (the "Insurance Certificates) which describe the Insured Benefits.

The Plan benefits also include prescription drug and Employee Assistance Plan (EAP) benefits. In addition to describing their eligibility and enrollment rules, this Summary also discusses the benefit provisions for the prescription drug, EAP, vision, pre-paid legal, and long-term care benefits.

Please note that the Plan also includes the following benefits, which are not described in this Summary: medical benefits (which include self-insured medical benefits administered by Aetna, Blue Cross and Blue Shield of RI, UnitedHealthCare and HMA, Inc.), dental benefits (which are self-insured and administered by Delta Dental of RI), and disability and life insurance benefits (insured with Unum). The eligibility, enrollment and benefit provisions that apply to these benefits are addressed in separate documents. If you would like a copy of these documents, call ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287).

If you are a CVS employee who resides in California or Hawaii, refer to the "California Supplement" or "Hawaii Supplement," as applicable, for additional eligibility and enrollment rules that apply to you. If you would like a copy of the California Supplement or Hawaii Supplement, call ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287).

If you are a CVS employee who resides in Puerto Rico, CVS has prepared a separate Summary Plan Description to describe your Plan benefits. If you would like a copy of that summary, call ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287).

ERISA Summary Plan Description

This Summary, combined with the Insurance Certificates for the Insured Benefits, described above, constitutes your summary plan description ("SPD") as required by the Employee Retirement Income Security Act (ERISA). This Summary is a resource you can reference when you have a question about the above-described Plan benefits.

The Insurance Companies that insure the Insured Benefits are listed in the "General Plan Information" Section of this Summary. This Summary is intended to supplement the Insurance Certificates provided as follows: by Kaiser Permanente for CVS employees residing in California and Hawaii; by Health Net of California, Inc. for CVS employees residing in California; by HMSA/Blue Cross Blue Shield of Hawaii for CVS employees residing in Hawaii; by Aetna Life Insurance Company for dental DMO benefits; and by Genworth Life for long term care benefits. Because this Summary is intended to "supplement" the Insurance Certificates provided to you by the Insurance Companies for the insured medical, dental, and long term care benefits, please note that:

- This Summary does not fully describe the coverage for the Insured Benefits. For details on these benefits coverages, please refer to the applicable insurance certificate, which is the binding document between the Insurance Companies and their members.
- For details on the benefit and claims review and adjudication procedures for the Insured Benefits, please refer to the Insurance Certificate issued by the applicable Insurance Company.
- If there are any discrepancies between benefits included in this Summary and the Insurance Certificate, the applicable Insurance Company's Insurance Certificate will prevail in determining the services and benefits provided under the Plan. However, the Insurance Certificates will not prevail in determining the Plan's eligibility rules.
- For insured medical benefits insured by an Insurance Company listed in the "General Plan Information" section of this summary, a Plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat your medical condition. The services and supplies must be provided, prescribed, authorized, or directed by a Plan physician. You must receive the services and supplies at a Plan facility or skilled nursing facility inside the Plan's Service Area, except where specifically noted to the contrary in the Insurance Certificate.

ERISA Plan Document

Portions of this document, together with the insurance contracts entered into between CVS and the applicable insurance company constitute the written Plan document with respect to the insured benefits offered under the Plan.

Certain benefits under the Plan (such as medical benefits in California and Hawaii, Aetna DMO dental benefits, and long term care benefits) are provided pursuant to an insurance contract, which, together with this Summary, constitute the governing plan document adopted by CVS. For purposes of determining medical, dental, and long term care services covered under the Plan, to the extent applicable, the terms of the insurance contract or Insurance Certificate will control in the event of a conflict with this Summary. However, if any of the other rules (including the eligibility rules) set forth in this Summary conflict with the terms of such insurance contract or any other document, then the terms of this Summary shall control, unless otherwise required by law.

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Eligibility

Your Eligibility

You are eligible for coverage under the Plan if you:

- are an eligible employee (described below); and
- the Plan Administrator has determined that you live in the Service Area covered under the respective plan.

You are an eligible employee if you are an active full-time employee of CVS (or related company or business division that has adopted the Plan, referred to herein as "CVS") working in the United States and you meet the Plan's employment requirements (discussed in the section of this Summary titled "**How to Enroll and When Your Coverage Begins**").

You will <u>not</u> be eligible to participate in the Plan if you are:

- covered by a collective bargaining agreement where benefits were the subject of good faith bargaining (unless that agreement provides for participation in the Plan), or
- classified, by CVS in its sole discretion under its customary worker classification procedures, as a part-time employee, temporary employee, seasonal employee, leased employee, independent contractor, consultant or other designation that would exclude eligibility (whether or not you actually are an employee), unless your specific contract or agreement with CVS provides for coverage under the Plan.

For purposes of the benefits provided under the Plan, you generally are considered a full-time employee if you are designated as a full-time employee and work an average of at least 30 hours per week for a single business unit. (The Plan's employment requirements are discussed below in the section of this Summary titled "**How to Enroll and When Your Coverage Begins**.") To remain eligible for the Plan, you must work an average of at least 30 hours per week.

If you are not actively at work due to a health factor, your absence will be counted for purposes of determining eligibility for purposes of medical, prescription, dental, and vision benefits. Continued eligibility for benefits is reviewed for all eligible employees regularly. Note that employees who work for Retail and PBM are classified according to the respective jobs they hold for each business unit. Hours worked are not aggregated for purposes of benefit eligibility.

Employees Residing in California. If you are a resident of California, refer to the California Supplement that accompanies this Summary for special eligibility rules that apply to you.

Employees Residing in Hawaii. If you are a resident of Hawaii, refer to the Hawaii Supplement that accompanies this Summary for special eligibility rules that apply to you.

Prescription Plan. For purposes of prescription plan eligibility, in addition to being subject to the above eligibility requirements, you must be enrolled for medical coverage under the Plan. If you are enrolled for medical benefits under the Plan, you are automatically enrolled in the prescription plan. Likewise, if your dependents are enrolled for medical coverage under the Plan, they are automatically enrolled in the prescription plan.

Long Term Care Plan. To be eligible for the long term care plan, in addition to being subject to the above eligibility requirements, you must maintain a permanent United States residence and meet the criteria imposed by the Genworth Life Insurance Company.

Dependent Eligibility

You may enroll your eligible dependents (described below) when you are first eligible for Plan coverage and during the Plan's Annual Enrollment period. Generally, you may also enroll newly eligible dependents within 30 days of their becoming eligible by marriage and within 60 days of their becoming eligible by birth, adoption, or placement for adoption. You may also drop coverage of an eligible dependent only upon a Change in Status event (described below) or at Annual Enrollment, unless your dependent's coverage is paid for on an after-tax basis (in which case you can disenroll that dependent at any time).

No person can be covered as both an employee and a dependent. In addition, no dependent may be covered without the employee having coverage. No person can be covered as a dependent of more than one employee under the Plan.

You should be aware that not all coverage for eligible dependents under the Plan can be paid for on a pre-tax basis. As discussed under the "***Paying for Coverage***" section below, due to current tax laws coverage for dependents can be paid for on a pre-tax basis only if the dependent:

- is your opposite-sex spouse, your biological child, adopted child, stepchild or child for whom you are the legal guardian, or
- meets the IRS' definition of a tax dependent under Section 152 of the Internal Revenue Code.

Shortly after you enroll a dependent, CVS' audit partner, Dependent Verification Services, will send you a letter requesting proof that your dependent is eligible under the terms of the Plan. Required documentation may include a government-issued marriage certificate, government-issued birth certificate, and a Federal tax return.

Note that a child who is not your biological child, legally adopted child, or child for whom you are the legal guardian is not an eligible dependent if you divorce, separate from, or otherwise terminated the relationship with your spouse or domestic partner, or if your domestic partner or same-sex spouse no longer lives with you.

Note: If a covered person is ineligible or unverified, he or she will be dropped from coverage under the Plan, and you will be required to pay to the Plan all claims incurred on behalf of ineligible or unverified person(s). If this is the case, you may not be eligible for future coverage under the Plan until you pay all amounts owed. If the termination of coverage for such a person results in a coverage level change, such as from family to individual coverage, you will not be refunded for premiums deducted from your pay at the higher coverage level. Your coverage level will be adjusted only for pay periods that occur after the removal of any non-verified person(s).

Eligible Spouses and Domestic Partners – All Benefits

The following is a list of the eligible spouses and domestic partners for medical, prescription, dental, vision, EAP and legal benefits under the Plan.

- Your legal spouse* of the same or opposite sex where the marriage is legally certificated. A marriage between same-sex spouses will be considered "legally certificated" if the marriage certificate was legal on the date of issuance under applicable state laws, or, for marriage certificates issued outside the United States, under applicable foreign laws. To confirm eligibility for coverage under the Plan, CVS requires a copy of your marriage certificate and proof that you remain married.

  **If you are separated from your spouse, your spouse is not an eligible dependent.*

- Your same-sex domestic partner for whom you do not qualify under a State's marriage law, but where you meet the Plan's requirements: you and your domestic partner must be in a committed, exclusive relationship, must have resided together for at least six months, and must be mutually responsible for basic living expenses.

  Shortly after you enroll your same-sex domestic partner, you will be required to attest and verify to the Plan Administrator that these requirements are met (and provide requested supporting documentation). In addition, you may be asked to recertify annually that you continue to meet the domestic partner criteria.

  Domestic partner coverage is not available in States where same-sex marriage is legal.

  If you terminate your domestic partner relationship or cease to meet any of the domestic partner eligibility criteria, your domestic partner will cease to be an eligible dependent.

Eligible Children – Prescription Benefits

The following is a list of dependent children who are eligible for medical, prescription and dental benefits under the Plan.

- A child who is less than age 26, where the child is <u>one</u> of the following:
  - Your biological child, legally adopted child (including a child placed with you for adoption), stepchild* from an opposite-sex spouse, or child for whom you are the legal guardian (as determined by an authorized placement agency, or by judgment, decree, or any order of a court).

    **A child who is your step-child will no longer be an eligible dependent in the event of a divorce.*
  - Your same-sex spouse's or eligible domestic partner's unmarried biological or legally adopted child, provided he or she:
    - resides with you (or his or her biological parent if divorced or separated) for more than one-half of the year (or, if less than one-half of the year has resided with you since birth or adoption), *and*
    - receives over 50% of his or her support and maintenance from you, your spouse or eligible domestic partner.

- An unmarried child or child whom your spouse or eligible domestic partner is the legal guardian (as determined by an authorized placement agency, or by judgment, decree, or any order of a court), provided he or she:
    - resides with you (or his or her biological parent if divorced or separated) for more than one-half of the year (or, if less than one-half of the year has resided with you since birth or adoption), and
    - receives over 50% of his or her support and maintenance from you, your spouse or eligible domestic partner.
- Your, your spouse's or domestic partner's unmarried grandchild, provided he or she:
    - is also your tax dependent,
    - resides with you for more than one-half of the year (or, if less than one-half of the year has resided with you since birth or adoption), and
    - receives over 50% of his or her support and maintenance from you, your spouse or eligible domestic partner.

  Shortly after you enroll a dependent, you will be required to attest to the Plan Administrator (and provide supporting documentation) that a child meets the above requirements. In addition, you may be asked to re-certify annually that a grandchild continues to meet the Plan's requirements.

- A child who is 26 or older and has a physical or mental disability that is expected to last for a continuous period of not less than 12 months (as determined by the Insurance Company or Claims Administrator, as applicable), provided the child:
    - is incapable of engaging in substantial gainful activity;
    - receives over 50% of his or her support and maintenance from you, your spouse or your eligible domestic partner; and
    - has the same residence as you for more than one-half of the year (or if less than one-half of the year, has resided with you since birth or adoption)

  You must provide proof of the ongoing disability as often as requested by the Plan. The child must be disabled prior to age 26 or become disabled while covered as a dependent under the Plan's medical and prescription features.

- A child who is the subject of a "qualified medical child support order" ("QMCSO") as determined by a judgment, decree, or any order of a court. Note that the Plan Administrator will not recognize an order that requires a child of your spouse (other than your stepchild) or your eligible domestic partner to be covered under the Plan if your spouse or domestic partner does not live with you.

Eligible Children – Dental, Vision, EAP and Prepaid Legal Benefits

The following is a list of dependent children who are eligible for dental, vision, EAP and prepaid legal coverage under the Plan:

- A child who is less than 19 years of age or, if a full-time student, less than age 23 where the child meets one of the following criteria:
    1. your unmarried biological child, legally adopted child (including a child placed with you for adoption), or step-child*;

** A child who is your stepchild will no longer be an eligible dependent in the event of a divorce.*

2. your same-sex spouse's or domestic partner's unmarried biological or legally adopted child;
3. an unmarried child for whom you, your spouse or eligible domestic partner are the legal guardian (as determined by an authorized placement agency, or by judgment, decree, or any order of a court); or
4. your, your spouse's or your eligible domestic partner's unmarried grandchild. However, for your or your opposite-sex spouse's grandchild, the grandchild must also be your tax dependent to be eligible.

A child, as described in the above list, must have the same residence as you (or his/her biological parent, if divorced or separated) for more than one-half of the year. (Temporary absences for special circumstances, such as education, are not considered in determining whether a child meets the residency requirement); and, receive over 50% of their support and maintenance from you, your spouse or eligible domestic partner; and, must not be regularly employed on a full-time basis.

Shortly after you enroll a dependent, you will be required to attest to the Plan Administrator (and provide supporting documentation) that a child meets the above requirements. In addition, you may be asked to recertify annually that a grandchild continues to meet the Plan's requirements.

If a child is age 19 or older (but under age 23) and is enrolled in an accredited secondary or post-secondary school or university on a full-time basis (as defined by the applicable school or university), you must document and certify his/her status as often as requested by the Plan.

- A child in one of the categories described above, who is older than 19 and has a physical or mental disability that is expected to last for a continuous period of not less than 12 months (as determined by the insurer/claims administrator), provided the child meets the residency and financial support requirements described above. The child must be disabled prior to age 23 or become disabled while covered as a dependent under the dental and/or vision feature(s) under the Plan.
- A child who is the subject of a "qualified medical child support order" ("QMCSO") as determined by a judgment, decree, or any order of a court. Note that the Plan Administrator will not recognize an order that requires a child of your spouse (other than your stepchild) or your eligible domestic partner to be covered under the Plan if your spouse or domestic partner does not live with you.

Eligible Family Members – Long Term Care Benefits

If you are an Eligible Employee, your family members – *i.e.*, your legal spouse or domestic partner, parents, grandparents, parents-in-law, and grandparents-in-law -- may apply for long term care benefits if they are between the ages of 18 and 79, maintain a permanent United States residence, and have an active Social Security number or tax identification number issued by the United States government.

How to Enroll and When Your Coverage Begins

EAP coverage is automatic and begins on your first day of employment. All other plans require you to take action before your Eligibility Date (described below). Except for long-term care and pre-paid legal benefits, you can enroll from home or work anytime (24/7) by logging onto: **myhr.cvs.com**. Once at the **myhr.cvs.com** site, you will need to follow the prompts on screen to make your coverage elections. Also, additional instructions are supplied with your enrollment materials. Customer Service Representatives are available to answer your enrollment questions. Call ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287). For long term care and pre-paid legal benefits, you can enroll by logging onto www.cvscaremarkvoluntarybenefits.com or by calling 800-375-1655.

You must enroll prior to your Eligibility Date, otherwise you will have waived coverage and will need to wait until the next Annual Enrollment (which begins in April) or you may be able to enroll mid-year if you experience a Change in Status or a Special Enrollment event (described below).

Your Eligibility Date is the first day of the month following 90 days of continuous full-time employment with CVS, provided you are actively at work. Your Eligibility Date will be the date that your coverage begins – provided you enroll in advance of that date. When you enroll at **myhr.cvs.com**, your Eligibility Date will be reflected. (Note that if you are not actively at work due to a health factor, your absence will be counted for purposes of satisfying the 90-day requirement for purposes of medical, prescription, dental, and vision benefits.) Employees who experience a break in full-time employment will be required to fulfill the 90-day waiting period from their most recent full-time employment date, as described in the "Rehires" discussion below.

Long term care. You may apply for long term care coverage on your 59th day of continuous, active full-time employment with CVS. If you apply for coverage prior to your Eligibility Date (described above) and are approved, your coverage will begin on your Eligibility Date. If you apply for coverage after your Eligibility Date, you will be subject to full underwriting (evaluation of your health information) and, if approved, coverage will be effective on the date designated by the Insurance Company.

By enrolling in the Plan, you authorize CVS to deduct coverage contributions from your pay. In the event you owe premiums to the Plan, you are also authorizing CVS to deduct the outstanding benefit contribution balance through payroll deductions in an amount not to exceed double the required contribution of the benefit option and level you selected, until the balance is repaid in full. Any questions about enrolling should be directed to ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287).

New Hire

If you are a new hire who is scheduled to work an average of 30 hours or more per week, your coverage begins on the first day of the month following 90 days of continuous full-time employment with CVS (this is your Eligibility Date), assuming you properly and timely enroll in the Plan (as described below). However, your coverage under the Employee Assistance Plan (EAP) begins on your hire date. Your enrolled dependents' coverage takes effect on the same date your coverage takes effect.

If you are not continuously at work due to a health factor (such as being absent from work on sick leave), your absence will be counted for purposes of determining eligibility for medical, prescription, dental and vision benefits under the Plan. (The eligibility rules for other benefits, such as life and disability insurance, do not count sick leave and other health-related absences

toward satisfying the 90-day employment requirement.) However, if you are not continuously at work due to a reason other than a health factor, your absence will not be counted.

As a new hire, you must enroll prior to your Eligibility Date. Failure to enroll prior to your Eligibility Date results in your benefits being waived. Your next opportunity to enroll is during the Annual Enrollment period which begins in April. Annual Enrollment elections are effective June 1. You will be notified of the Annual Enrollment period.

Rehires. If you are a rehired employee who returns to employment after a 30-day break in employment, you will have to re-satisfy the 90-day waiting period described above, measured from your date of rehire.

If you are a rehired eligible employee who has returned to employment within 30 days of your date of termination, you will not have to satisfy the waiting periods described above and the benefit elections you had in place on your last day of employment will resume on the date you are rehired. You may not change these elections upon your rehire. However, if you are rehired during a new Plan Year, you will have to make a new benefit election if your prior coverage option is no longer available. Your next opportunity to change your benefit enrollment election is during the Annual Enrollment period or upon a Special Enrollment event or a Change in Status (discussed below).

For long term care, if you continued your policy during your break in employment, you may ask CVS to move you to payroll deduction to pay for your long term care policy. If you did not continue your long term care policy during your break in employment, you will need to reapply for coverage, which will be reinstated on your new Eligibility Date (the first day of the month following 90 days of continuous, active full-time service from your date of rehire), provided you timely apply for, and are approved, for coverage.

Employees Residing in California. If you are a resident of California, refer to the California Supplement that accompanies this Summary for special enrollment rules that apply to new hires.

Employees Residing in Hawaii. If you are a resident of Hawaii, refer to the Hawaii Supplement that accompanies this Summary for special enrollment rules that apply to new hires.

Annual Enrollment

The Annual Enrollment period is the period of time during which you are given the opportunity to enroll in the Plan, drop coverage, or change your coverage level (for example, from employee to employee plus more than one dependent). The Annual Enrollment period commences in April, and elections made during this period are effective June 1. You may need to reenroll in the Plan during each Annual Enrollment period to continue your previous year's coverage. Look for information from CVS regarding Annual Enrollment to determine whether reenrollment action is required to continue coverage into the next Plan Year.

Special Enrollment

Ordinarily, if you do not enroll for coverage when you are first eligible, you must wait until the next Annual Enrollment period. However, in certain cases you and/or your dependents may be eligible for "Special Enrollment" outside of the Annual Enrollment period. If this is the case, you may make election changes concerning your medical/prescription, dental and vision benefits under the Plan. You may also change benefit options when a Special Enrollment event is the result of marriage, birth, or adoption. If you or your dependent experience a Special Enrollment

event described below, you must take action within the time period described below to make your election change. You can do this by logging onto **myhr.cvs.com**, or calling ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287) during normal business hours – to advise CVS of the Special Enrollment event and make your election change. Once at **myhr.cvs.com**, look for the "Life Events" menu, which will provide you with directions on how to make your election change online. If you do not see the Life Event that pertains to you at **myhr.cvs.com**, be sure to call ***myHR*** within the required time period to make your election change. Note that for Special Enrollment events relating to Medicaid or CHIP eligibility, you must call ***myHR*** within the required time frame to make your election change (online election changes due to these events are not available).

Note: *Coverage is retroactive to the date of the event or loss of coverage, provided you complete the enrollment transaction by the required deadline. By completing the enrollment transaction, you authorize CVS to deduct contributions required for retroactive coverage from your pay.*

A Special Enrollment period is not available to an eligible employee and his or her dependents if coverage under the prior plan was terminated for cause, or because required contributions were not paid on a timely basis.

Loss of Other Coverage

If you decline enrollment (in medical/prescription, dental or vision benefits under the Plan) for yourself and your dependents due to other health coverage, you may be able to enroll yourself and your dependents for these benefits under the Plan within 30 days after the other coverage ends. Go to **myHR** at **myhr.cvs.com**.

For this Special Enrollment event to apply, you must have stated that you were declining coverage under the Plan for you and/or your dependents due to other health coverage, and you or your dependent's other coverage must be lost because it was one of the following:

- COBRA coverage that was exhausted,
- other coverage for which you or your dependent are no longer eligible (for example, by reason of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or incurring a claim that would meet or exceed a lifetime limit on all benefits under the other coverage), or
- the coverage was provided by another employer that ceased to pay for it.

If you fail to provide the written statement required above (stating that you were declining coverage due to coverage under another plan), the Plan may not provide Special Enrollment to you or any of your dependents. Note that neither a loss of coverage due to a failure to pay premiums nor a loss of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation) will trigger Special Enrollment rights.

Addition of New Dependent

If you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents for medical/prescription, dental or vision coverage under the Plan, provided you enroll your new dependent within 30 days after your date of marriage, and within 60 days after a birth, adoption, or placement for adoption. To enroll, go to myHR at **myhr.cvs.com** Changes to your coverage are effective as of the date of the event.

Special Rules in Case of Medicaid and CHIP

If you or a dependent are eligible for coverage under the terms of the Plan, but are not enrolled, you or your dependent may enroll for medical/prescription, dental or vision coverage under the terms of the Plan if either one of the following conditions is met:

- you or your dependents are covered under a Medicaid plan or a State child health plan under the Children's Health Insurance Program ("CHIP"), and coverage under the Medicaid or CHIP plan is terminated because of a loss of eligibility for such coverage. You may then request coverage under the Plan no later than 60 days after termination of the Medicaid or CHIP coverage, or
- you or your dependents become eligible for a premium assistance program (that could be used toward the Plan costs) under a Medicaid or state child health plan under CHIP (including any waiver or demonstration project conducted under or in relation to such a plan). You may then request coverage under the Plan no later than 60 days after the date you or your dependent is determined to be eligible for the premium assistance.

Call ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287) during normal business hours within 60 days after termination of the Medicaid or CHIP coverage or the date you or your dependents are determined to be eligible for premium assistance, as applicable. The call center representative will make your election changes on the phone at the time of your request.

Level of Coverage

With regards to medical, prescription, dental and vision coverage, you may choose from four levels of coverage: coverage for you, coverage for yourself plus your spouse/domestic partner, coverage for yourself plus one or more children, or family coverage (you, your spouse, and children).

Paying For Coverage

Generally, you and CVS share the cost of your Plan coverage (with CVS paying the majority of the cost). However, for vision benefits, prepaid legal services, and long term care benefits offered under the Plan, you pay the full cost of your coverage. Your contributions are not used to pay Plan expenses for vendors or other service providers who are affiliated with CVS (such as Caremark), except as may be permitted by ERISA.

Your contributions for your medical, prescription, dental, and vision coverage will be deducted from your pay on a before-tax basis and are subject to change on June 1 of each year or when you change your benefits. (Paying for your coverage on a before-tax basis means you don't pay Social Security or Federal (and, in most cases, state) income tax on your contributions. Since your taxable earnings are lower, you pay less in taxes.) Also, CVS's contributions towards your medical, prescription, dental and vision coverage are not taxed. This tax-preferred treatment is available for coverage for your opposite-sex spouse and for a dependent child who is your biological child, adopted child (or child placed with you for adoption), step-child, or a child for whom you are the legal guardian. However, tax-preferred treatment is not available for coverage of other dependents unless the dependent is considered your dependent for federal tax purposes. For example, unless your domestic partner qualifies as a "dependent" for federal tax purposes, the cost of a same-sex domestic partner's coverage and a domestic partner's child(ren)'s coverage (both the portion withheld from your pay on a pre-tax basis and CVS's contributions) is taxable and thus will be reflected as imputed income. This means that if you have coverage for a domestic partner or a child of a domestic partner who is not your federal tax

dependent, your payroll contribution will be made with before-tax dollars, but CVS will impute income to you to reflect the cost of their Plan coverage.

If you fail to pay monies owed to the Plan, the Plan Administrator may pursue any means of collection, including reporting the debt to a credit agency or prohibiting you from enrolling in the Plan in the next Annual Enrollment period.

Changing Your Coverage

You may change your coverage under the Plan during the Annual Enrollment period each year, or during the year if you have a Change in Status as provided below. However, election changes relating to long term care coverage can be made at any time, subject to the terms described in the "Long Term Care Plan" Section below.

Changes to your coverage during the year due to a Change in Status are effective as of the date of the Change in Status.

If you want to change your coverage due to a Change in Status, you must go to myHR at **myhr.cvs.com** to make the change within 30 days of the date of your Change in Status. However, for birth or adoption, you have up to 60 days to make the change. You will be able to report your Change in Status and change your coverage at the same time. If you do not complete the transaction within the required timeframe, you will have to wait until the next Annual Enrollment period to add coverage under the Plan.

A change in coverage must be consistent with your Change in Status. For example, if you become divorced, you may drop coverage for your former spouse, but you cannot change your own coverage options. Changes in Status include:

- marriage, divorce, legal separation, annulment, or termination of an eligible domestic partner relationship;
- birth or adoption (or placement for adoption) of your child, or the addition of your stepchildren;
- death of a dependent;
- change in employment status including termination or commencement of employment, a commencement of or return from an unpaid leave of absence or change in work schedule (including part-time to full-time or vice versa) for you or your dependent that affects eligibility for this plan or another employer plan;
- change in health insurance eligibility due to a relocation of residence or work place for you;
- a judgment, decree, or order resulting from your marriage, divorce, legal separation, annulment, or change in child custody requiring you to add or allowing you to drop coverage for your dependent child (this is dependent on state mandates);
- your or your spouse's or dependent child's entitlement, or loss of entitlement, to Medicare or Medicaid benefits;
- a significant increase in cost of coverage, or a reduction in benefits, under the Plan or your spouse's plan; and
- a change in a dependent's coverage under another employer plan that is permitted under that plan and applicable IRS regulations.

You may also drop coverage if your spouse or domestic partner gains coverage for you during his/her plan's annual enrollment, or add coverage if your coverage under another employer plan is dropped at the other plan's annual enrollment. You must show documentation from your spouse's or domestic partner's plan of such activity. You are not allowed to drop your coverage other than during the Annual Enrollment period unless you have a Change in Status.

For more information, go to myHR at **myhr.cvs.com** **or** call ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287). If you believe you are eligible to make a mid-year election change due to a Change in Status described above, go to myHR at **myhr.cvs.com** and make your enrollment change within 30 days of the date of the event (except in the case of a birth or adoption, in which case you have 60 days to make your enrollment change).

When Coverage Ends

Your coverage and your dependents' coverage end on your last day of employment with CVS. Under certain circumstances, you may be able to continue your coverage under COBRA, which is described later in this Summary.

Coverage also ends if any of the following events occurs:

- you no longer meet the eligibility requirements for coverage under the Plan;
- you retire;
- you stop making contributions for coverage;
- you pass the time frame for Plan coverage to continue while on a leave of absence (discussed in the "Other Important Information" Section later in this Summary); or
- the Plan is terminated.

Coverage for your dependents will end on the date any of the following events occurs:

- your coverage ends;
- except with regard to a disabled child, your dependent child turns age 26 (for medical, and prescription coverage) or age 19, unless a full-time student (for dental and vision coverage);
- for dental and vision coverage, your full time student turns age 23 or ceases to be a full-time student (for example due to graduation), whichever is sooner.
- you are divorced or legally separated, you terminate your domestic partner relationship or same-sex marriage, or you (i) no longer hold yourselves out to the public as spouses or domestic partners, or (ii) either you or your same-sex spouse has married, or entered into a domestic partnership or civil union with someone else. These events affect your spouse/domestic partner's eligibility and the eligibility their children and grandchildren;
- your dependent child no longer meets the eligibility requirements for coverage under the Plan;
- you stop making contributions for dependent coverage;
- you disenroll your dependent as provided under the Plan (for example, due to a Change in Status). You may disenroll your dependents who are domestic partners at any time, unless your domestic partner coverage is paid for on a pre-tax basis; or
- the Plan is terminated.

Note that you are required to provide notice by going to myHR at **myhr.cvs.com** or by calling ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287) no later than 30 days following your dependent ceasing to be eligible under the Plan.

Rescissions of Coverage

Fraud and Misrepresentation

The Plan may rescind (*i.e.*, cancel or discontinue on a retroactive basis) coverage if you or your dependents perform an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact. If the rescission relates to medical/prescription coverage, you and/or your dependents (as applicable) will receive at least 30 days advance notice before the coverage is rescinded.

Administrative Delays and Failure to Pay Premiums

Coverage may be retroactively terminated due to administrative delays in processing or due to a failure to timely pay required premiums or contributions toward the cost of coverage. Except where required by law, coverage may be terminated for these reasons without advance notice.

Loss of Benefits

You or your dependents also may experience a reduction or loss of benefits in any of the following circumstances:

- you fail to follow the Plan's procedures;
- you fail to reimburse the Plan for a claim that was paid in error;
- you receive reimbursement for a covered expense by another similar insurance plan which is primary to the Plan while also receiving primary reimbursement from the Plan;
- you receive a judgment, settlement or otherwise from any person or entity with respect to the sickness, injury or other condition which gives rise to expenses the Plan pays;
- you are found to have committed a fraudulent act against the Plan including, but not limited to, the fraudulent filing of a claim for reimbursement;
- the Plan is amended or terminated, but only with respect to expenses incurred after the amendment or termination becomes effective; or
- you or your provider fails to file a claim within 12 months of the date service is provided.

Erroneous Claims and Administrative Errors

If the Plan Administrator determines that a benefit was paid under the Plan that either (a) exceeds the covered expenses or (b) was paid in error (for example, if the Plan provided coverage to an ineligible or unverified dependent), you will be required to repay to the Plan the improperly covered benefits. The Plan provides that the Plan Administrator in its discretion may recoup the improperly covered benefits under any methods of collection available, including any of the following:

- notification to you of the error, and an accompanying request that you immediately pay the amount of the improperly covered benefit as directed by the Plan Administrator;
- offsetting the amount of the improperly covered benefit against any other eligible Plan benefits (regardless of the Plan Year in which it is submitted); and
- if permissible under applicable law, withholding the amount of the improperly covered benefits from your pay on an after-tax basis.

If the Plan Administrator is unable to recover all or a portion of your debt to the Plan, you may not be eligible to participate in the Plan during the next Annual Enrollment period.

Disclaimer

CVS Human Resources (HR) employees and employees of the Insurance Companies and/or Claims Administrators often respond to outside inquiries regarding coverage as part of their job responsibilities. These employees do not have the authority to extend or modify the benefits provided under the Plan.

In the event of a discrepancy between information given by a Claims Administrator, Insurance Company or CVS HR employees and the written terms of the Plan, the terms of the Plan will control.

Any changes or modifications to benefits under the Plan must be provided in writing and made according to the Plan's amendment procedures.

Administrative errors will not invalidate benefits otherwise in force or give rise to rights or benefits not otherwise provided by the Plan.

The Pharmacy (Rx) Plan

Schedule of Benefits		
	CVS/pharmacy **Up to a 30-day supply**	**CVS/pharmacy or CVS Caremark Mail Service** **Up to a 90-day supply**
Preventive Care Treatment	You pay $0.00	You pay $0.00
Generic Drugs	You pay $ 7.50	You pay $9.99 for Value Generics For all others, you pay $15.00
Preferred Brand Drug (on the Preferred Drug List)	You pay 20%	You pay $41.50
Non-Preferred Brand Drug	You pay 35%* *Limits apply.	You pay $91.00
Specialty Medicine	You pay $75 for up to a 30-day supply.	
Non-Participating Pharmacy	The Plan reimburses 50% of the covered rate.** **Preventive care treatments are not covered.	Not covered
Infertility Medications	$10,000 Lifetime Maximum	
Quantity Limit and Prior Authorization	Log in to www.caremark.com or call Customer Care at 1-866-284-9226 to find out if your medicine has a quantity limit or requires prior authorization.	

How the Prescription (Rx) Plan Works

Prescription benefits are administered by a Claims Administrator, CaremarkPCS Health, L.L.C. (hereinafter referred to as "Caremark"). Upon enrollment, Caremark will mail an identification card to your home. Present this card, along with your prescription or refill order at any CVS/pharmacy, Longs Drugs or CVS Caremark Mail Service Pharmacy and pay the applicable copay. The pharmacy may dispense up to a thirty (30)-day supply or an eighty-four to ninety (90)-day supply of the drug to you. Certain drugs are limited to the dosage recommended by the drug manufacturer. Such dosage recommendations may result in less than a thirty (30)-day or ninety (90)-day supply. Refer to the section of this Summary below titled "***Quantity Restrictions on Covered Medications***" for more information.

You can call or contact Caremark at (866) 284-9226 or www.caremark.com, or write to the address listed in the "General Plan Information" Section of this Summary.

Retail Pharmacy Service

You must use CVS/pharmacy or Longs Drugs for your retail benefits. If you use a non-participating pharmacy, you must pay 100% of the prescription price, then, you need to submit a paper claim form along with the original prescription receipt(s) to Caremark for 50% reimbursement of covered expenses (which is based on the negotiated/reduced rate that would have been charged by a participating pharmacy). However, if you use a non-participating pharmacy, the Plan will not reimburse you for preventative care treatment. You can download and print a claim form when you log in to www.caremark.com or call the Caremark Customer Care toll-free number on your prescription benefit ID card.

Mail Service Pharmacy

If you use maintenance medications for chronic illnesses like high blood pressure, diabetes, arthritis and high cholesterol, you may want to consider purchasing your prescriptions through Caremark Mail Service Pharmacy. You may receive up to a ninety (90)-day supply of medication through Caremark's mail order service. For more information on mail order service, call Caremark at (866) 284-9226.

Covered Medications

All Federal legend drugs are covered, subject to the Plan's limits and exclusions, and subject to the drug being on the Plan's formulary.

The listing below of prescription drug categories provides an overview of drug types covered under the Plan, unless specifically excluded below under the "***Excluded Drugs and Items***" section of this Summary.

- Blood Factors / Clotting Factors
- Compounds with at least one legend drug
- Diabetic medications and supplies
- Emergency Allergy Kits
- Immunosuppressive Agents
- Legend vitamins
- Oral Contraceptives
- Fluoride agents (topicals and supplements)
- Injectable drugs

- Growth hormones
- Smoking Cessation

Note that to be a covered medication, the drug must be on the Plan's formulary. The formulary is a list of prescription drugs – both generic and brand – that has been developed by Caremark through a rigorous review process. The Plan has adopted Caremark's formulary, including its Preferred Drug List (discussed further below). If a drug is not on Caremark's formulary – *i.e.*, is determined to be "non-formulary" – it will not be covered by the Plan.

Because agents are added to or removed to the formulary on a regular basis (based on factors such as effectiveness, safety, therapeutic role in the management of disease, and cost), it is important for you to confirm that a prescription is on the current formulary. You can confirm a drug is on the formulary and is not subject to a Plan exclusion or limitation, as well as answer Plan coverage questions, by accessing www.caremark.com, as described below:

Using Caremark.com to answer drug coverage questions

- Log onto Caremark.com and register
- Navigate to the tab labeled "understand my plan and benefits"
- Select Drug Coverage and Cost from the menu
- Enter drug information
- The web page will provide the coverage and cost results
- The coverage and cost results page may be printed and shared with the physician

Safety Measures & Prescription Modifications. Caremark ensures safety in dispensing prescriptions through a review process that evaluates prescriptions filled through CVS/pharmacy or through Mail Service. In some instances, a Caremark pharmacist may consult with your physician by telephone or fax to discuss a current prescription. Your physician may agree to change the medicine, adjust the number of doses or alter the length of time you need to take the medicine. However, the prescribing physician is the final decision-maker regarding any changes in the course of therapy. Caremark cannot change a prescription without the full consent of the prescribing physician, either directly or through an authorized agent. If the pharmacist and the physician agree that an alternate medicine is not appropriate, the prescription is filled as originally written.

Preventive Care Services

If your physician prescribes any of the following pharmacy related preventive care treatments for you or a covered dependant, the Plan will cover the full cost of such treatments if you obtain the treatments from a participating network pharmacy. Preventive care treatments purchased at a pharmacy that is not a participating network pharmacy, are not covered by the Plan.

The specific preventive care treatments covered under the Plan are:

- Daily dosages of generic aspirin of up to 325 mg for covered individuals age 45 and over;
- Daily dosages of folic acid 0.4 mg to 0.8 mg for covered women through age of 55 years;
- Daily dosages of iron supplements for children aged 6 months through 12 months;
- Daily dosages of oral fluorides of up to 0.5 mg for children through age of six years; and
- Selected tobacco cessation products (generic only if available) for a maximum of 24 weeks in any twelve month benefit period.

Preferred (Brands and Generic) Drug List

Caremark's formulary (which the Plan has adopted), includes a Preferred Drug List, which is a guide with select therapeutic categories for Plan members. Brands and generics are listed in therapeutic categories for reference only. If a brand drug is on the Preferred Drug List (a "Preferred Brand Drug"), you pay less than a brand drug that is not on the Preferred Drug List (a "Non-Preferred Brand Drug"). Refer to the Schedule of Benefits above for the differing copays.

The Preferred Drug List is not an all-inclusive list, as new medications frequently enter the market. As a result, you should check for updates periodically at www.caremark.com.

To make the best use of the Plan, generics should be considered the first line of prescribing. If there are no generics available, there may be more than one brand name drug to treat a condition. Refer to the Preferred Drug List to locate the Preferred Brand Drugs that are clinically appropriate and cost-effective.

As indicated on the above Schedule of Benefits, brand name drugs are subject to larger copay than generic drugs, and Non-Preferred Brand Drugs are subject to a larger copay than Preferred Brand Drugs.

Note: To educate your physician on the Plan's Preferred Drug List, ask your physician to make a copy of the preferred drug list to place in your medical file. If you can't find your Preferred Drug List, or you need an updated copy, log in to www.caremark.com or call Caremark at (866) 284-9226.

Reducing Health Care Costs with Generics

To control costs and save money, consider the use of generic drugs. Generic drugs are approved by the U.S. Food and Drug Administration, which means that a generic drug has the same quality, strength and effectiveness as the brand name equivalent. By taking a generic drug, you also save money. To realize these savings, ask the physician to prescribe a generic drug or ask the pharmacist if there is a generic drug that is equal to the brand name drug.

If there is a less expensive alternative to a medicine you have been prescribed, Caremark may contact your physician or other prescriber and ask whether it might be appropriate to substitute another product. In most cases, the alternative is a generic equivalent. Caremark will not make such a substitution without your physician or other prescriber's approval.

Value Generics

Value Generics are simply generic drugs that are widely used and commonly prescribed. They are subject to a reduced copay, as reflected on the above Schedule of Benefits. Ask your doctor if a generic on the Value Generic Drug List is right for you. To determine if the generic is a Value Generic, *log in to www.caremark.com or call Caremark at (866) 284-9226.*

Generic Step Therapy

As part of Caremark's clinical approach to managing your prescription benefit for certain therapeutic classes, in order for a brand name drug to be covered, you will be required to try a generic drug first. This applies even if your physician prescribes the brand drug with no substitutions ("dispense as written"). As part of this step-therapy approach, if you choose a brand drug without first trying a generic drug, you may be responsible for the full cost of the brand drug, even if there is clinical approval for the brand name drug. The drug classes subject

to this "Generic Step Therapy" include, but are not limited to, those used to treat high blood pressure, allergies, pain and inflammation, high cholesterol, depression, and insomnia/sleep problems. ***Log in to www.caremark.com or call Caremark at (866) 284-9226 for more information.***

Paying For Non-Preferred Brand Drugs with Generic Alternatives

If you or your physician selects a brand-name drug when a generic is available, you are required to pay the brand co-payment *plus* the cost difference between the generic and the brand drug. Generally, Brands with generics are Non Preferred Brands.

Paying For Preferred Brand Drugs without Generic Alternatives

Preferred Brand Drugs without generic alternatives are covered at the preferred brand name co-payment, unless the drug is an excluded medication.

Paying For Non-Preferred Brand Drugs without Generic Alternatives

Non-Preferred Brand Drugs with no preferred equivalent are covered at the non-preferred brand name co-payment, unless the drug is an excluded medication.

For specific medicine information, please log in to www.caremark.com or call Caremark at (866) 284-9226.

Specialty Medications

Specialty medications are used to manage long-term (chronic), rare and complex conditions or genetic disorders. These include rheumatoid arthritis, cancer, multiple sclerosis, growth hormone disorders, immune deficiencies, and more. The medications are often injectable or intravenously (IV) infused, but may also be in oral or inhaled form. These medications typically have special storage and handling needs and cost more than other drugs because of the way the drugs are made. CVS Caremark provides special support for these patients, including 24-hour access to pharmacy services and emergency pharmacist consultation, as well as ongoing support and counseling. Learn more about the CVS Caremark Specialty Pharmacy at www.caremark.com/specialty.

As a part of your pharmacy benefit, specialty oral and injectable medication services are available to you exclusively through the Caremark Specialty Pharmacy.

The Caremark Specialty Pharmacy program not only provides specialty medications, but also provides personalized pharmacy care management services:

- Access to an on-call pharmacist 24 hours a day
- Convenient, prompt and discreet delivery
- Disease-specific education and counseling
- Proactive refill reminder phone calls
- Benefit verification and reimbursement support
- Coordination of patient care with physician's office
- Caremark Specialty supports safe, clinically appropriate and cost-effective use of specialty medications and may make calls to your physician about your therapy which may result in changes to you therapy. may occur

Specialty Step Therapy is part of two therapeutic classes. Specialty will encourage the use of a drug on the Preferred Drug List prior to the use of medicines that are not on the Preferred Drug List. If you have not tried the drug on the Preferred Drug List, a Prior Authorization must be completed before the non–preferred will be covered.

- Growth Hormone, preferred drugs
- TNF Inhibitors (Rheumatoid Arthritis, Psoriasis, etc)

Specialty services are available toll-free at 1-800-237-2767, through CaremarkConnect®, Monday through Friday from 6:30 a.m. to 8 p.m. (Central Time). For those plan participants requiring telecommunications device (TDD) assistance, please dial toll-free 1-800-231-4403.

Quantity Restrictions on Covered Medications

There may be quantity limits on certain medicines. Quantity limits are based on the Food and Drug Administration's (FDA) recommended dosing guidelines for each medication and are reviewed regularly by Caremark to ensure clinical appropriateness. Limits are set to ensure safety and efficacy in the treatment of various health conditions.

Medicines that have limits on the quantity allowed are less than the standard, which is a thirty (30) day supply. For specific medicine limitations, please log in to www.caremark.com or call Caremark at (866) 284-9226. Quantity limits may change periodically based on updates from the FDA's recommended dosing guidelines.

Examples of Drug Categories with Quantity Restrictions

- Beta-Agonists and Combinations
- Sexual Dysfunction Agents
- Intra-nasal Corticosteroids (Allergies)
- Mast Cell Stabilizers and Anticholinergics
- Influenza Treatment and Prevention
- Insomnia Agents
- Glucose Monitors
- Pain Medications (including those containing Acetaminophen, Aspirin or Morphine)

Maximum Allowable Benefits

Certain medications are covered under the Plan only up to a certain level of coverage, as listed below:

- Infertility Drugs (up to $10,000 per lifetime)

Prior Authorizations (PA)

Certain medications may only be covered by the Plan under certain conditions with a prior authorization (PA) from Caremark prior to purchasing the medicine. For consideration, your attending physician must submit a letter describing your medical condition and treatment plan. To find out if a drug requires a PA, log in to www.caremark.com and run a test claim for coverage or call Caremark at (866) 284-9226.

Additionally, prior authorization is required for replacement medications that are lost, stolen, or broken; for an advance supply if you plan to be out of the service area (*i.e.* vacation or travel); and, for a unit/supply quantity in excess of the limits described above.

Examples of Drug Categories with Prior Authorization Required

- ADHD / Narcolepsy
- Anabolic Steroids
- Anti-fungal
- Pain / Oral Fentanyl and Topical
- Testosterone Oral and Topical
- Topical Acne
- Infant Formula

Nutritional Supplements (Infant Formula)

Effective January 1, 2012, the Plan covers certain infant formulas with a prescription. A prior authorization is also required. All formulas are covered at the Non-Preferred Brand Drug level. To confirm if the formula is eligible for coverage, go to www.caremark.com and run a test claim for coverage or call Caremark at (866) 284-9226.

Prescription Plan Definitions

Brand Name Drugs - The brand name drug is generally the trade name given to the drug while a patent (during which time it can be produced and sold only by the company holding the patent) protects it. A brand-name drug is therapeutically equivalent and more costly than a generic drug.

Compound Drugs – Drugs that contain at least one FDA approved component and is custom mixed by a pharmacist.

Co-payment or copay **-** A co-payment or copay is the amount you pay to have your prescription filled. The type of medication you purchase determines the amount of your co-payment.

Generic Drugs, Generics – Commonly used terms to identify a non-brand name drug. Generic versions of a drug can be offered for sale when the patent protection for a brand name drug expires. Generic drugs cost less than brand name drugs because manufacturers don't typically advertise, and don't have to invest in the original research, development, and testing. A generic drug is a pharmaceutical equivalent to a brand drug and has identical strength, dosage form, quality, active ingredient and effectiveness. All generic drugs are approved by the Food and Drug Administration (FDA) as a generic equivalent to the brand-name drug.

Federal Legend Drugs – All drugs that require a prescription.

Excluded Drugs and Items

The following drugs and items are excluded from coverage in the Plan:

- Over the counter (OTC) products
- Preventive care treatments purchased at a non-participating pharmacy
- Investigational and experimental drugs
- Smoking cessation products, unless otherwise specifically noted in this Summary

- Cosmetic drugs
- Non-insulin needles and syringes
- Appetite suppressants
- Appliances, devices and durable medical equipment (DME)
- Weight control products
- Vaccines and immunizations
- Surgical supplies and devices
- Drugs obtained while under the care of a treatment facility, clinic, hospital, etc.
- Charges for the administration of any drug
- Drugs administered in a physician's office
- Formulary exclusions

Using Caremark.com to answer drug coverage questions

- Log onto Caremark.com and register
- Navigate to the tab labeled "understand my plan and benefits"
- Select Drug Coverage and Cost from the menu
- Enter drug information
- The web page will provide the coverage and cost results
- The coverage and cost results page may be printed and shared with the physician

Medical Plans (California and Hawaii)

For CVS employees who reside in California, this Summary, together with the California Supplement, addresses eligibility and enrollment for the medical benefits insured by Kaiser Permanente and Health Net of California, Inc. For CVS employees residing in Hawaii, this Summary, together with the Hawaii Supplement, addresses eligibility and enrollment for the medical benefits insured by Kaiser Permanente and HMSA Blue Cross Blue Shield of Hawaii. Refer to the Insurance Certificates issued by these Insurance Companies for a summary of the medical benefits provided in those locations.

There is also a self-funded PPO medical option in Hawaii, which is administered by HMA, Inc., and a self-funded PPO option in limited areas in California. For a summary of these medical options rules regarding eligibility, enrollment and benefits, refer to their separate Summary Plan Descriptions. You may request a copy of these summaries by calling ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287).

Dental Plan (Aetna DMO Plan)

Under the dental DMO benefit option insured with Aetna Life Insurance Company, you are only covered for services from network dentists, there is no deductible, no calendar-year limit on the amount the Plan pays, and no claim forms to file. Orthodontia for both children and adults is covered with a $2,400 copay, and there is no lifetime maximum for orthodontia. However, you **must** select a primary dentist by contacting Aetna at **1-800-770-2386** when you enroll. Also, before you enroll, be sure to check if there is an Aetna DMO network dentist close to you, by logging onto www.aetna.com/docfind.

For a complete description of the dental DMO benefits provided to you and your eligible dependents under the Plan, please refer to the insurance certificate provided by Aetna Life

Insurance Company. A summary of the dental benefits under the Aetna dental DMO benefit option is also provided at myhr.cvs.com.

There is also a self-funded dental option, administered by Delta Dental. For a summary of the eligibility and benefit terms for this dental option, refer to its separate Summary Plan Description.

Vision Service Plan (VSP)

Vision benefits are offered to eligible employees through an insurance contract with VSP. The vision benefits provided through VSP help you pay for eye exams, eyeglasses and other eye care expenses.

Refer to this Summary's description of the Plan's eligibility terms and enrollment procedures for information on eligibility and enrollment for vision benefits through VSP.

Note that VSP does not provide an ID card for this benefit. To verify your eligibility for services, you can log onto www.vsp.com. You must register on the site by using the employee's data. If you cover dependents, their enrollment information will appear under your record. For assistance, please call VSP Member Services at (800) 877-7195.

Cost of Coverage

As discussed above under the "***Paying for Coverage***" section of this Summary, you pay the full cost of vision coverage for both you and your eligible dependents. The cost of your vision coverage depends on the level of coverage you choose.

In-Network and Out-of-Network Coverage

You receive a higher benefit under the vision plan when you use a VSP network doctor. If you use a non-VSP doctor, you will still receive benefits, but they will be at a lower, out-of-network level. The VSP network doctors are listed in a provider directory. You can access the VSP provider directory by logging onto www.vsp.com. You also can request a copy of the provider directory from VSP by calling (800) 877-7195, which will be furnished without charge. If there is no vision care provider close to where you live and you go to a provider that is not part of the network, you will receive out-of-network benefits.

For a summary of in-network and out-of-network coverage by benefit type, please see the **Schedule of Benefits** that follows.

Benefit	How much and how often
Vision exams for eyeglasses	**In-network:** the Plan pays 100% after $10 co-pay **Out-of-network:** the Plan pays $35
Eyeglass frames	**In-network:** the Plan pays $180 after the $25 co-pay **Out-of-network:** the Plan pays $45
Single vision lenses	**In-network:** the Plan pays 100% for basic lenses **Out-of-network:** the Plan pays up to $25
Bifocal lenses	**In-network:** the Plan pays 100% for basic lenses **Out-of-network:** the Plan pays up to $40

Trifocal lenses	**In-network:** the Plan pays 100% for basic lenses **Out-of-network:** the Plan pays up to $55
Lenticular lenses	**In-network:** the Plan pays 100% for basic lenses **Out-of-network:** the Plan pays up to $80
Necessary contacts *	**In-network:** the Plan pays 100%, includes fitting & evaluation (must be prescribed and preauthorized by VSP); no co-pay on contacts **Out-of-network:** the Plan pays 100% up to $210 (see exclusions); no co-pay on contacts
Elective contacts **	**In-network:** the Plan pays 100% up to $150 (see exclusions); no co-pay on contacts. Exam fee discounted 15%. **Out-of-network:** the Plan pays 100% up to $150 (see exclusions); no co-pay on contacts

** Necessary contacts are contact lenses prescribed (by a doctor) for certain medical or visual/refractive conditions that prevent the patient from obtaining the best visual correction with glasses. Patients must meet certain criteria in order to qualify for necessary contacts.*

*** Elective contacts are contact lenses that are not required for the visual welfare of the patient, but rather are an optional choice over eyeglasses.*

Covered Benefits

The VSP vision plan generally covers eyeglasses and contact lenses you may need to correct your vision.

The Plan covers each of the following <u>once</u> per plan year:

- one eye exam with a $10 co-pay
- one frame and one set of eye glass lenses with $25 co-pay, or
- contact lenses covered up to $150

Other covered benefits include:

- *Added Lenses.* If provided in-network, polycarbonate and blended lenses are covered. Out of network, you will be 100% responsible for any lens options added to your eyeglasses.
- *Rimless Mounted Frames.* This frame is covered if provided in-network. Out of network, you will be 100% responsible for any frame coverage above the amount of allowance.
- *Prescription Sunglasses.* Prescription sunglasses are covered the same as any other pair of eyeglasses.

Discounts

You can receive a discount from the VSP network of providers on the following merchandise:

- *Laser Vision Correction*
    - After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.
- *Glasses and Sunglasses*
    - Savings on lens options such as scratch resistant and anti-reflective coatings and progressives
    - 30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam
- *Contacts*
    - 15% off cost of contact lens exam (fitting and evaluation); available from any VSP doctor within 12 months of your last eye exam

VSP Contact Lens Program

New and current contact lens wearers may qualify for a program that includes a contact lens evaluation and initial supply of lenses. Check with your VSP doctor to see if you qualify.

Excluded Benefits

The vision benefits offered through VSP under the Plan do not cover:

- Both eyeglasses and contact lenses
- Replacement of lost, stolen or broken eyeglasses or contact lenses
- Safety eyewear
- Services or supplies covered by a medical option, including medical or surgical treatment, drugs, or medication
- Cosmetic lenses or processes
- Oversize lenses
- The coating or laminating of the lens or lenses
- Photo chromic lenses: tinted lenses except Pink #1 and Pink #2
- Corrective vision treatment of an experimental nature
- Coverage for medical treatment and illnesses associated with your eyes (Refer to the description of your medical coverage in the insurance documents distributed with this Summary to determine the extent of coverage under the medical portion of the Plan.
- Accessories for eyeglasses
- Vision care solutions

Note that the VSP vision plan does not have a mail-order contact lens program.

Employee Assistance Plan (EAP) – LifeScope for You

LifeScope for You is available 24 hours a day, 7 days a week, with trained and licensed counselors who can provide confidential advice, counseling or referral services to assist employees and their family members to resolve a full range of human life, work-family, or health problems. Employees and their dependents (described in the "**Eligibility**" section) are eligible for LifeScope for You EAP services on the first day of employment.

Assistance is available for a wide range of situations including emotional and personal concerns (such as depression and stress); financial concerns; legal assistance; marriage, family and relationships; elder care and child care resources and counseling; and drug and alcohol addictions.

If you are enrolled in a CVS medical plan, you are also eligible for up to six face-to-face, private counseling sessions per issue per plan year **at no cost** to you. Sessions must be approved by LifeScope in advance. Counseling sessions after the sixth session may be covered under the medical plan at the same copay as an office visit. See your medical plan Summary Plan Description for more information.

LifeScope will work with you to find a specialist in your network and close to your home.
LifeScope for You can be accessed 24 hours per day, 7 days per week. For assistance, call LifeScope for You at 1-800-789-8990, or visit www.LifeScope4you.com

Legal Services Plan

The Plan offers prepaid legal services through Hyatt Legal Plans (Metlaw), which provides personal legal services for eligible employees, their spouses, domestic partners, and dependent children for a monthly fee.

Enrollment

If you are an eligible employee and desire to enroll in the legal plan, you may enroll upon hire (after satisfying the service requirements); your election for coverage will remain in effect for the remainder of the Plan Year. If you do not enroll in the legal plan when first eligible upon hire, you may enroll if you experience a Change in Status that affects your eligibility for coverage (*e.g.*, you change from part-time to full-time status). You may also elect coverage during the Annual Enrollment period held each Spring, for which coverage will be effective for the upcoming Plan Year.

Cost of Coverage

As discussed above under the "***Paying for Coverage***" section of this Summary, you pay the full cost of prepaid legal services coverage for both you and your eligible dependents. Refer to the enrollment materials for the monthly cost of coverage, which rate covers your spouse and eligible dependents.

How the Plan Works

Through the prepaid legal service plan, you, your spouse and/or domestic partner and covered dependents can have access to covered legal services for the same affordable price. Visit www.cvscaremarkvoluntarybenefits.com for a list of matters for which advice and consultation

services (and in certain circumstances, court assistance) are available through the prepaid legal services plan.

You can also call the Metlaw benefits line at **(800) 375-1655**, Monday through Friday from 8 a.m. to 6 p.m. (Eastern Time) for more information or to locate a participating attorney. A Customer Service Representative will refer you to a participating attorney closest to you and will provide you with a case number to allow the attorney to be paid directly by the plan. If you choose to use an out of network attorney, you will be reimbursed for the cost of the covered service based on a set fee schedule. The fee schedule is available by calling the benefits line.

What Services are Covered?

The prepaid legal plan entitles you and your covered dependents to certain personal legal services. The benefits are comprehensive, but there are limitations and other conditions that must be met. Through the prepaid legal services plan, representation is provided for legal services, including:

- Estate planning documents (e.g., Wills and Codicils, Living Wills, Powers of Attorney and Trusts);
- Document review of personal legal documents;
- Family law assistance (e.g., Prenuptial Agreement, Protection from Domestic Violence, Adoption, Guardianship or Conservatorship and Name Change;
- Immigration assistance;
- Elder law matters;
- Real estate matters (*e.g.*, related to sale, purchase, or refinancing of your primary or secondary residence or vacation home, eviction and tenant problems, boundary or title disputes);
- Document preparation (*e.g.*, Affidavits, Deeds, Demand Letters, Mortgages);
- Traffic ticket defense (No DUI) and Restoration of Driver's License;
- Financial matters (*e.g.*, negotiations with creditors, personal bankruptcy and identity theft defense);
- Juvenile Court Defense;
- Civil litigation Defense;
- Consumer protection matters; and
- Personal property protection.
- A detailed schedule of benefits is available upon request. Call 1-**800-375-1655** Monday through Friday from 8 a.m. to 6 p.m. (Eastern Time) or visit www.cvscaremarkvoluntarybenefits.com.

What Services are Not Covered?

The prepaid legal plan does not provide any services, not even a consultation, for the following matters:

- employment-related matters (including benefit matters);
- matters involving CVS, Caremark, MetLife and affiliates, and plan attorneys;
- matters in which there is a conflict of interest between you, and your spouse or dependents, in which case services are excluded for your spouse and dependents;

- appeals and class actions;
- farm and business matters including rental issues when the participant is the landlord;
- patent, trademark and copyright matters;
- costs and fines; frivolous or unethical matters; and
- matters for which an attorney-client relationship exists prior to you becoming eligible for plan benefits.

Long Term Care Plan

The long term care plan provides you and your eligible family members with coverage that can protect you from the high costs of long term care services, including care at home, in the community, in assisted living facilities (including Alzheimer's facilities), and in nursing homes. Insurance provided under the long term care plan is intended to be federally tax-qualified long term care insurance within the meaning of Internal Revenue Code Section 7702B(b), as amended.

The long term care plan benefits are insured through Genworth Life Insurance Company ("Genworth Life"), which administers benefits and long term care claims. If you apply for, and are approved, for long term care coverage, Genworth Life will provide you with a Certificate of Insurance, which explains your coverage and the applicable conditions in more detail.

What Does the Long Term Care Plan Cost?

Premium rates are included in an Information Kit. You may request an Information Kit by calling Genworth Life's offices at (800) 416-3624. Long term care coverage for you or your spouse or domestic partner can be paid for through payroll deductions. Coverage for other family members will be billed to you directly.

What Coverage is Available?

Two Optional Levels of Coverage:

- Essential Plan
    - 1,095 Days benefit duration
    - 75% Facility Care Maximum (FCM) Home & Community Care
    - Informal Care Included
- Preferred Plan
    - 1,825 Days benefit duration
    - 75% FCM Home & Community Care
    - Informal Care included

Three levels of the Facility Care Maximum

- $100 per day
- $200 per day
- $300 per day

Three Inflation Protection Options

- Future Purchase Option Benefit
- Automatic 3% Compound for Life
- Automatic 5% Compound for Life

Optional Non-forfeiture Benefit Rider: Available to Residents of Connecticut, Delaware, Montana, Oklahoma and Wisconsin only: An optional Nonforfeiture Benefit Rider is also available for additional premium. The rider allows the insured to retain partial coverage if he or she decides to cancel his or her long term care coverage after it has been in force for more than three years.

What Are the Long Term Care Benefits?

Long term care benefits are payable for expenses incurred for:

- Care and services during confinement in a nursing facility or assisted living facility, up to the Facility Care Maximum based on the option selected
- Home and community care which includes adult day care, and nurse or therapist services, home health or personal care services, and incidental homemaker and chore care provided in the insured's home, up to the Home and Community Care Maximum, based on the option selected
- Bed reservation for a temporary absence from a nursing facility or assisted living facility, up to the Facility Care Maximum for up to 60 days per calendar year
- Home assistance expenses that are stated in and furnished in accordance with the insured's Plan of Care and intended to enable the insured to remain in his or her home, including home modifications, emergency medical response systems and caregiver training, up to the lifetime maximum of two times the Facility Care Maximum
- Hospice care and support services (including room and board) provided by a hospice care facility, nursing facility, an assisted living facility, or home health or personal care services, and incidental homemaker and chore care, subject to the appropriate maximums
- Informal care for maintenance or personal care services provided in the insured's home, by someone who does not normally reside there, a daily benefit up to 25% of the Facility Care Maximum, up to 30 days per calendar year
- Respite care provided through a nursing facility, an assisted living facility, or home and community based care on a temporary basis to relieve the unpaid person who normally provides the insured with care at home, subject to the appropriate maximums, up to the Facility Care Maximum in a calendar year.
- Alternate care expenses not otherwise covered by the Plan, may be covered when the insured, his or her physician if appropriate, and Genworth Life agree in writing to the alternate care services. Prior approval is required. Genworth Life must determine that

the care or services are Qualified Long Term Care Services that are cost-effective and appropriate; are consistent with general standards of care; provide an equal or greater quality of care than other services covered the Plan; and are clearly specified in the insured's Plan of Care, and in a separate written mutual agreement.

Other long term care plan benefits include:

- Care coordination services are available. Professional care coordinators review the insured's specific situation and develop an appropriate Plan of Care to meet those needs. The cost of this service is not deducted from the Policy Lifetime Maximum.
- International coverage for care and support services including room and board provided by a nursing facility located outside of the United States, limited to 75% of the Facility Care Maximum, for up to 48 months.
- Waiver of premiums while the insured is receiving benefits for facility care or home and community care.

What is Inflation Protection?

The types of inflation protection available under the long term care plan are:

- Future Purchase Options: This benefit will apply if neither of the Automatic options are selected. Every three years the insured is offered the opportunity to increase his or her benefit amounts by 5% compounded annually. The premium for the additional coverage is based on the insured's attained age as of the effective date of the increase. The offer is not made if the insured is in claim, is benefit eligible, is receiving benefits, or is satisfying the Elimination Period.
- Automatic 3% Compound Benefit Increases for Life: Under this optional rider, the benefit amounts increase automatically each year by 3% compounded annually while the insurance is in effect and premiums are paid. There is an additional premium for this rider.
- Automatic 5% Compound Benefit Increases for Life: Under this optional rider, the benefit amounts increase automatically each year by 5% compounded annually while the insurance is in effect and premiums are paid. There is an additional premium for this rider.

What Long Term Care Expenses Are Covered?

The long term care plan pays benefits as reimbursement for covered expenses for Covered Care. Covered Care must:

- Constitute Qualified Long Term Care Services; and
- Be provided pursuant to a written Plan of Care prescribed by a Licensed Health Care Practitioner; and
- Occur while coverage is in force and prior to the exhaustion of any benefit limits, and the Policy Lifetime Maximum.

Conditions for Receiving Benefits

For an insured to be eligible for benefits, Genworth Life must receive:

- An eligibility certification, signed by a Licensed Health Care Practitioner during the preceding 12 month period, that the insured is a Chronically Ill Individual; *and*
- Ongoing proof that demonstrates the Covered Care received is needed due to the insured continually being a Chronically Ill Individual.

Before benefits are payable, the Elimination Period must be satisfied. The Elimination Period is a period of 90 calendar days during which the insured remains a Chronically Ill Individual before benefits are payable. The Elimination Period begins on the first day that the insured is both a Chronically Ill Individual and incurs a Covered Expense. However, the insured is not required to continue to incur covered expenses to satisfy the Elimination Period. The insured must remain a Chronically Ill Individual for each consecutive day after the first day of the Elimination Period in order to satisfy the Elimination Period. It needs to be met only once during the insured's lifetime.

Important Definitions: **Other definitions for this coverage can be found in your Certificate of Insurance.**

A **Chronically Ill Individual** is a person who has been certified by a Licensed Health Care Practitioner as:

- Being unable to perform, without substantial assistance (either standby assistance or hands-on assistance) from another individual, at least two Activities of Daily Living due to a loss of functional capacity. In addition, this loss of functional capacity must, at first, be expected to exist for a period of at least 90 days; OR
- Requiring substantial supervision to protect the person from threats to health and safety due to Severe Cognitive Impairment.

Activities of Daily Living are bathing, continence, dressing, eating, toileting, and transferring (getting into and out of a bed, chair or wheelchair).

Covered Care means only those Qualified Long Term Care Services for which the insurance pays benefits or would pay benefits in the absence of an Elimination Period.

Facility Care Maximum is the maximum amount that will be paid for confinement in a nursing facility, assisted living facility or hospice care facility. This amount is also used to determine other benefit maximums.

Licensed Health Care Practitioner means any of the following who is not a member of Your Immediate Family:

- A Physician (as defined in Sec. 1861(r)(1) of the Social Security Act);
- A registered professional nurse;
- A licensed social worker; or
- Any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States.

A **Plan of Care** is a written, individualized plan for care and support services for the insured that specifies:

- The type, frequency and duration of all services required to meet those needs;
- The kinds of providers appropriate to furnish those services; and
- An estimate of the appropriate cost of such services.

Policy Lifetime Maximum is the maximum amount of benefits payable to the insured, and is reduced by the amount of claims paid. The Policy Lifetime Maximum is determined by multiplying the Facility Care Maximum by the benefit duration.

Qualified Long Term Care Services are necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services which are required

Severe Cognitive Impairment is a loss or deterioration in intellectual capacity that:

- Is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and
- Is measured by clinical evidence and standardized tests that reliably measure impairment in the person's:
    - Short-term or long term memory;
    - Orientation as to people, places, or time;
    - Deductive or abstract reasoning; and
    - Judgment as it relates to safety awareness.

How Do I Get More Information?

To receive an Information Kit and get answers to your questions, contact the Genworth Life's offices at (800) 416-3624.

What Are the Exclusions and Other Limitations For the Long Term Care Plan?

Exclusions: Benefits are not paid for any expenses incurred for any room and board, care, treatment, services, equipment, or other items:

- For which no charge is normally made in the absence of insurance;
- Provided outside the United States of America, its territories and possessions; except as described in the International Coverage Benefit;
- Provided by the insured's Immediate Family, unless a benefit specifically states that a member of the Immediate Family can provide Covered Care. We will not consider care to have been provided by a member of the Immediate Family when:
    - He or she is a regular employee of the organization that is providing the services; and
    - Such organization receives payment for the services; and
    - He or she receives no compensation other than the normal compensation for employees in her or his job category;
- Provided by or in a Veteran's Administration or Federal government facility, unless a valid charge is made to the insured's estate;

- Resulting from war or any act of war, whether declared or not;
- Resulting from attempted suicide or an intentionally self-inflicted injury;
- Resulting from participation in a felony, riot, or insurrection;
- Resulting from the insured's alcoholism or addiction to drugs or narcotics (except for an addiction to a prescription medication when administered in accordance with the advice of a Physician);
- For which the insured receives, or is eligible to receive, workers' compensation benefits, occupational disease act benefits, or similar benefits.

Benefits are payable for Alzheimer's disease, subject to the same exclusions, limitations and provisions otherwise applicable to other Covered Care.

Non-Duplication of benefits: Benefits will be paid only for Covered Care expenses that are in excess of the amount paid or payable under:

- Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount); and
- Any other federal, state or other governmental health care program or law except Medicaid.

Coordination of Benefits: Benefits will be reduced for Covered Care when the total amount payable under this and all other Long Term Care Coverage is greater than the actual expense incurred
.
State variations may apply to coverage options and exclusions and limitations. Read the Outline of Coverage in the Information Kit carefully. It will reflect any required state variations and other details of the Plan. All state variations are included in the Certificate of Insurance that is part of the Group Policy.

When Does Long Term Care Insurance Take Effect?

Optional coverage is subject to underwriting approval by Genworth Life, and will take effect upon approval.

However, any optional coverage for an employee will take effect upon such approval only if he or she is actively at work for the prior 30 calendar day period. If this requirement is not met, the effective date of coverage will be deferred until the first day of the payroll billing period on which the employee is actively at work and has been actively at work for the prior 30 calendar day period.

When Does Long Term Care Insurance End?

Coverage ends on the first to occur of:

- The date the insured dies;
- The date coverage is cancelled by the insured;
- The date the policy lifetime maximum is exhausted; or
- The end of the grace period if the amount of any overdue premium is not received.

If a person ceases to be eligible, he or she can long term care coverage outside the Plan by paying premiums directly to Genworth Life.

Can an Insured Change Coverage Options?

Long term care coverage selections can be changed at any time, as follows:

- To increase the coverage level to a higher option at any time a request must be sent with satisfactory proof of good health. Upon approval, premiums for the additional coverage will be based on the age of the insured on the date the change is effective.
- To decrease the coverage level, proof of good health is not required. The premium for the reduced coverage will be based on the original issue age.

What if the Insured's Employment Status Changes?

If the status of employment changes, for example, if the insured employee takes an unpaid leave of absence or goes out on long term disability, coverage will continue as long as premiums are paid when due. Payroll deductions for premiums will stop, and the insured will be set up for direct billing purposes. If the employee subsequently returns to work, payroll deductions can be resumed.

What if the Insured Dies?

Coverage ends at the death of the insured. If the surviving spouse also has coverage, that coverage will remain in place, as long as he or she continues to pay the premiums. If premiums were paid through payroll deductions for the spouse's coverage, upon the employee's death, those deductions will end, and the surviving spouse will be set up for direct billing purposes.

Guaranteed Renewal

Once insurance takes effect, coverage is guaranteed for renewal and cannot be canceled by Genworth Life. Premiums will never increase due to changes in your health status or age.

30-Day Refund

If the insured is not completely satisfied with the long term care insurance coverage, he or she may return the Certificate of Insurance within 30 days of receipt for a full refund of any premiums paid.

Subrogation & Right of Reimbursement

When This Provision Applies *(Prescription Plan Only)*

You or your dependent(s) (hereinafter "beneficiary") may incur prescription expenses because of illness or injuries for which benefits are paid by the Plan but which were caused by another party. The beneficiary may therefore have a claim against the other party for payment of the medical or prescription expenses incurred. In these instances, the Plan has no duty or obligation to pay claims related to this illness or injury. However, if the Plan chooses to pay benefits, it has both a right of Subrogation and a right of Reimbursement. Each right is separate and the waiver of one right by the Plan shall not be deemed to waive the other right. Under the Plan's right of Subrogation, the Plan is subrogated to all of the rights the beneficiary may have

against that other party. This right of Subrogation also applies when a beneficiary has a right to recover under an uninsured or underinsured motorist's plan, homeowner's plan, renter's plan, or any other insurance policy under which the beneficiary is insured. The Plan also retains a right of first lien against any monies received by the beneficiary from the other person. Any monies received by a beneficiary or his attorney to which this Plan has a right of Subrogation or Reimbursement shall be held in trust for the benefit of the Plan. Under this right of Reimbursement, the beneficiary must reimburse the Plan from any monies he or she receives from the other person (or on behalf of the other person) as a result of judgment, settlement, or otherwise, without regard as to:

- whether the recovery has been apportioned between medical and other damages, and
- whether full or complete recovery of damages has occurred.

The Plan specifically rejects the "make-whole doctrine" and the "common-fund doctrine" with respect to its rights of Subrogation and Reimbursement. The Plan will not be responsible for expenses or attorney's fees incurred by a beneficiary in connection with any recovery. Accordingly, beneficiaries must pay their own legal fees. Furthermore, the Plan is subrogated to attorney's fees and expenses in enforcing its rights.

The beneficiary may be required to execute a Subrogation Reimbursement Agreement and/or a Trust Agreement to receive benefits under the Plan. Failure to execute these documents upon request by the Plan Administrator may result in the non-payment of any related claims. Further, if the beneficiary fails to return signed copies of these documents within the time period specified by the Plan Administrator, the Plan may refuse to pay claims incurred with respect to the Illness or Injury from the date of your injury or illness through the date the Plan Administrator receives the signed documents. If the documents are received after the deadline established by the Plan Administrator, the Plan will pay eligible claims incurred subsequent to its receipt of the signed documents.

Amount Subject to Subrogation and Reimbursement

In no case will the amount subject to Subrogation or Reimbursement exceed the amount of prescription benefits paid for the illness or injuries under the Plan.

The beneficiary is required to provide information and assistance including testimony or the execution of documents to enforce the Plan's rights of Subrogation and Reimbursement. In addition, the beneficiary must notify the Plan Administrator of any action, judgment, settlement or other recovery for which the Plan has rights of Subrogation and Reimbursement. Further, the beneficiary will do nothing to prejudice the right of the Plan to Subrogation or Reimbursement. The Plan also reserves the right to initiate an action in the name of the Plan or in the name of the beneficiary to recover the Plan's subrogation and/or reimbursement interest.

The beneficiary shall be entitled to recover payment for benefits under the Plan only once. In the event a beneficiary becomes entitled to recovery from the Plan Administrator for a work-related illness or injury, and the amount of such recovery includes amounts for prescription benefits previously paid by the Plan, the Plan Sponsor shall be entitled to offset the amount of such recovery by the amount of benefits previously paid by the Plan.

Defined Terms

"*Recovery*" means monies paid to the beneficiary by way of judgment, settlement, claim, or otherwise by the other party to compensate for the Illness or Injuries sustained.

"*Subrogation*" means the Plan's right to pursue the beneficiary's Claims for prescription charges against the other party and to be compensated in accordance with appropriate laws and regulations.

"*Reimbursement*" means repayment or reimbursement to the Plan of prescription benefits that it has paid toward care and treatment of the beneficiary's Illness or Injuries.

Right of Recovery

Whenever payments have been made by the Plan with respect to allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Plan, the Plan shall have the right, exercisable alone and in its sole discretion, to recover such excess payments.

Claim Information

A "Claim" is defined as any request for a Plan benefit, made by a covered person or by a representative of a claimant that complies with the Plan's procedure for making benefit claims. The term "covered person" means an employee or dependent for whom the coverage provided by the Plan is in effect.

Medical Claims

The claims procedures for the medical benefits insured by the Insurance Companies listed in the "General Information" Section are contained in the Insurance Certificates.

Dental Claims (Aetna DMO Plan Only)

The claims procedures for the Aetna DMO dental benefits provided to you under the Plan are contained in the Insurance Certificate issued by Aetna Life Insurance Company, and are intended to comply with regulations governing claims procedures contained in Department of Labor Regulations Section 2560.503-1.

EAP

If you believe the EAP Administrator has denied you any right or benefit you feel you have under the EAP plan, you must notify the Plan Administrator (listed in the "**General Plan Information**" section below), in writing of your claim to EAP benefits. The Plan Administrator will investigate the claim and respond to you in writing. If the Plan Administrator determines that your claim has merit, the Plan Administrator will work with the EAP Administrator to provide you the benefit.

If the Plan Administrator determines that your claim is without merit, you will be notified in writing that your claim is denied. You will have 180 days to appeal the Plan Administrator's decision. Your appeal letter may include any documents, records, or other information relating to your claim for benefits. Upon request and free of charge, you will be provided access to and copies of all documents, records, and other information relevant to your claim for benefits. Your appeal will be reviewed (without deference to the initial determination for a claim that relates to a health benefit under the EAP plan) and you will receive a written response of the outcome of your appeal.

If you are not satisfied with the Plan Administrator's response to your appeal, you may file suit in court. If you file a lawsuit, you must do so within 90 days from the date of the Plan Administrator's written response to your appeal. Failure to file a lawsuit within the 90-day period will result in your waiver of the right to file a lawsuit.

Legal Claims

If you are denied coverage by Hyatt Legal Plans or by any plan attorney, you may appeal that determination by sending a letter within 60 days to:

Hyatt Legal Plans, Inc.
Director of Administration
1111 Superior Avenue
Cleveland, OH 44114-2507

Your appeal letter may include any documents, records, or other information relating to your claim for benefits, and all such information will be taken into account, without regard to whether the information was submitted or considered when you were initially denied coverage. Upon request and free of charge, you will be provided access to and copies of all documents, records, and other information relevant to your claim for benefits.

Hyatt Legal Plans will issue a final determination of your appeal within 60 days of receiving your letter. The determination will include the reasons for the denial with reference to the specific Plan provisions on which the denial is based, a statement that you are entitled to receive any relevant documents to your claim for benefits, and an explanation of the review procedure and notice of right to bring a civil action under Section 502(a) of ERISA.

If you are not satisfied with the Hyatt Legal Plan's response to your appeal, you may file suit in court. If you file a lawsuit, you must do so within 90 days from the date of Hyatt Legal Plan's written response to your appeal. Failure to file a lawsuit within the 90-day period will result in your waiver of the right to file a lawsuit.

Long Term Care Claims

<u>Payment of Claims.</u> Payment of claims under the long term care plan will be made by the long term care plan Claims Administrator for that plan, Genworth Life Insurance Company. Claims for benefits under the long term care plan are to be submitted to Genworth Life Insurance Company as provided in the Claim Payments section of the Certificate of Insurance.

Contact the Claims Administrator with any questions regarding a claim or need for claim forms.

Notify Genworth Life Insurance Company within 30 days of the date the covered loss starts or as soon as reasonably possible thereafter.

Upon receipt of a notice of claim, the claim forms needed to file proof of loss will be sent. If the claim forms are not received within 15 days, proof of loss can be filed without them with a letter describing the nature and extent of the loss and the covered expense for which a claim is being made. If the claim is for a continuing loss, written proof of loss must be given to Genworth Life Insurance Company within 90 days after the end of each monthly period for which benefits may be payable. For any other loss, written proof must be given within 90 days after the date of such loss. Unless the insured is not legally capable, the required proof must always be given to Genworth Life Insurance Company no later than one year from the time specified.

Genworth Life Insurance Company must receive updates to the insured's Plan of Care on an ongoing basis.

Once the Elimination Period is satisfied, benefit payments will be made on a monthly basis after receipt of claim as long as the insured remains eligible to receive benefits. When a claim is paid, a notice showing the total amount of benefits that have been paid to date will be sent.

No action may be brought to recover under the long term care plan until 60 days after proof of loss has been given. No action can be brought more than 3 years from the date written proof of loss was required to be given.

Denied Claims – Appeals. If a claim under the long term care plan is denied in whole or in part, the insured will receive written notice of the claim denial. This notice will include the reasons for the denial, with reference to the specific provisions of the long term care plan on which the denial was based, a description of any additional information needed to process the claim, and an explanation of the claims review procedure.

Within 60 days after denial, the insured may submit a written request for reconsideration of the claim. Documents or records in support of the appeal should accompany any such request. The insured may review pertinent documents and submit issues and comments in writing. Genworth Life will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended by an additional 60 days under certain circumstances.) In the written response, Genworth Life will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based.

Genworth Life Insurance Company has the exclusive right to interpret the appropriate long term care plan. Decisions of Genworth Life Insurance Company are conclusive and binding.

Vision & Prescription Claims

Vision Claims

If you use a provider that is part of the VSP network, you do not need to file a claim. If you do not go to a network provider, you will need to pay for the services when received and submit a claim for reimbursement. You have 180 days following the date you incur a vision expense to file a claim with VSP. However, failure to submit a claim may not invalidate your right if it was not reasonably possible to submit the claim. You can get a claim form by calling (800) 877-7195 or visiting VSP's website at http://www.vsp.com/go/cvs. Include the claim form and the bill when you file your claim with VSP. Indicate on your claim form if you want the check for claim payment to be mailed to you or to your provider.

Prescription Claims

With respect to prescription drug coverage, when services are rendered with a network provider, that provider will submit your claim to Caremark on your behalf. For claims that you paid directly to a pharmacy and seek reimbursement from Caremark, please mail your claim to:

Caremark Pharmacy Services
Attention: Claims Department
PO Box 52196
Phoenix, AZ 85072-2196

With respect to claims under the prescription plan, Caremark will have full discretion and authority, within the limits of CVS policies, to determine questions concerning the interpretation or administration of this plan. Except for determinations on External Review, the determinations of Caremark shall be conclusive and binding regarding all persons for all purposes.

Internal Claims Review Procedure – Vision and Prescription Claims

To receive benefits under the Plan as quickly as possible, complete the claim forms clearly and accurately. Following is a description of how the Plan processes Claims for benefits for you or your authorized representative to follow. Note that if you disagree with a Claim determination, you must exhaust the claims procedures below before taking any legal action against the Plan.

The discussion of claims processing below relates to **vision and prescription** drug claims. Refer to the Insurance Certificates issued by the Insurance Companies for a discussion of the claims procedures applicable to the medical and dental benefits addressed in this Summary.

For purposes of the claim procedures below, reference to an "adverse benefit determination" means a denial, reduction, termination of, or a failure to provide or make a payment, in whole or in part, for a benefit, including benefit determinations relating to a claimant's eligibility, and determinations that particular services are experimental and/or investigational or not medically necessary or appropriate.

For purposes of a prescription benefit Claim, an adverse benefit determination includes a "rescission of coverage." A "rescission of coverage" is a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to administrative delays or a failure to timely pay contributions towards the cost of coverage.

Types of Claims and Time Period for Processing.

There are different kinds of Claims and each one has a specific timetable for approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Claims Administrator. A period of time begins at the time the Claim is filed. "Days" means calendar days.

<u>Urgent Care Claim</u> *(Prescription Plan Only)*

A claim involving Urgent Care Claim is any Claim for medical care or treatment where:

- using the timetable for a non-urgent care decision could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or
- in the opinion of the attending or consulting Physician, would subject the covered person to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

In the case of the Claim involving Urgent Care, the following timetable shows the maximum amount of time in which particular events generally must occur:

Event	Time Permitted
Notification to covered person of benefit determination (adverse or not)	72 hours
If there is insufficient information on the Claim, or the Covered Person has failed to follow the Plan's procedure for filing a Claim:	
Notification to covered person of deficiency, orally or in writing	72 hours
Response by covered person, orally or in writing	Not less than 48 hours
Benefit determination, orally or in writing	72 hours after receipt of additional information or expiration of Covered Person's time to respond
Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	72 hours
Review of adverse benefit determination	72 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the covered person. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the covered person by telephone, facsimile, or other similarly expeditious method.

Pre-Service Claim *(Prescription Plan Only)*

A Pre-Service Claim means any Claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-authorization (PA) under the prescription plan.

In the case of a Pre-Service Claim, the following timetable shows the maximum amount of time in which particular events generally must occur:

Event	Time Permitted
Notification to covered person of benefit determination (adverse or not)	15 days
Extension due to matters beyond the control of the Plan	15 days
If there is insufficient information on the Claim:	
Notification to covered person of deficiency	15 days
Response by covered person	At least 45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days

Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	15 days
Determination as to extending course of treatment	15 days
Review of adverse benefit determination	30 days

Post-Service Claim *(Prescription and Vision Plans)*

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim. In other words, a Claim that is a request for payment under the Plan for covered medical services already received by the covered person for which no prior approval was required. Most Claims for vision benefits through VSP under the Plan will be Post-Service Claims. In the case of a Post-Service Claim, the following timetable shows the maximum amount of time in which particular events generally must occur:

Event	Time Permitted
Notification to covered person of benefit determination (adverse or not)	30 days
Extension due to matters beyond the control of the Plan	15 days
If there is insufficient information on the Claim:	
Notification to covered person of deficiency	15 days
Response by covered person	At least 45 days
Review of adverse benefit determination	30 days

If Your Claim Is Denied

If your Claim for a prescription or vision benefit is denied, in whole or in part, you will receive written notice of the denial. The Claims Administrator will provide written or electronic notification of any adverse benefit determination. The notice will set forth:

- information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- the specific reason(s) for the adverse determination;
- reference to the specific Plan provision(s) on which the determination was based;
- a description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary;
- a description of the available internal and external review procedures under the Plan (including information regarding how to initiate an appeal) and the time limits applicable to such procedures, including a statement of the claimant's right to bring an action under Section 502(a) of ERISA following an adverse benefit determination on review;

- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim; and
- for a prescription benefit Claim, contact information for any applicable office of health insurance consumer assistance.

In addition, if the adverse benefit determination is based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

Further, if the adverse benefit determination is based on the fact that the treatment was not medically necessary or the experimental/investigational exclusion or similar exclusion or limit was applied, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the covered person's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Internal Appeal of Adverse Benefit Determination

When you receive an adverse benefit determination, you have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records and other information relating to the Claim. If you so request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The review will take into account all comments, documents, records, and other information submitted by you relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. For Claims related to prescription benefits, all evidence and testimony is taken into account

The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary will consult with a health care professional who was not involved in the original benefit determination.

This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified upon request.

Before the Claims Administrator can issue a final internal adverse benefit determination for the internal appeals process with respect to a prescription benefit Claim, you will be provided with any new or additional evidence or rationale considered, relied upon, or generated by the Claims Administrator in connection with the claim. The evidence will be provided as soon as possible and sufficiently in advance of the date by which the final internal adverse benefit determination notice is required to be provided to give you a reasonable opportunity to respond before that date.

While an appeal relating to an ongoing course of treatment is pending, the Plan will provide continued coverage pending the outcome of the appeal.

Notice of Adverse Determination on Internal Appeal

The Claims Administrator will provide written or electronic notification of an adverse benefit determination on appeal. The notice will set forth:

- information sufficient to identify the claim involved;
- the specific reason(s) for the adverse determination;
- reference to the specific Plan provision(s) upon which the determination was based;
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claimant's Claim for benefits;
- a statement describing any additional mandatory or voluntary appeal required or offered by the Plan (including the opportunity for External Review, if applicable) your right to obtain information about such procedures, and a statement of your right to bring suit under ERISA Section 502(a);
- for a prescription benefit Claim, contact information for any applicable office of health insurance consumer assistance; and
- any other information required by law.

In addition, if the determination is based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included in the notice of adverse determination that such rule, guideline, or protocol was relied on in making the adverse benefit determination and a copy will be provided free of charge upon request.

Further, if the adverse benefit determination was based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the covered person's medical circumstances, or a statement that such explanation will be provided free of charge upon request will be included in the notice of adverse determination.

External Review Program (*Prescription Plan Only*)

The External Review Program described below applies to prescription benefits under the Plan, and does not apply to vision coverage. (Refer to the applicable Evidence of Coverage for a discussion of any available external review program for medical and dental coverage.) No external review is available for vision coverage.

- The External Review Program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after you have exhausted the appeals process described above provided your claim meets one of the following requirements:
    - Your appeal relates to a rescission of coverage (coverage that was cancelled or discontinued retroactively); or
    - You have received an unfavorable (or adverse) decision on appeal based on a medical judgment – *e.g.*, based on clinical reasons or the exclusions for Experimental or Investigational Services or Unproven Services).

- The External Review Program does *not* apply if the adverse benefit determination is based on an administrative determination, such as:
  - your eligibility;
  - explicit benefit exclusions; or
  - defined benefit limits.
- *Deemed Exhaustion of Internal Claims Procedures & De Minimis Exception to Deemed Exhaustion Rule.* You will not be required to exhaust the internal claims and appeals processes described above if the Plan fails to adhere to the claims procedure requirements. In such an instance, you may proceed immediately to the External Review Program or make a claim in court. However, the internal claims and appeals process will not be deemed exhausted (meaning you must adhere to them before participating in the External Review Program or bringing a claim in court) in the event of a *de minimis* violation that does not cause, and is not likely to cause, prejudice or harm to you as long as the Claims Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the claimant, and the violation is not reflective of a pattern or practice of non-compliance.

  If you believe the Claims Administrator has engaged in a violation of the claims procedures and would like to pursue an immediate review, you may request that the Plan provide a written explanation of the violation, including a description of the Plan's bases for asserting that the violation should not result in a "deemed exhaustion" of the claims procedures. The Plan will respond to this request within 10 days. If the External Reviewer or a court rejects a request for immediate review because the Plan has met the requirements for the "de minimis" exception described above, the Plan will provide the claimant with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

Standard External Review

- Under the External Review Program, after you have exhausted your internal appeals, you may request an independent review of an adverse benefit determination. An adverse benefit determination related to your failure to meet the Plan's eligibility requirements is not eligible for external review.

All requests for an external review must be made within 4 months of the date you receive the adverse benefit determination. If there is no corresponding date four months after the date of receipts of such a notice, then the request must be filed by the first day of the fifth month following receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday. You, your treating physician or an authorized designated representative may request an external review by writing the Claims Administrator.

The Claims Administrator will review your request for external review within five (5) business days of its receipt of the request to determine whether:

- you were covered under the Plan at the time the service was requested or provided;

- the adverse determination was based on medical judgment and does not relate to eligibility;
- you have exhausted the Plan's internal appeals process, unless you are not required to exhaust the internal appeals process due to the deemed exhaustion rule described above; and
- you have provided all paperwork necessary to complete the external review.

The Claims Administrator will notify you in writing within one (1) business day of the completion of its review, whether your adverse benefit determination is eligible for external review and if any additional information is required. If the request is not eligible for external review, the notification will include the reasons why it is not eligible and contact information for the Employee Benefits Security Administration (866-444-EBSA). If the request was incomplete, the notification will state the information or materials needed to complete the request, and you must supply the information by the later of

(a) the last day of the 4-month filing period described above; or

(b) 48 hours after receipt of the Claims Administrator's notification.

If your adverse benefit determination is eligible for external review, the Claims Administrator will forward your request to an Independent Review Organization (IRO) with which the Plan has contracted. The IRO will be chosen based on a rotating list of at least three approved IROs. The IRO acts as a fiduciary of the Plan with respect to the external reviews that are delegated to the IRO.

The IRO will provide you with a written notification that it has received and accepted your request for external review, and give you the opportunity to submit additional information within 10 business days. The Claims Administrator will provide the IRO any information and documentation it considered in making its adverse benefit determination. If you supply additional information to the IRO, the IRO will forward that information to the Claims Administrator, at which point the Claims Administrator may reconsider its adverse benefit determination.

The IRO will review your claim without giving deference to the Claims Administrator's prior decisions, and will take into account any additional information you have supplied. In addition, in making its determination, the IRO may consider all documents and information provided, including, but not limited to, your medical records, your physician's recommendations, the terms of the Plan, appropriate practice guidelines, and the opinion of the IRO's clinical reviewer(s).

- The IRO will render its decision within 45 days of its receipt of the request for review and will provide written notification to both you and the Plan. This notification will include:
- a general description of the reason for the request for external review, including sufficient information to identify the claim;
- the date the IRO received the request for external review and the date of its decision;
- reference to the evidence or documentation considered in reaching its decision;
- the reason(s) for its decision, including any evidence-based standards that were relied on;
- a statement that the determination is binding except to the extent other remedies are available under state or federal law;
- a statement that judicial review may be available; and

- current contact information for any applicable office of health insurance consumer assistance or ombudsman.

If the decision of the IRO reverses the adverse benefit determination, the Plan will accept the decision and provide benefits for the service or procedure in accordance with the terms and conditions of the Plan. If the decision of the IRO confirms the Claims Administrator's adverse benefit determination, the Plan will not be obligated to provide benefits for the service or procedure.

After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for 6 years, and make them available for review by your and the Claims Administrator upon request, except if the disclosure would violate State or Federal privacy laws.

Expedited External Review

Your adverse benefit determination may be eligible for an expedited external review if:

- you have received an adverse benefit determination involving a medical condition for which the timeframe for completion of an expedited internal appeal (as described above) would seriously jeopardize your life or health, or your ability to regain maximum function and you have filed a request for an expedited internal appeal, or
- you have received an adverse benefit determination involving a medical condition for which the timeframe or completion of a standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, or if the adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

If you make a request for an expedited external review, the Claims Administrator will immediately review your request and provide you with written notice of whether your adverse benefit determination is eligible for external review. If your adverse benefit determination is eligible for external review, the Claims Administrator will forward your request to an IRO (electronically, by telephone or fax, or by other similar manner) as described above under the **Standard External Review Procedures**, along with all documents and information it considered in making its adverse benefit determination.

The IRO will follow the review process described above, and render a decision within 72 hours after it receives the request for review. The IRO will provide a written confirmation of its decision to both you and the Plan with 48 hours thereafter.

You may contact the Claims Administrator at the number in the "**General Information**" section of this Summary for more information regarding your external appeal rights and the independent review process.

Legal Action

If you believe your Claim under the Plan is being improperly denied in whole or in part, you have the right to sue for those benefits. However, no legal action may be commenced or maintained against the Plan prior to your exhaustion of the Plan's internal claims procedures. In addition, for purposes of claims with regard to vision, prescription, Long Term Care, EAP and prepaid legal benefits, no legal action may be commenced against the Plan more than 90 days after the Plan Administrator's decision on review. However, the 90-day period is tolled for any period

during which an External Review is pursued, and such tolling will end as of the date of a notice of a final external review decision.

Other Important Information

Women's Health and Cancer Rights Act

Under CVS Caremark's medical plans, coverage for the following procedures is available to covered women who have a mastectomy:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment required as a result of physical complications for all stages of mastectomy, including lymphedemas.

Keep in mind, coverage is subject to all of the terms of the Plan including applicable copayments, deductibles, and/or coinsurance provisions.

If you have questions, please contact your medical Plan's member services department.

Newborns' and Mothers' Health Protection Act

Under the Newborns' and Mothers' Health Protection Act of 1996, health plan benefits for you or your spouse for any hospital length of stay in conjunction with childbirth for the mother or newborn child may not be restricted to less than 48 hours following a normal delivery or less than 96 hours following a cesarean delivery. In addition, there can be no requirement that providers obtain authorization from the medical plan or the claims administrator for prescribing a length of stay within the above periods. Coverage for longer periods may be permitted with the prior authorization of the plan administrator.

A new mother may be released prior to 48 hours (or 96 hours) if she and her doctor agree to an earlier release date. However, the medical plan cannot offer financial incentives to either the mother or physician to prescribe a reduced hospital stay.

Continuing Coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA)

A federal law called "COBRA" requires the Plan to offer employees and their dependents the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan otherwise would end due to the occurrence of a "qualifying event."

Limited Continuation of Coverage

You and your covered dependents may be able to continue medical, prescription, dental, vision and/or EAP benefits under this Plan upon the occurrence of a qualifying event. If your coverage terminates because your employment is terminated (for reasons other than gross misconduct) or your number of hours of employment is reduced, such that you are no longer eligible for

coverage, then you and your covered dependents may elect to continue coverage under the Plan for up to 18 months as a result of these qualifying events.

The 18 months of continuation coverage may be extended in two situations: (a) if you or your covered dependents are determined to be disabled or (b) another event occurs which would cause your covered dependent(s) to lose coverage, provided certain notices are timely provided to the COBRA Administrator. See the paragraphs below titled "Notice: Disability Extension" and "Notice: Second Qualifying Events."

Your covered dependents may elect to continue medical, prescription, dental, vision and/or EAP benefits under the Plan for up to 36 months, if their coverage terminates because of one of the following qualifying events:

- you die;
- you are divorced, legally separated, or your domestic partnership is terminated;
- you become entitled to Medicare benefits under the Social Security Act (under Part A, Part B, or both); or
- your covered dependent ceases to be a dependent under the terms of the Plan.

Notice: General

Covered Person's Responsibility

You or your covered dependents must notify ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287) to advise them of a divorce, legal separation, termination of your domestic partnership, or when a covered dependent ceases to be a dependent under the terms of the Plan, within 60 days of such event. Failure to do so will result in the loss of the right to elect to continue coverage under this continuation of coverage provision. Notice must be given prior to the qualifying event or as soon as possible thereafter, and not later than 60 days after the qualifying event occurs.

If you or your covered dependents fail to provide ***myHR*** with timely notice when one of these qualifying events occurs, the right to COBRA coverage will be waived. A covered person who elects COBRA coverage will have the same enrollment rights that apply to active employees.

CVS's Responsibility

For other qualifying events (your end of employment or reduction of hours of employment or your death), CVS will notify the COBRA Administrator. Upon notice of a qualifying event, the COBRA Administrator will notify you and your covered dependents (individually or jointly) of the right to elect COBRA coverage.

Notice: Disability Extension

If you or one of your covered dependents is totally disabled (under the Social Security definition) at the time of a reduction in hours or termination of employment, or are determined to be disabled within 60 days of beginning COBRA coverage, all covered persons with respect to the disabled individual(s) may extend the continuation coverage period an additional 11 months, for up to a total of 29 months.

To extend coverage beyond the 18-month period, you or your covered dependent must notify the COBRA Administrator of the Social Security Administration's ("SSA's) determination within 60 days after the later of:

- the date of the SSA's determination,

- the date on which the qualifying event occurs under the Plan, or
- the date on which you or your covered dependent are informed of your responsibility to provide notice of your disability to the COBRA Administrator and of the Plan's procedures for providing such notice (which descriptions are included in this Summary), and
- in all cases before the end of the 18-month period of COBRA coverage.

Notice must be provided in writing to the COBRA Administrator and must be sent, along with a copy of the SSA's disability determination, to the COBRA Administrator at the address listed under the "**General Plan Information**" section at the end of this Summary.

If there is a determination by the SSA that you or the applicable covered dependent is no longer disabled, the COBRA Administrator must be notified of that fact within 30 days of the SSA's determination. Upon receipt of this notice, COBRA coverage extended beyond the maximum period that would otherwise apply will be terminated on the first day of the month, which is 30 days after the determination that you or your covered dependent is no longer disabled.

<u>Notice: Second Qualifying Events</u>

If you or your covered dependents experience another qualifying event while already on COBRA coverage due to your termination of employment or reduction in hours, your covered dependents may elect to extend the period of COBRA coverage for up to 36 months from the date of termination or reduction in hours, provided notice of the second qualifying event is properly given (as described below).

A covered person must notify the COBRA Administrator of the second qualifying event within 60 days of the second qualifying event. This notice must be provided in writing to the COBRA Administrator at the address listed under the "**General Plan Information**" section at the end of this Summary.

Election

You and your covered dependents are entitled to a period of 60 days in which to elect to continue coverage under the Plan. The 60-day election period begins on the date you or your covered dependents would lose Plan coverage because of one of the events described above, and ends on the later of 60 days following such date or the date the notice is sent about eligibility to elect to continue coverage.

If you or your covered dependents elect continuation coverage within the 60-day election period, continuation coverage will generally begin on the date regular Plan coverage ceases. Even if you or your covered dependents waive continuation coverage, but within the 60-day election period revoke the waiver, continuation coverage will also begin on the date regular Plan coverage ceases. A waiver may not be revoked after the end of the 60-day election period.

If you or your covered dependents do not choose continuation coverage within the 60-day election period, eligibility for continuation coverage under the Plan ends at the end of that period.

Acquiring New Dependents during Continuation

If you acquire any new dependents during a period of continuation (through birth, adoption or marriage), they can be added for the remainder of the continuation period if:

- they meet the definition of an eligible dependent;
- you notify the Plan within 30 days of their eligibility (or within 60 days for birth and adoption); and
- you pay the additional required premiums.

Cost of Continuation Coverage

To receive continuation coverage, you or your covered dependents, or any third party, must pay the required monthly premium plus a two percent administrative charge. If you or your covered dependents are eligible for an extension of coverage due to disability, the cost of continuation coverage will be 150% of the normal required monthly premium for all months after the 18th month of continuation coverage.

Each monthly premium for continuation coverage is due on the first day of the month for which coverage is being continued. However, the first such monthly premium is not due until 45 days after the date on which you and/or your covered dependents initially elect continuation coverage.

Termination

Coverage under this continuation of coverage provision will terminate on the earliest of:

- the date on which CVS ceases to provide a group health plan to any employee;
- the date you or your covered dependents first become covered under any other group health plan after electing continuation coverage, provided that the new plan does not contain any pre-existing condition exclusion that would affect the covered person's coverage under the new plan;
- the date you or your covered dependents become entitled to Medicare benefits after electing continuation coverage;
- the date the required monthly premium is due, if you or your covered dependents fail to make payment within 30 days after the due date; or
- the end of the applicable continuation coverage period described above.

Coverage will <u>not</u> be extended beyond 36 months from the original qualifying event, even if a second qualifying event occurs during the continuation coverage period.

Continuation Coverage under the Uniformed Services Employment and Re-Employment Rights Act of 1994

Under a federal law called the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), you have certain rights regarding continuance of Plan benefits while you are on a leave of absence for military service or uniformed service (referred to herein as a "military leave of absence"). The terms "uniformed services" or "military service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency. A "leave of absence" is a predetermined period of time in which you are not working for CVS. However, you are expected to return to active employment at the end of your leave of absence.

It is CVS's policy to allow employees on a military leave of absence to continue medical, prescription, dental, vision and/or EAP benefits under the Plan for up to 12 months at the active-

employee cost. Under USERRA, if you continue to be on a military leave of absence at the time the foregoing 12-month period is exhausted, you may elect to continue your medical, prescription, dental, vision and/or EAP benefits for an additional 24 months (or if less, for the period you are on military leave. However, you must pay the full cost of the benefits plus a 2% administrative charge to continue coverage. Under USERRA, covered dependents also have a right to continue their health coverage during the employee's period of military leave of absence.

If you choose not to continue medical, prescription, dental, vision and/or EAP benefits while on a military leave of absence, and you return to a position of employment with CVS, your coverage and that of your eligible dependents may be reinstated under the Plan, provided you call ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287) to re-enroll or enroll online at **myhr.cvs.com** within 30 days of your return to work.

If you do not call ***myHR*** or go to **myhr.cvs.com** and follow the necessary steps for reenrollment within the first 30 days of returning to work, you will be required to wait until the Annual Enrollment period to reinstate your Plan coverage. No exclusions or waiting period may be imposed on you or your eligible dependents in connection with this reinstatement, unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

For more information about filing for coverage while you are on a military leave of absence, and applicable costs, call ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287).

Family and Medical Leave Act (FMLA)

All eligible participants of this Plan who have worked for CVS for at least one year and worked at least 1,250 hours over the previous 12 months are covered under a federal law called the Family and Medical Leave Act (FMLA). According to this law, you are eligible for at least 12 weeks of unpaid job-protected leave for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for your child after birth, or placement for adoption or foster care;
- To care for your spouse, son or daughter, or parent who has a serious health condition;
- For your own serious health condition that makes you unable to perform your job;
- Because of any qualifying exigency arising out of the fact that your spouse, son, daughter, or parent is on active duty (or has been notified of an impending call or order to active duty) in the armed forces in support of a contingency operation; or
- To care for your spouse, son, daughter, parent, or next of kin who is recovering from a serious injury or illness suffered while on active duty in the armed forces. You are eligible for 26 work weeks in a single 12-month period.

If you experience a qualifying FMLA leave event and want to take a leave of absence under FMLA, you should first discuss it with your supervisor as soon as possible. You must then contact the Leave of Absence Department to initiate your leave by logging onto **myhr.cvs.com** (select the **myLeave** link and follow the prompts) or by calling ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287) (and following the prompts to the Leave of Absence Department).

If you take a leave of absence under FMLA, you may continue your coverage for medical, prescription, dental, and vision benefits under the Plan during the leave period by continuing to pay the required contributions.

To the extent any portion of your FMLA leave is paid leave, you will continue to have your benefit contributions deducted from your pay. Otherwise, you must submit your contributions on an after-tax basis. If your required contribution during FMLA leave is more than 30 days late, your coverage will be terminated in accordance with the FMLA retroactive to the date through which you have paid for coverage.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for continued coverage on the same terms as would be applicable to you if you were actively at work, not on an approved FMLA leave.

If you choose not to continue your coverage while on a FMLA leave, you will not be reimbursed for any benefit claims incurred while you are on the FMLA leave. When you return from leave, call ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287) or go to **myhr.cvs.com** to reenroll, within 30 days of returning from your FMLA leave. If you do not call ***myHR*** or visit **myhr.cvs.com** and follow the necessary steps for reenrollment, you will be required to wait until the Annual Enrollment period to reinstate your Plan coverage.

If you do not return to work after your FMLA leave ends, you may be allowed to continue your coverage at the active-employee rate under another CVS leave policy (provided premiums are paid). Otherwise, your coverage at the active-employee rate will terminate (although as described below you and your dependents may have COBRA continuation coverage rights).

If your medical, prescription, and/or vision coverage ends because your approved FMLA leave is considered terminated by CVS, you and your dependents may, on the date of such termination, be eligible to elect to continue your coverage under COBRA. COBRA continuation coverage will be available on the same terms as though your employment terminated, for reasons other than for gross misconduct, on such date.

Impact of Leaves of Absences (Other than FMLA or USERRA) on Coverage under the Plan

Company-Approved Leaves

If you are on a CVS-approved leave of absence (other than a personal leave or military leave of absence), it is CVS's policy to allow you and your dependents to continue your medical, prescription, dental and vision coverage under the Plan for up to 180 days at the active employee rate. However, you must continue to pay Plan premiums to CVS, unless your collective bargaining agreement indicates otherwise. If you continue to be on a company-approved leave of absence at the end of the foregoing 180-day period, you may be eligible to elect to continue your health coverage under COBRA. COBRA continuation coverage will be available on the same terms as though your employment terminated, for reasons other than for gross misconduct. As discussed in detail in this Summary above, under COBRA you must pay the full cost of the benefits plus a 2% administrative charge.

Personal Leaves

If you are on a personal leave of absence, it is CVS's policy to allow you and your dependents to continue your medical, prescription, dental and vision coverage under the Plan for up to 30 days at the active-employee rate, provided you continue to pay Plan premiums to CVS. If you continue to be on a leave of absence at the end of the foregoing 30-day period, you may be eligible to elect to continue your coverage under COBRA. COBRA continuation coverage will be available on the same terms as though your employment terminated (for reasons other than

gross misconduct). As discussed in detail in this Summary above, under COBRA you must pay the full cost of the benefits plus a 2% administrative charge.

Return from Leave

If you choose not to continue your coverage while on a CVS-approved leave of absence (including a personal leave), you may reinstate your coverage when you return to work. Reinstatement of coverage is ***not*** automatic. When you return to work, call ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287) or visit **myhr.cvs.com** within 30 days of returning from your FMLA leave to reenroll in the medical, prescription, dental or vision plan. If you do not call ***myHR*** or visit **myhr.cvs.com** and follow the necessary steps for reenrollment within the first 30 days of returning to work, you will be required to wait until the Annual Enrollment period to reinstate your Plan coverage.

Plan is Not an Employment Contract

The Plan is not to be construed as a contract for or of employment. Accordingly, nothing in this document says or should be read to imply that participation in the Plan is a guarantee of continued employment with CVS.

Non-discrimination

Notwithstanding anything in the Plan to the contrary, the Plan may not discriminate against any individual or dependent of that individual with respect to health coverage on the basis of a health factor. Further, the Plan shall not (a) adjust premium contribution amounts based on genetic information, (b) request or require an individual or family member of an individual to undergo a genetic test (except in certain circumstances related to research), or (c) request, require, or purchase genetic information with respect to any individual prior to the individual's enrollment in the Plan or coverage in connection with enrollment in the Plan.

Qualified Medical Child Support Order

The Plan complies with the requirements of a "Qualified Medical Child Support Order" as defined in Section 609(a)(2)(A) of ERISA. A Medical Child Support Order is any judgment, decree, or order (including a National Medical Support Notice and approval of a settlement agreement) issued by a court of competent jurisdiction or state agency that:

- provides for child support with respect to your child under a group health plan or provides for health benefit coverage for your child; and
- is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under the company's health care plan.

A Qualified Medical Child Support Order creates or recognizes the existence of an Alternate Recipient's rights to — or assigns to an Alternate Recipient the right to — receive benefits for which you are eligible under the Plan. The Plan Administrator has developed procedures to determine whether a medical child support order is qualified and for complying therewith (which among other things, address the effective date of coverage). A covered person may obtain, without charge, a copy of these procedures upon request to the Plan Administrator.

Your Privacy Rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

We understand that your health information is private, and we are committed to maintaining the privacy of your medical information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives you certain rights to privacy concerning your health information. The Plan will follow the policies below to help ensure that your health information (or "protected health information" ("PHI")) is protected and remains private.

Each time you submit a claim to the Plan for reimbursement, and each time you see a health care provider who is paid by the Plan, a record is created. The record may contain your PHI. In general, the Plan will only use or disclose your PHI without your authorization for the specific reasons detailed below. Except in limited circumstances, the amount of information used or disclosed will be limited to the minimum necessary to accomplish the intent of the use or disclosure.

The Plan does not operate by itself; it is operated and administered by CVS and the Insurance Companies acting on the Plan's behalf. As a result, PHI used or disclosed by the Plan (as discussed below) necessarily means that CVS and the Insurance Companies, as applicable are using or disclosing the PHI on behalf of the Plan. As a result, references to the Plan in this section shall also be construed as references to CVS and the Insurance Companies to the extent necessary to carry out the actions of the Plan.

Permitted Uses and Disclosures

The following categories describe different ways that the Plan may use or disclose your medical information. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

The Plan may use or disclose your PHI for the following reasons:

- for treatment, payment, and health care operations (including disclosures to the Plan's Business Associates to carry out these functions);
- to family members, relatives, and close personal friends involved in your care or payment for your care (but only to the extent of their involvement);
- as required by law;
- to avert a serious threat to your health and safety or the health and safety of the public or another person;
- for purposes of organ or tissue donation;
- as required by military command authorities, if you are a member of the armed forces;
- for workers' compensation or similar programs;
- for public health activities (for example, to prevent or control disease, injury, or disability, to report reactions to medications or problems with products, etc.);
- for certain health oversight activities (for example, audit and inspection to monitor the health care system);
- in response to a court or administrative order or subpoena or discovery request;
- to the Department of Health and Human Services for purposes of determining the Plan's compliance with these privacy rules;
- to coroners, medical examiners, and funeral directors (for example, to identify a deceased person or determine the cause of death);

- for national security and intelligence activities; and
- if you are an inmate of a correctional institution for specified reasons such as the protection of your health and safety.

Disclosures to CVS

The Plan will disclose your PHI to CVS for Plan administration purposes only upon receipt of a certification from CVS that the Plan sets forth the permitted uses and disclosures of PHI by CVS on behalf of the Plan, and that CVS has agreed to the following assurances:

- CVS shall implement administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- CVS shall not further use or disclose your PHI other than as permitted or required by the Plan documents or as required by law;
- CVS shall ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to CVS with respect to such information and agree to implement reasonable and appropriate security measures to protect such information;
- CVS shall not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of CVS;
- CVS shall report to the Plan any use or disclosure of PHI that is inconsistent with the permitted uses and disclosures, including any security incidents, of which it becomes aware;
- CVS shall make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services for purposes of determining whether the Plan is complying with applicable regulations;
- CVS shall, if feasible, return or destroy all PHI received from the Plan about you and retain no copies of the information when it is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, to limit further uses or disclosures to those purposes that make such return or destruction infeasible;
- CVS shall ensure that there is adequate separation between the Plan and CVS (as described below) and that the separation is supported by reasonable and appropriate security measures;
- CVS shall make your PHI available to you (as described below);
- CVS shall make your PHI available to you for amendment and incorporate any amendment into your PHI (as described below); and
- CVS shall make available the information required to provide you an accounting of disclosures (as described below).

Access to PHI

The Plan will make your PHI available to you for inspection and copying upon your written request to the applicable Insurance Company. The Plan may charge a fee for the costs of copying, mailing or other supplies associated with your request. The Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed.

Amendment of Medical Information

If you feel that PHI the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. Your request must be made in writing and submitted to the applicable Insurance Company. In addition, you must provide a reason that supports your request.

The applicable Insurance Company may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the applicable Insurance Company may deny your request if you ask the Insurance Company to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Accounting of Disclosures

If you wish to know to whom your PHI has been disclosed for any purpose other than (a) treatment, payment, or health care operations, (b) pursuant to your written authorization, and (c) for certain other purposes, you may make a written request to the applicable Insurance Company. Your request must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. The accounting will not include disclosure for the purposes of treatment, payment, or health care operations. In addition, the accounting will not include disclosures that you have authorized in writing.

Separation between the Plan and CVS

Only employees of CVS who are involved in the day-to-day operation and administrative functions of the Plan will have access to your medical information. In general, this will only include the following individuals: employees of the Human Resources Department and the Legal and Employee Relations Departments. These individuals will receive appropriate training regarding the Plan's privacy policies. In the event an individual fails to comply with the Plan's provisions regarding the protection of your medical information, CVS will take appropriate action in accordance with its established policy for failure to comply with the Plan's privacy provisions.

Other Uses of PHI

Any other uses and disclosures of your PHI will be made only with your written authorization. If you provide the Plan authorization to use or disclose your PHI, you may revoke that authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization. Please note that the Plan is unable to take back any disclosures it has already made with your authorization.

If you have a question about your rights under the HIPAA regulations, call ***myHR*** at 1-888-MY-HR-CVS (1-888-694-7287).

Your Rights under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under 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 specified locations, such as work sites 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 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 because 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 pre-existing 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,
  - you become entitled to elect COBRA continuation coverage, or
  - 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 pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 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 pension 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 form 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 that is denied or ignored, in whole or in part, you may file suit in a state or Federal court subsequent to exhausting the Plan's claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court subsequent to exhausting the Plan's claims procedures. 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 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, U.S. Department of Labor, listed in your telephone directory or the Department of Labor's 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 publications hotline of the Employee Benefits Security Administration at (800) 998-7542.

General Plan Information

This section provides administrative information for the Plan, but is subject to the terms of the legal documents, which may be modified from time to time. Where this description and the official documents differ, the official plan documents or insurance booklets/contracts are the final authority. This description of administrative information is not an employment contract or any type of employment guarantee.

The Plan is a welfare benefit plan. The Plan provides medical benefits (including in California and Hawaii) dental, vision, prepaid legal, and long term care benefits that are fully insured through the Insurance Companies. The Insurance Companies, not CVS, are responsible for paying claims. CVS and the Insurance Companies share responsibility for administering the Plan's benefits. With respect to prescription benefits, the Plan is self-insured and administered through Caremark. The EAP benefits under the plan are also self-insured, and administered by

the EAP Administrator listed below. Although not addressed in this Summary, the Plan also includes medical and dental benefits that are self-insured and insured life and disability benefits.

The Plan Administrator will help resolve any problem you might have about your rights to benefits. The official plan documents, insurance contracts, and related information are available if you want to review these materials. If, for some reason, it becomes necessary to contact the U.S. Labor Management Services Administration, Department of Labor, you will need to provide the information contained in this section to identify the plan properly.

Formal Plan Name

The CVS Caremark Welfare Benefit Plan

Plan Year

The Plan's records are kept on a 12-month period beginning June 1 and ending May 31.

Plan Sponsor

CVS Pharmacy, Inc.
One CVS Drive
Woonsocket, RI 02895
(401) 765-1500

Plan Identification Number

The employer identification number assigned to the Plan Sponsor by the Internal Revenue Service (IRS) is 05-0340626.

The Plan number assigned to the Plan is 510.

Plan Administrator

The Plan Administrator is the Senior Vice President and Chief Human Resources Officer of CVS Pharmacy, Inc. Communications to the Plan Administrator should be directed as follows:

Attn: Lisa Bisaccia
Senior Vice President and Chief Human Resources Officer
CVS Pharmacy, Inc.
One CVS Drive
Woonsocket, RI 02895
(401) 765-1500

The Plan Administrator has delegated administrative authority to determine all claims as follows:

- medical (with regard to the insured coverage California and Hawaii), dental, vision, and long term care coverage claims are determined by the Insurance Companies;
- prescription coverage claims are determined by the prescription plan's Claims Administrator, CaremarkPCS Health, L.L.C.;
- EAP claims are determined by the EAP Administrator, E4 Health, Inc.; and
- prepaid legal services claims are determined by Hyatt Legal Plans.

Such discretionary authority is intended to include, but is not limited to, the determination of whether a person is entitled to benefits under the Plan and the computation of any and all benefit payments. The Plan Administrator also delegates to Caremark PCS Health the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial that has been appealed by a claimant or his or her duly authorized representative.

Except with regard to administrative authority delegated above, the Plan Administrator shall have the sole discretionary authority to construe the terms of the Plan and all facts surrounding claims under the Plan (such as whether an individual is eligible for coverage under the Plan), and shall determine all questions arising in the administration, interpretation and application of the Plan. All determinations of the Plan Administrator shall be conclusive and binding on all parties.

Agent for Service of Legal Process

CT Corporation System
155 South Main Street, Suite 301
Providence, Rhode Island 02903

Process may also be served on the Plan Administrator.

Named Fiduciary

The named fiduciary is the Senior Vice President and Chief Human Resources Officer of CVS Pharmacy, Inc. Communications to the named fiduciary should be directed to:

Attn: Lisa Bisaccia
Senior Vice President and Chief Human Resources Officer
CVS Pharmacy, Inc.
One CVS Drive
Woonsocket, RI 02895
(401) 765-1500

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan, or has discretionary authority or responsibility in the administration of the Plan.

The "Named Fiduciary" is the one named in the Plan, which is the Plan Administrator. The named fiduciary can appoint others to carry out fiduciary responsibilities under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary will generally not be liable for any act or omission of such person.

Claims Fiduciary

While the Plan Administrator is the Named Fiduciary, the Claims Administrator is the Plan fiduciary with respect to decisions regarding whether a claim for benefits will be paid under the Plan.

Claims Administrator

The Claims Administrator receives, processes, and pays for the benefits under the Plan. The Claims Administrator for medical, dental, vision, pre-paid legal, and long term care benefits provided through insurance contracts are the applicable Insurance Companies listed below. The

Claims Administrator for the prescription plan is CaremarkPCS Health, L.L.C. With regard to administrative authority delegated to the Claims Administrator, the Claims Administrator shall have the sole discretionary authority to construe the terms of the Plan and all facts surrounding claims under the Plan and shall determine all questions arising in the administration, interpretation and application of the Plan. All determinations of the Claims Administrator shall be conclusive and binding on all parties.

Prescription Plan Claims Administrator

Caremark PCS Health, L.L.C.
211 Commerce St - 8th Floor
Nashville, TN 37201
(866) 284-9226
www.caremark.com

Insurance Companies

Medical

Medical benefits in Hawaii and California are provided through insurance contracts with the following Insurance Companies:

California

Kaiser Permanente
Claims Administration Department
P. O. Box 7004
Downey, CA 90242-7004
(800) 464-4000
www.kaiserpermanente.org

Health Net of California, Inc.
P.O. Box 14702
Lexington, KY 40512
(888) 893-1598
http://www.healthnet.com/cvscaremark

Hawaii

Kaiser Permanente - Hawaii
Claims Administration Department
80 Mahalani Street
Wailuku, HI 96793
(808) 243-6610 (Maui) or toll free at (877) 875-3805 (Oahu and Neighbor Islands)
www.kaiserpermanente.org

HMSA, Blue Cross Blue Shield of Hawaii
HPHP
P. O. Box 1958
Honolulu, HI 96805-1958
(808)948-5090 or (800) 462-2085
www.HMSA.com

Dental

Dental benefits are provided through an insurance contract with the Insurance Company listed below.

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
(800) 770-2386
www.aetna.com/docfind/custom/aahc

Vision

Vision benefits are provided through an insurance contract with the Insurance Company listed below.

Vision Services Plan (VSP)
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195
http://www.vsp.com/go/cvs

Legal

Hyatt Legal Plans, a MetLife Company*
1111 Superior Avenue
Cleveland, OH 44114
(800) 423-0300
www.legalplans.com

* In certain states, the coverage is provided through insurance underwritten by Metropolitan Property and Casualty Insurance Company and Affiliates, Warwick, Rhode Island.

For further information on the prepaid legal plan, call 1-800-375-1655, Monday through Friday from 8 a.m. to 6 p.m. EST, or visit www.cvscaremarkvoluntarybenefits.com.

Long Term Care

Long term care benefits are provided through an insurance contract with the Insurance Company listed below:

Genworth Life Insurance Company
Group Processing Center – CVS Caremark
P.O. Box 64010
St. Paul, MN 55164-0010
(800) 416-3624

EAP Administrator

The EAP Administrator processes benefits under the EAP plan.
E4 Health, Inc.
55 Cedar Street
Suite 100
Providence, RI 02903
(800) 789-8990

COBRA Administrator

Aon Hewitt

myHR
P.O. Box 563927
Charlotte, NC 28256
(888)694-7287

Future of the Plans

The continued maintenance of the Plan is completely voluntary on the part of CVS and neither its existence nor its continuation will be construed as creating any contractual right to or obligation for its future continuation. While CVS expects to continue the Plan indefinitely, CVS reserves the right at any time and for any reason, in its sole discretion, to curtail benefits under, otherwise amend, modify, or terminate the Plan or any portion thereof without notice, including, without limitation, those portions of the Plan outlining the benefits provided or the classes of employees or dependents eligible for benefits under the Plan. The Plan may be amended by the Board of Directors of CVS Caremark Corporation, by the Management Planning and Development Committee, or, in certain circumstances, by approval of the Senior Vice President and Chief Human Resources Officer of CVS Pharmacy, Inc. Any claims requested after the effective date of termination, modification, or amendment are payable in accordance with the respective Plan documents. However, no amendment or termination can reduce or otherwise affect any claim for a benefit you became entitled to before the date of amendment or termination. In the event the Plan terminates, you will be informed of any termination rights you may have.