SUMMARY PLAN DESCRIPTION

FOR THE

CBIZ Operations, Inc.

$1,000 Deductible, Out-of-Area $1,000 Deductible,

and Hawaii PPO Plans

Effective: January 1, 2021

This document replaces and supersedes any prior summary plan descriptions relating to the CBIZ Operations, Inc. Prescription Drug Plan.

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FACTS ABOUT THE PLAN	
Name of the Plan	CBIZ Operations, Inc. Welfare Benefit Plan
Employer/Plan Sponsor/ Plan Administrator	CBIZ Operations, Inc. 6050 Oak Tree Boulevard South Suite 500 Cleveland, OH 44131 (216) 447-9000
Employer Identification Number	22-2769024
Effective Date of the Plan	January 1, 2021
Plan Number	512
Type of Plan	The Plan is a welfare benefit plan that provides prescription drug coverage.
Plan Year	January 1 – December 31
Funding Medium and Type of Administration	The benefits available under the Plan are self-funded. This means that the Company's portion of the cost of benefits is paid directly out of its general assets. The Company is ultimately responsible for providing the benefits under the Plan, although the Company and Covered Employees may share the cost of funding the Plan. The Covered Employees' portion of the benefit cost, if any, is paid by pre-tax payroll deductions. However, the Company has a contract with an excess insurance carrier to pay claims that exceed a certain amount during the Plan Year (stop-loss insurance). CBIZ Operations, Inc. has contracted with a Pharmacy Benefit Manager, CVS Caremark to process claims and provide administrative services to the Plan. CVS Caremark does not serve as an insurer. It processes claims, requests and receives funds from the Company to pay the claims, and then makes payment on the claims to pharmacies and other health care providers.
Pharmacy Benefit Manager	CVS Caremark 2211 Sanders Road Northbrook, IL 60062 (888) 202-1654 www.caremark.com
Agent for Legal Service	Service of process may be made upon the Plan Administrator at the above-listed address.
For More Information	If you have any questions about the Plan or need more information than this booklet contains, you may contact the CBIZ Employee Service Center at 1-877-227-4372.

INTRODUCTION

CBIZ Operations, Inc. (the "Company") has established the CBIZ Operations, Inc. Welfare Benefit Plan (the "Plan") in order to provide prescription drug benefits to its Eligible Employees and their Eligible Dependents. The Plan is a welfare benefit plan, as defined by the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

Purpose of this Booklet

This booklet summarizes the main provisions of the Plan and serves as the ERISA-required summary plan description (SPD) relating to the benefits provided under the Plan.

You should read this SPD carefully and share it with your family members who are covered under the Plan. It is your responsibility to become familiar with the terms of the Plan and to ask questions if you do not understand how the requirements impact you. If you have any questions about your benefits, please contact Caremark using the number on the back of your CVS Caremark ID card.

This SPD provides only a summary of the terms and conditions of the Plan. It does not interpret, extend or change the Plan in any way. The full provisions of the Plan can only be determined precisely by consulting the applicable Plan documents. Copies of the Plan documents that govern the operation of the Plan are available for inspection in the Company's business offices during normal business hours. If there are any differences between the information set forth in this SPD and the information set forth in the Plan documents, the Plan documents will control and govern.

Nothing in the Plan or in this booklet is intended to provide employees, former employees or their dependents with a vested right to any benefits and/or any rights to continued employment.

Plan Interpretation

The Plan Administrator has the discretionary authority to construe, interpret and administer the Plan. The decisions of the Plan Administrator shall be final and binding. The Plan Administrator may also amend or terminate the Plan, in whole or in part, at any time and for any reason. The Plan Administrator has, however, delegated decision-making authority to the Pharmacy Benefit Manager with respect to benefit claims and appeals. With respect to benefit claims and appeals, the decision of the Pharmacy Benefit Manager shall be final and binding.

DEFINITIONS

The following words and phrases shall have the following meanings when used in this SPD, unless a different meaning is plainly required by the context:

"Adverse Benefit Determination" means a rescission of Plan coverage, or a denial, reduction, or termination of, or a failure of the Plan to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan.

"Appendix" refers to the description of Plan benefits and costs attached hereto.

"ATAA" refers to the alternative trade adjustment assistance, including an additional opportunity to elect COBRA Continuation Coverage, available under the Trade Act of 2002.

"CHIP" refers to a state's Children's Health Insurance Program.

"COBRA" refers to the Consolidated Omnibus Budget Reconciliation Act of 1985.

"COBRA Continuation Coverage" refers to the temporary extension of Plan coverage that is available under COBRA.

"Code" refers to the Internal Revenue Code of 1986, as amended.

"Company" means CBIZ Operations, Inc.

"Covered Dependent" refers to an Eligible Dependent who is covered under the Plan.

"Covered Employee" refers to an Eligible Employee who is covered under the Plan.

"EBSA" refers to the Employee Benefits Security Administration established by the Department of Labor.

"Eligible Dependents" refers to:

- your Spouse [or your domestic partner];
- you or your Spouse's child who is under age 26, including a natural child, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian;
- an unmarried child age 26 or over who is or becomes disabled and dependent upon you.

"Eligible Employees" refers to those employees of the Company who have satisfied the eligibility provisions hereunder and are eligible to participate in the Plan.

"Employer" refers to CBIZ Operations, Inc.

"ERISA" refers to the Employee Retirement Income Security Act of 1974, as amended.

"FMLA" refers to the Family and Medical Leave Act of 1993, pursuant to which the Employer is required to provide leave to certain employees.

"HIPAA" refers to the Health Insurance Portability and Accountability Act of 1996, as amended.

"IRO" means an independent review organization, an independent entity that reviews certain claim appeals for the Plan.

"Notice" or "Notice of Privacy Practices" refers to the document that describes your privacy rights under HIPAA and identifies the instances in which the Plan may use or disclose your PHI.

"Participant" means any Eligible Employee or Eligible Dependent who has enrolled and participates in the Plan.

"PHI" refers to protected health information, as defined by HIPAA.

"Plan" refers to the CBIZ Operations, Inc. Prescription Drug Plan.

"Plan Administrator" refers to CBIZ Operations, Inc. or its designee.

"Plan Sponsor" refers to CBIZ Operations, Inc.

"Plan Year" means the 12-month accounting period of the Plan, which begins on January 1 and ends on December 31.

"Post-Service Claim" is any claim for prescription drug benefits that is not a Pre-Service Claim or an Urgent Claim.

"Pre-Service Claim" means a request for approval of a prescription drug benefit where receipt of the benefit is conditioned, in whole or in part, on approval in advance of obtaining the prescription drug. Examples include pre-authorizations of certain prescription drugs.

"Participating Network Pharmacy" means a pharmacy that has entered into a contract with CVS Caremark to participate in its network and to provide prescription drugs at discounted rates.

"Pharmacy Benefit Manager" refers to the entity selected by the Plan Sponsor to process claims and perform certain other administrative services in connection with the Plan, which, in this case, is CVS Caremark.

"Privacy Officer" refers to the person designated by the Plan to oversee the Plan's compliance with privacy-related laws, rules and regulations.

"QMCSO" or "Qualified Medical Child Support Order" means a judgment, decree or order requiring that a Participant obtain Plan coverage on behalf of his/her child.

"Summary Health Information" means information (i) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under the Plan; and (ii) from which individual identifiers have been deleted.

"SPD" or "Summary Plan Description" refers to this booklet, which describes the benefits available under the Plan and the terms and conditions applicable to the receipt of those benefits.

"TAA" refers to the trade adjustment assistance, including an additional opportunity to elect COBRA Continuation Coverage, available under the Trade Act of 2002.

"Urgent Care Claim" means a claim for prescription drugs or treatment where a delay in making a determination could jeopardize the life or health of you or your Covered Dependent or the ability of you or your Covered Dependent to regain maximum function, or, in the opinion of your physician or your Covered Dependent's physician, would subject you or your Covered Dependent to severe pain that cannot be adequately managed without the requested treatment.

"USERRA" refers to the Uniformed Service Employment and Reemployment Rights Act of 1994, as amended.

Waiting Period means the period that must pass, once you become eligible to participate in the Plan, before your coverage will begin. The Plan imposes a Waiting Period of the first of the month following one month of employment.

AVAILABLE BENEFITS

A description of the prescription drug benefits available under the Plan, including the costs associated with such benefits, is provided in the attached Appendix, which is incorporated by reference into this booklet.

CONTRIBUTIONS AND FUNDING

Company Contributions

Any Company contributions toward the cost of Plan coverage shall be determined by the Company. The Company may pay all, a portion, or none of the cost of Plan benefits.

Employee Contributions

The Company shall determine the amount of contributions, if any, required from employees. These contribution amounts are subject to change from time to time, as determined by the Company. The Company will generally distribute a schedule of required contributions relating to coverage of Eligible Employees and their Eligible Dependents prior to the Plan Year (or other period of coverage) for which the schedule is to be effective. No employee shall be required to contribute to the Plan as a condition of employment with the Company.

Pre-Tax Contributions

An important feature of the Plan is that employee contributions toward the cost of Plan coverage are made with "pre-tax" dollars. This means that your share of the cost of Plan coverage is deducted from your wages or salary paid by the Company before federal income and social security taxes are applied. Because your share of the benefit cost is deducted first, you do not pay taxes on that portion of your gross income from the Company. This will result in a real tax savings to you which helps offset your share of the cost of such benefits. All Eligible Employees must notify the Company prior to the beginning of each Plan Year if they do not want to pay for these benefits with pre-tax dollars.

Plan Funding

Plan benefits are intended to be provided from the Company's general assets. The Company is not obligated to establish a separate trust or fund with respect to the Plan.

ELIGIBILITY

You are eligible to enroll in the Plan if you are a regular full-time Employee who is scheduled to work at least 25 hours per week for 9 months in a 12 month period.

If an associate in a status other than regular full-time/benefit eligible, is identified as having completed 12 months of service, averaging 30 hours per week or more, the associate will be changed to Regular Full-Time/benefit eligible status as newly required under the Affordable Care Act. The effective date of coverage will be on the first of the month following 30 days from the date in which an employee is deemed to have met eligibility requirements.

Eligible Dependents

The following individuals are also eligible for coverage under the Plan:

- your Spouse [or your domestic partner];
- you or your Spouse's child who is under age 26, including a natural child, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian;
- an unmarried child age 26 or over who is or becomes disabled and dependent upon you.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse are both covered under the CBIZ Operations, Inc. Welfare Benefit Plan, you may each be enrolled as an Employee or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the CBIZ Operations, Inc. Welfare Benefit Plan, only one parent may enroll your child as a Dependent.

Warning: Enrolling an ineligible individual, failing to advise the Plan when a Covered Dependent is no longer eligible, or otherwise failing to comply with the Plan's requirements for eligibility will constitute fraud or an intentional misrepresentation of a material fact that will trigger a rescission (a retroactive termination) of Plan coverage. Upon such a rescission, you will be responsible for reimbursing the Plan for any benefits that have been improperly paid by the Plan.

ENROLLMENT AND COVERAGE

As an Eligible Employee who has satisfied the eligibility conditions, you may need to enroll formally through the Company's online enrollment system before you may participate in and receive coverage under the Plan.

Initial Eligibility (New Employee or Newly Eligible Employee)

When you first become eligible to participate in the Plan, you will have the opportunity to select coverage for yourself and your Eligible Dependents. You must formally enroll in the Plan and agree to pay any required contributions before you will become a Participant in the Plan. You must complete your online enrollment within the time period specified by the Company. If you do not complete your online enrollment on or before the enrollment deadline, you will be considered to have elected not to participate in the Plan. If you do not enroll yourself (or your Eligible Dependents) in the Plan at the time you initially

satisfy the eligibility requirements of the Plan, you must generally wait until the next annual open enrollment period to enroll for such coverage under the Plan (unless you or your Eligible Dependents experience a qualifying event).

Effective Date of Coverage

If you complete the online enrollment on or before the enrollment deadline, your Plan coverage will be effective the first of the month following one month of employment. If you have elected to enroll your Eligible Dependents in the Plan, their coverage will also be effective on that date.

Late Enrollment

If you do not enroll in the Plan when you are first eligible to enroll, and you are not entitled to special enrollment (as discussed below), you will not be permitted to enroll for coverage under the Plan until the next annual open enrollment period.

Annual Open Enrollment

Each year that you continue to be eligible for Plan coverage, you will have the opportunity to decide if you want to participate in the Plan by completing your online enrollment during the Company's annual open enrollment period.

Enrollment through a Qualified Medical Child Support Order

The Plan also provides coverage as required by the terms of a Qualified Medical Child Support Order ("QMCSO"). This coverage applies even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment restrictions that may otherwise exist for dependent coverage. If the Company receives a valid QMCSO and you do not enroll the child as required, the custodial parent or state agency may enroll the affected child. Additionally, the Company may withhold from your paycheck any contributions required for such coverage.

A QMCSO may be either a National Medical Child Support Notice issued by a state child support agency, or an order or a judgment from a state court or administrative body directing the Company to cover a child under the Plan. Federal law provides that a QMCSO must meet certain form and content requirements to be valid. The Company follows certain procedures to determine if a child support notice is "qualified." You may receive a copy of these procedures at no charge. If you have any questions, or would like a copy of the child support order qualification procedures, please contact the Company.

SPECIAL ENROLLMENT RIGHTS

In certain circumstances, you and/or your Eligible Dependents may have an opportunity to enroll for Plan coverage outside of the Plan's standard enrollment periods. (The Plan's standard enrollment periods include the period immediately following your initial eligibility and the Plan's annual open enrollment period, as described above). Thus, you and/or your Eligible Dependents may not be required to wait until the next open enrollment period to be enrolled for coverage under the Plan.

Loss of Other Coverage

Special enrollment rights are available to certain individuals who previously declined Plan coverage and wish to enroll themselves and/or one or more of their Eligible Dependents in the Plan. If you are eligible

to participate in the Plan, you (and your Eligible Dependents) will be entitled to special enrollment if all of the following conditions are met:

A. You lose (or your Eligible Dependent loses) eligibility or coverage due to:

(a) termination of employment in a class eligible for such coverage;
(b) reduction in hours of employment;
(c) death of an employee;
(d) divorce or legal separation;
(e) the exhaustion of COBRA continuation coverage;
(f) employer contributions toward the coverage being terminated;
(g) an individual ceasing to be a dependent under the plan (such as by attaining the maximum age to be eligible as a dependent child);
(h) termination of a benefit package option;
(i) if coverage is provided through an HMO, no longer living or working in the HMO's service area (and there is no other coverage available);
(j) the plan no longer offers coverage to a class of similarly situated individuals that includes you (or your Eligible Dependent); and

B. You request special enrollment within 30 days of the date of the loss of coverage for one of the reasons stated above.

In each of these cases, coverage under the Plan will end on the last day of the month following the Plan Administrator's receipt of information required to support your request for a special enrollment.

Acquisition of a New Dependent

Special enrollment rights are also available if you acquire a dependent through marriage, birth, adoption or placement for adoption. You and your Eligible Dependents will be entitled to special enrollment as follows:

A. ***Employee Only***: If you are eligible but have not enrolled in the Plan, you may enroll upon your marriage, or upon the birth, adoption, or placement for adoption of your child.

B. ***Spouse Only***: If you are already enrolled as a Participant, you may enroll your spouse at the time of his/her marriage to you. You may also enroll your spouse if you are already enrolled and you acquire a child through birth, adoption, or placement for adoption.

C. ***Employee and Spouse***: If you are eligible but have not enrolled in the Plan, you may enroll yourself and your spouse upon your marriage or upon the birth, adoption, or placement for adoption of your child.

D. ***New Dependent***: If you are already enrolled as a Participant, you may enroll a child who becomes your dependent through marriage, birth, adoption, or placement for adoption.

E. ***Employee and New Dependent***: If you are eligible but have not enrolled in the Plan, you may enroll yourself and a child who becomes your dependent through marriage, birth, adoption, or placement for adoption.

F. ***Employee and Spouse and New Dependent*:** If you are eligible but have not enrolled in the Plan, you may enroll yourself, your spouse and a child who becomes your dependent through marriage, birth, adoption, or placement for adoption.

In each of these cases, you must request special enrollment within 30 days of the date of the marriage, birth, adoption or placement for adoption, as applicable.

Coverage will be effective (i) in the case of your marriage, on the day of the marriage; or (ii) in the case of your child's birth, as of the date of such birth; or (iii) in the case of your child's adoption or placement for adoption, the date of such adoption or placement for adoption. However, coverage is added only after the Plan Administrator has received necessary documentation to support the request for a special enrollment.

Medicaid or CHIP Eligibility or Loss of Eligibility

Special enrollment rights also apply if an Eligible Employee or Eligible Dependent either (i) becomes eligible for employment assistance, with respect to Plan coverage, under Medicaid or CHIP, or (ii) loses coverage under Medicaid or CHIP due to loss of eligibility for such coverage.

You must request special enrollment within 60 days after the date of the eligibility determination or the termination of Medicaid or CHIP coverage, as applicable.

PLAN ENROLLMENT CHANGES

Once you make your election for a Plan Year (or in your initial year of eligibility, for the remaining portion of the Plan Year), you generally cannot change or revoke your election until the beginning of the next Plan Year unless you have a qualified change in status. Please refer to the "Special Enrollment Rights" section of this document for further information.

COVERAGE DURING FMLA LEAVE

Continuation of Benefits and Company Contributions

If you are on a personal leave of absence that qualifies as unpaid leave under the Family and Medical Leave Act ("FMLA"), and you wish to continue your coverage under the Plan during that time, the Company (to the extent required by FMLA) will continue to maintain your benefits under the Plan on the same terms and conditions as though you were still an active employee (i.e., the Company will continue to pay its share of the cost of coverage). The Company shall continue to maintain your coverage until the earlier of the date that (i) you fail to return to work on expiration of the FMLA leave, or (ii) you voluntarily give notice of your intent to terminate employment. The Company's obligation to provide ongoing coverage under this Plan during your FMLA leave ends if you are more than 30 days late making a required contribution payment (as described below). However, the Company may, at its option, cover your missed payments so that your coverage will be uninterrupted.

Employee Contributions

If you elect to continue your coverage during FMLA leave, you must pay your share of the cost of coverage. [You may pay your share with after-tax dollars while on leave (or pre-tax dollars to the extent you receive compensation during the leave), or you may be given the option to prepay all or a portion of your share

of the cost of coverage for the anticipated duration of the leave on a pre-tax salary reduction basis out of your pre-leave compensation by making a special election to that effect prior to the date such compensation normally would be made available to you (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next period of coverage)], or through other arrangements agreed upon by you and the Company (e.g., the Company may agree to fund coverage during the leave and withhold amounts upon your return).

Your Repayment Obligation

If you voluntarily terminate your employment due to reasons within your control at or before the end of the FMLA leave, the Company shall have the right to be reimbursed by you for any and all contributions the Company has made on behalf of you and your Covered Dependents during the leave. In this regard, the Company shall have the right to obtain reimbursement from any funds that the Company might otherwise owe you following your voluntary termination, including, but not limited to: (i) any regular or overtime wages, commissions, salary, or bonuses; (ii) accrued vacation pay or sick leave pay; or (iii) benefits payable under the Plan or any other employee benefit plan (to the extent permitted by law) under which you are otherwise entitled to payment. In addition, the Company shall have the right to pursue reimbursement in a court of law. Regardless of whether you return from FMLA leave, the Company shall be entitled to recover any required employee contributions the Company has made on behalf of you and your Covered Dependents during FMLA leave to ensure continuity of coverage.

Return from Leave

Upon your return from FMLA leave, you will be permitted to participate in the Plan on the same basis as you were participating prior to taking leave, or as otherwise required by the FMLA. Even if you did not choose ongoing coverage during your leave, upon return from FMLA leave, you and your Covered Dependents will be reinstated into the Plan on the same terms that applied prior to taking the leave, without any waiting period, physical examination, etc.

You will receive a Plan identification (ID) card that you may use to purchase prescription drugs from a Participating Network Pharmacy. When you use your Plan ID card at a Participating Network Pharmacy, the Participating Network Pharmacy will generally file a claim on your behalf by submitting information regarding your prescription to the Plan. The Plan will then pay the Participating Network Pharmacy for the Plan's share of the cost (if any) of the prescription drug. You will be responsible for paying any deductible, co-payment or co-insurance payment owed in connection with your prescription to the Participating Network Pharmacy at the time of your purchase.

Use of Claim Form

Your Plan ID card will also contain important information, including claim filing directions and contact information for the Plan's Pharmacy Benefit Manager. If you use a pharmacy that is not a Participating Network Pharmacy, or if you do not have your Plan ID card at the time of your purchase at a Participating Network Pharmacy, you may be required to pay for the entire cost of the prescription drug at the time of purchase. In that case, you may file a claim to recover from the Plan the amount payable by the Plan (if any) in connection with your prescription drug purchase.

You may obtain a claim form from the Plan's Pharmacy Benefit Manager (CVS Caremark) by calling (888) 202-1654. The claim form will include specific instructions on how and where to file the claim. The claim form must be mailed to the address indicated on the claim form.

Furthermore, if you believe you are being denied any rights or benefits under the Plan and you wish to seek those benefits, you, or your authorized representative on your behalf, must file a written claim and submit it to the Pharmacy Benefit Manager via fax at (866) 443-1172 or by having your physician call the physician-only toll-free number at (866) 443-1183. The Pharmacy Benefit Manager will review your claim and notify you of its determination under the procedures described below.

Following Plan Procedures

You should follow the procedures described in this section to request your benefits under the Plan. If your request is denied, you may appeal your claim under the claims procedures below.

Decisions on Coverage

All claims and questions regarding your claims under the Plan should be directed to the Pharmacy Benefit Manager. It is the Pharmacy Benefit Manager that is ultimately responsible for making the final determinations on such claims and for providing a full and fair review of the decision on such claims in accordance with the provisions below and in accordance with applicable law. Benefits under the Plan will be paid after the Pharmacy Benefit Manager decides, in its sole discretion, that you are entitled to such benefits. The Pharmacy Benefit Manager is a fiduciary of the Plan and has the authority to make decisions involving the use of discretion.

Deadline for Filing

All claims relating to benefits covered under the Plan must be filed within the 12-month period following the date on which the service/prescription drug is received.

CLAIMS PROCEDURES

Notification of the Plan's Determination

Once your claim is submitted to the Plan, the Pharmacy Benefit Manager will make a decision with respect to your claim. If your claim is wholly or partially denied, the Pharmacy Benefit Manager will notify you of that decision in a writing which will contain: (i) specific reasons for the claim's denial, (ii) specific reference to relevant Plan provisions, (iii) a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary, and (iv) information as to the steps to be taken if you wish to appeal the Pharmacy Benefit Manager's decision. In addition, you will be notified of any Adverse Benefit Determination that results in a rescission of your coverage. A rescission of coverage refers to a cancellation or discontinuance of coverage that has retroactive effect, but does not include any such cancellation or discontinuance to the extent it results from a failure to pay on a timely basis premiums or contributions towards the cost of Plan coverage. You will also be notified of the steps to be taken if you wish to appeal the Pharmacy Benefit Manager's decision regarding your rescission.

In addition to the information above, the notice will also contain any information regarding an internal rule, guideline or protocol that was relied on in making the benefit determination. Also, if the denial is based on medical necessity, experimental treatment or a similar exclusion or limit, the notice will contain an explanation of the scientific or clinical judgment used in the determination. If the notice does not contain such statements or explanations, the notice will contain a statement indicating that this information will be provided to you upon written request at no charge.

Timing of Notification

Notification regarding your claim will be given within the following timeframes, depending on the type of claim you submitted:

A. ***Urgent Care Claims*** – within 72 hours after receipt of your claim, unless you do not provide enough information for the Pharmacy Benefit Manager to determine whether or to what extent benefits are payable under the Plan. If this occurs, the Pharmacy Benefit Manager will notify you of the deficiency within 24 hours of receiving your claim. You will have a reasonable amount of time, not less than 48 hours, to provide the additional necessary information. The Pharmacy Benefit Manager will notify you of the Plan's determination as soon as possible, but no later than 48 hours after the earlier of (i) the Plan's receipt of the additional information, or (ii) the end of the time period given to you to provide additional information.

An "urgent care claim" is a claim for prescription drugs care or treatment where a delay in making a determination could jeopardize the life or health of you or your Covered Dependent or the ability of you or your Covered Dependent to regain maximum function, or, in the opinion of your physician or your Covered Dependent's physician, would subject you or your Covered Dependent to severe pain that cannot be adequately managed without the requested treatment.

B. ***Pre-Service Claims*** – within a reasonable time, but no longer than 15 days after receipt of your claim. An extension of an additional 15 days may be granted due to matters beyond the control of the Pharmacy Benefit Manager, but only if the Pharmacy Benefit Manager notifies you before the end of the first 15 days of the circumstances requiring the extension and the date by which the Pharmacy Benefit Manager expects to make a decision. If the extension is due to your failure to submit necessary information, the extension notice will describe the additional necessary information, and the time period for deciding your claim will be suspended until the earlier of (i) the day you respond to the notice, or (ii) at least 45 days from receipt of the notice requesting additional information.

A "pre-service claim" is a request for approval of a prescription drug where receipt of the prescription drug is conditioned, in whole or in part, on approval in advance of obtaining the prescription drug. Examples include pre-authorizations for certain prescription drugs.

C. ***Post-Service Claims*** – within a reasonable time, but no later than 30 days after receipt of your claim. The review period may be extended for 15 days due to matters beyond the Pharmacy Benefit Manager's control if the Pharmacy Benefit Manager notifies you of the extension before the end of the first 30-day period, the circumstances requiring the extension and the date by which the Pharmacy Benefit Manager expects to make a decision. If the extension is due to your failure to submit necessary information, the extension notice will describe the additional necessary information, and the time period for deciding your claim will be suspended until the earlier of (i) the day you respond to the notice, or (ii) at least 45 days from receipt of the notice requesting additional information.

A "post-service claim" is any claim for prescription drug benefits that is not a pre-service claim or an urgent claim.

D. ***Ongoing Treatment*** – if you are receiving ongoing treatments (*i.e.*, treatment over a period of time or a specified number of treatments) that have been previously approved by the Plan, any reduction or termination of ongoing treatments is an Adverse Benefit Determination. The Pharmacy Benefit Manager must notify you within a reasonable time prior to the reduction or termination of services.

Ongoing Urgent Care. If you request to extend urgent care beyond the approved period of time or number of treatments, the Pharmacy Benefit Manager will notify you of its decision as soon as possible, but no later than 24 hours after receiving your claim, provided that your request was made at least 24 hours in advance of the end of the approved ongoing treatment. If you do not make your claim at least 24 hours before the expiration of the ongoing treatment, then the time frames for urgent care claims (discussed above) will apply.

Other Ongoing Care. If your request to extend ongoing treatment does not involve urgent care, your claim will be treated as either a pre-service claim or post-service claim, as applicable.

If notice of a benefits determination is not given to you within the applicable time period, your claim will be considered denied as of the last day of the applicable Plan review period.

INTERNAL APPEAL PROCEDURES

If your claim is denied and you wish to have the claim reconsidered, you, or your authorized representative on your behalf, may appeal the denial and request a review of your claim. Your appeal must be received by the Pharmacy Benefit Manager within 180 days after your receipt of the notice of denial.

When you submit your appeal, you may also submit additional comments, records and documents related to your claim. You may also, upon request and at no charge, review copies of the documents and information relevant to your claim.

Appeals should include the following information:

- name of the Participant who is the subject of the appeal;
- the Participant's CVS Caremark ID number;
- the Participant's date of birth
- a written statement of the issue(s) being appealed;
- name of the drug(s) being requested; and
- written comments, documents, records or other information relating to the claim being appealed.

Your appeal and supporting documentation may be mailed or faxed to the Pharmacy Benefit Manager as follows:

CVS Caremark, Inc.
Appeals Department
MC109
PO Box 52084
Phoenix, AZ 85072-2084
Fax Number for Appeals: (866) 443-1172

Note that the Plan provides for an expedited review process with respect to urgent care claims. You may request an expedited appeal of an Adverse Benefit Determination orally or in writing. The expedited process allows you to transmit and receive information from the Plan by telephone, facsimile or other similar expedited means. [Physicians may submit urgent appeal requests by calling the physician-only toll-free number at (866) 443-1183.]

Notification of the Plan's Determination; Timing

If your appeal is received by the appropriate deadline, the Pharmacy Benefit Manager will independently review your appeal and any additional information that you submit. The Pharmacy Benefit Manager will notify you of its decision regarding your appeal within the following timeframes:

A. ***Urgent Care Claims*** – as soon as possible, but no later than 72 hours after receipt of your appeal.

B. ***Pre-Service Claims*** – within a reasonable period, but no later than 30 days after receipt of your appeal.

C. ***Post-Service Claims*** – within a reasonable period, but no later than 60 days after receipt of your appeal.

With respect to any appeal that is based in whole or in part on a medical judgment, including determinations with respect to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Pharmacy Benefit Manager delegates its fiduciary decision-making authority to one of its outside vendors. In rendering its decision on Plan coverage, the outside vendor, will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The Pharmacy Benefit Manager will identify the medical or other experts who provided advice to the Plan with respect to your claim. The Pharmacy Benefit Manager currently uses the following vendors for such appeals: Medical Review Institute, MES Solutions, National Medical Review, and Managing Care Managing Costs. However, the outside vendors used by the Pharmacy Benefit Manager may change from time to time.

If your appeal is denied, the Pharmacy Benefit Manager will send you a statement containing: (i) specific reasons for the denial, (ii) specific references to relevant Plan provisions, (iii) a statement that you may have access to or receive, upon request and at no charge, copies of all documents, records and information relevant to your claim, and (iv) a statement describing your right to bring an action in federal court under Section 502(a) of ERISA. In addition to the information above, the notice will contain any information regarding an internal rule, guideline or protocol used in making the appeal decision and an explanation of the scientific or clinical judgment used in the denial. If the appeal notice does not contain such statements or information, the notice will contain a statement indicating that this information is available upon written request and at no charge. If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice will also contain an

explanation of the scientific or clinical judgment for the determination. If the appeal notice does not contain such explanation, it will contain a statement indicating that this explanation is available upon written request and at no charge.

The Pharmacy Benefit Manager will provide to you, free of charge, any new or additional evidence or any new or additional rationale, that is considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with your claim. In order to give you an opportunity to respond to such new or additional evidence or the new or additional rationale, this evidence or rationale will be provided to you in advance of the date on which you are to receive a decision on your appeal (as described above). You may review your claim file and present evidence and testimony relevant to your claim.

You must exhaust your rights to appeal under the terms of the Plan before you may bring an action in federal court.

EXTERNAL APPEAL PROCEDURES

Possible Right to External Appeal

If your appeal is denied, you may pursue an external review of your claim by an independent, third party if your claim denial involved either medical judgment (such as a denial based on medical necessity, appropriateness, health care setting, level of care, or effectiveness, or a determination that the treatment is experimental or investigational) or a rescission of coverage.

Standard External Review

If you wish to pursue an external appeal, you must file a request for an external appeal within four months of the date your appeal was denied.

The request for an external appeal should include:

- the Participant's name,
- contact information including mailing address and daytime telephone number,
- the Participant's ID number, and
- a copy of the prior appeal denial.

The request for an external appeal and supporting documentation may be mailed or faxed to the Pharmacy Benefit Manager as follows:

CVS Caremark
External Review Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-3092
Fax Number: (866) 689-3092

Within five days after its receipt of a request for an external appeal, the Pharmacy Benefit Manager will confirm whether your request is complete and eligible for an external appeal. If the request is complete and eligible for an external appeal, the Pharmacy Benefit Manager will forward the request to an independent review organization ("IRO"), together with all relevant medical records, all other documents relied upon by the Pharmacy Benefit Manager in making a decision on the case, and all other information

or evidence that you or your physician has already submitted to the Pharmacy Benefit Manager. If there is any information or evidence you or your physician wish to submit in support of the request that was not previously provided, you may include such information with the request for an external appeal.

Except in the case of an expedited external appeal, as described below, the assigned IRO will provide you and the Plan with written notice of its decision on your external appeal within 45 days of its receipt of your request. If the IRO needs additional information to make a decision, this time period may be extended as permitted by law. The IRO's notice to you shall also include such other information as required by applicable law.

Expedited External Appeal

The external appeal process will be expedited if you meet the criteria for an expedited external appeal, as defined by applicable law. For example, if you have received an Adverse Benefit Determination that involves a medical condition for which the timeframe for completing an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal, you may expedite your external appeal as well. Similarly, if you have received a final denial of your claim under the internal appeal procedures and you have a medical condition for which the timeframe for completion of a standard external appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, or your claim involved an admission, availability of care, continued stay, or a prescription drug benefit for which you received emergency treatment, but have not been discharged from a facility, you may expedite your external appeal.

You or your physician may request an expedited external appeal by calling the Customer Care number on your Plan ID card. The request should include:

- the Participant's name,
- contact information including mailing address and daytime telephone number,
- the Participant's ID number, and
- a copy of the prior appeal denial.

Alternatively, a request for an expedited external appeal and the supporting documentation may be faxed to the Pharmacy Benefit Manager at:

CVS Caremark
External Review Appeals Department
Fax number: (866) 443-1172

All requests for an expedited external appeal must be clearly identified as "urgent" at the time of submission.

Immediately upon its receipt of a request for an expedited external appeal, the Pharmacy Benefit Manager will confirm whether your request is complete and eligible for an external appeal. If the request is complete and eligible for an external appeal, the Pharmacy Benefit Manager will forward the request to an IRO, together with all relevant medical records, all other documents relied upon by the Pharmacy Benefit Manager in making a decision on the case, and all other information or evidence that you or your physician has already submitted to the Pharmacy Benefit Manager. If there is any information or evidence you or your physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an external appeal.

The assigned IRO will provide you and the Plan with notice of its decision on your external appeal as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives your request for an expedited external appeal. If this notice is not provided in writing, within 48 hours after providing the notice, the IRO will provide you and the Plan with written confirmation of its decision. The IRO's notice shall also include such other information as required by applicable law.

Final Decision of IRO

If the final independent decision of the IRO is to approve payment/coverage of the benefit that was previously denied, the Plan will accept the decision and provide coverage for your prescription drug in accordance with the terms and conditions of the Plan. If the final independent decision of the IRO is that payment/coverage will not be made or provided, the Plan will not be obligated to provide coverage for the prescription drug.

Please contact the Plan Administrator or the Pharmacy Benefit Manager for more information on filing an external appeal.

Legal Action

Before pursuing legal action, a person claiming Plan benefits or seeking redress related to the Plan shall first exhaust all claim and appeal procedures provided by the Plan, as described above. Any legal action by a person claiming Plan benefits or seeking redress relating to the Plan must be filed within 24 months of the date the eligible charge/claim was incurred.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies to you if you are covered by more than one health/prescription drug benefits plan, including any one of the following:

- Another employer sponsored health/prescription drug benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health/prescription drug benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

Determining Which Plan is Primary

Order of Benefit Determination Rules

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent.
- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.
- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - The parents are married or living together whether or not they have ever been married and not legally separated.
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - The parent with custody of the child; then
  - The Spouse of the parent with custody of the child; then
  - The parent not having custody of the child; then
  - The Spouse of the parent not having custody of the child.
- Plans for active employees pay before plans covering laid-off or retired employees.
- The plan that has covered the individual claimant the longest will pay first.
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

When This Plan is Secondary

If this Plan is secondary to any plan other than Medicare, it determines the amount it will pay for a Covered Service by following the steps below.

- The Plan determines the amount it would have paid based on the allowable expense.

- The Plan pays the entire difference between the allowable expense and the amount paid by the primary plan - as long as this amount is not more than the Plan would have paid had it been the only plan involved.

You will be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the allowable expense.

Determining the Allowable Expense If This Plan is Secondary

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When This Plan is Secondary to Medicare".

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved

amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid had it been the only plan involved.
- The Plan pays the entire difference between the allowable expense and the amount paid by the primary plan - as long as this amount is not more than the Plan would have paid had it been the only plan involved.

The maximum combined payment you may receive from all plans cannot exceed 100% of the applicable allowable expense.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. CVS Caremark may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

CVS Caremark does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give CVS Caremark any facts needed to apply those rules and determine benefits payable. If you do not provide CVS Caremark the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical/prescription drug plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, CVS Caremark reserves the right to recover the excess amount from the provider pursuant to Refund of Overpayments, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future benefits that are payable in connection with services provided to persons under other plans for which CVS Caremark makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party,

you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.

- Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.

- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the employee, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of

the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

TERMINATION OF COVERAGE

Termination of Employee Coverage

Your participation in the Plan will terminate upon the earliest of:

- the last day of the month during which you cease to be part of the group of employees that is eligible to participate in the Plan (including due to termination of employment);

- the last day of the month during which you cease to satisfy the eligibility conditions for participation in the Plan;
- on the last day of the stability period following the measurement period in which you fail to satisfy the eligibility conditions for full-time employee status;
- the date the Plan is no longer offered;
- the date the Plan terminates;
- the date you revoke your election to participate in the Plan (whether pursuant to your annual enrollment or as otherwise permitted);
- the last day of the month during which you fail to make any contribution required under the Plan;
- the last day of the month during which you fail to return to work after FMLA leave or fail to return from a disability leave within the applicable time parameters; or
- the date of your death.

Termination of Dependent Coverage

Generally, your Covered Dependents' coverage ends when your coverage ends. [However, if you die while covered under the Plan, your dependents will continue to be covered until the last day of the month in which your death occurs.] In addition, your dependents' coverage also ends:

- on the last day of the month on which the dependent ceases to be a dependent;
- on the last day of the month during which you fail to make the required contributions for the dependent's coverage; or
- on midnight of the date dependent coverage under the Plan is terminated.

COBRA Rights Triggered

Under certain circumstances, even though your participation in the Plan has terminated, you may be permitted to continue to participate in the Plan at your own cost. See the COBRA Continuation Coverage section below for more details.

COBRA CONTINUATION COVERAGE

COBRA Continuation Coverage

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA Continuation Coverage is a temporary extension of health coverage, available to you and to other members of your family who are covered under the Plan, at group rates in certain instances where coverage under the Plan would otherwise end. **This information is intended to provide notice and explain, in a summary fashion, COBRA Continuation Coverage, when it may become available to you and your family, and what you must do to continue your health care**

coverage under the Plan, including what to do to protect the right to receive it. This information gives you only a summary of your COBRA Continuation Coverage rights. Both you and your spouse, if any, should take the time to read this information carefully.

The Plan Administrator, as listed in the front of this booklet, is responsible for administering COBRA Continuation Coverage.

COBRA Continuation Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. COBRA Continuation Coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and other Covered Dependents of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage.

Rights of Employees

If you are an employee of the Company and covered by the Plan, you will become a qualified beneficiary if you lose your coverage under the Plan because of:

- a reduction in your hours of employment; or
- the termination of your employment (for reasons other than gross misconduct on your part).

Rights of Spouses

If you are the spouse of the Covered Employee, you will become a qualified beneficiary if you lose coverage under the Plan for any of the following reasons:

- the death of your spouse;
- a termination of your spouse's employment (for reasons other than his/her gross misconduct) or a reduction in your spouse's hours of employment;
- divorce or legal separation from your spouse; or
- your spouse becomes enrolled in Medicare (Part A, Part B or both).

Rights of Children

In the case of a child of the Covered Employee, the child will become a qualified beneficiary if the child's coverage under the Plan is lost for any of the following reasons:

- the death of the Covered Employee;
- the termination of the Covered Employee's employment (for reasons other than the Covered Employee's gross misconduct) or a reduction in the Covered Employee's hours of employment with the Company;
- the Covered Employee becomes enrolled in Medicare (Part A, Part B or both);
- parents' divorce or legal separation; or
- the child ceases to be an Eligible Dependent under the Plan.

Separate Elections

If there is a choice among types of coverage under the Plan, each person eligible for COBRA Continuation Coverage is entitled to make a separate election among the types of coverage. Thus, a Covered Dependent spouse or Covered Dependent child is entitled to elect COBRA Continuation Coverage even if the Covered Employee does not make that election. Similarly, a Covered Dependent spouse or Covered Dependent child may elect a different coverage from the coverage elected by the Covered Employee.

Notification of the Plan Administrator

The Plan will offer COBRA Continuation Coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or enrollment of the employee in Medicare (Part A, Part B or both), the Company must notify the Plan Administrator of the qualifying event within 30 days of such event.

For the other qualifying events (divorce or legal separation of you and your spouse, or a Covered Dependent child's loss of eligibility for coverage), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to the Plan Administrator at the address listed for the Plan Administrator at the beginning of this booklet. Your notice must be in writing and must include: (i) the Plan name, (ii) your name and the name of each qualified beneficiary impacted by the qualifying event, (iii) the type of qualifying event, and (iv) the date of the qualifying event. The notice to the Plan Administrator can be provided by you or any other qualified beneficiary, or any representative on behalf of you or any other qualified beneficiary.

Beginning of Coverage and Length of Coverage

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA Continuation Coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have 60 days to make an election. For each qualified beneficiary who elects COBRA Continuation Coverage, COBRA Continuation Coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA Continuation Coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's enrollment in Medicare (Part A, Part B or both), the employee's divorce or legal separation or a Covered Dependent child losing eligibility, COBRA Continuation Coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA Continuation Coverage lasts for up to 18 months. However, if the qualifying event is the employee's termination of employment or reduction in hours of employment and the qualifying event occurs within the 18-month period after the employee becomes enrolled in Medicare, the employee's Covered Dependent spouse and Covered Dependent children are entitled to COBRA Continuation Coverage for up to 36 months from the date the employee enrolled in Medicare.

Possible Extensions

There are two additional ways in which this 18-month period of COBRA Continuation Coverage can be extended:

A. ***Disability Extension***. If you or anyone in your family who is covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA Continuation Coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months.

You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the later of: (i) the date of the qualifying event (the employee's termination of employment or reduction in hours); (ii) the date of the Social Security Administration determination; and (iii) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event. **In addition, you must notify the Plan Administrator of the Social Security Administration determination before the end of the 18-month period of COBRA Continuation Coverage.** Notice should be sent to the Plan Administrator at the address set forth at the beginning of this booklet. The notice must be in writing and must include: (a) the Plan name, (b) the name of the employee and the disabled qualified beneficiary, if different, (c) the date of the Social Security Administration's determination of disability, and (d) a copy of the Social Security Administration's determination of disability. The notice can be provided by the employee, the qualified beneficiary or any representative on behalf of the employee or the qualified beneficiary.

B. ***Second Qualifying Event Extension***. If your family experiences another qualifying event while receiving COBRA Continuation Coverage, your Dependent spouse and Dependent children in your family can receive additional months of COBRA Continuation Coverage, for up to a maximum of 36 months. This extension is available to your Dependent spouse and Dependent children if you die, get divorced or legally separated, or enroll in Medicare Part A and/or Part B (and your enrollment in Medicare Part A and/or Part B would have been a qualifying event if it occurred before your termination of employment or reduction in hours of employment). The extension is also available to a Dependent child when that child stops being eligible under the Plan as a Dependent child.

In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator at the address set forth at the beginning of this booklet. The notice must be in writing and must include: (i) the Plan's name, (ii) the name of the employee and each qualified beneficiary impacted by the second qualifying event, (iii) the nature of the second qualifying event, and (iv) the date of the second qualifying event. The notice can be provided by the employee, the qualified beneficiary or any representative on behalf of the employee or the qualified beneficiary.

<u>More Information About Individuals Who May Be Qualified Beneficiaries</u>

A child born to, adopted by, or placed for adoption with a Covered Employee during a period of COBRA Continuation Coverage is considered to be a qualified beneficiary provided that, if the Covered Employee is a qualified beneficiary, the Covered Employee has elected COBRA Continuation Coverage for himself/herself. The child's COBRA Continuation Coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA Continuation Coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must

satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

A child of the Covered Employee who is receiving benefits under the Plan pursuant to a QMCSO received by the Company during the Covered Employee's period of employment with the Company is entitled to the same rights to elect COBRA Continuation Coverage as a Covered Dependent child of the Covered Employee.

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

COBRA Continuation Coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA Continuation Coverage, under another group health plan;
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA Continuation Coverage;
- the Company ceases to provide any group health plan for its employees; or
- during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA Continuation Coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate).

COBRA Continuation Coverage may also be terminated for any reason the Plan would terminate coverage of a Covered Employee or Covered Dependent not receiving COBRA Continuation Coverage (such as fraud).

You must notify the Plan Administrator in writing within 30 days if, after electing COBRA Continuation Coverage, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage. In addition, if you were already entitled to Medicare before electing COBRA Continuation Coverage, you must notify the Plan Administrator of the date of your Medicare entitlement. If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Plan Administrator of that fact within 30 days after the Social Security Administration's determination.

Special Considerations in Deciding Whether to Elect COBRA

In considering whether to elect COBRA Continuation Coverage, you should take into account that you may have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your coverage under the Plan ends because of one of the qualifying events listed above. Your special enrollment options may cost less than COBRA Continuation Coverage. You will also have the same special enrollment right at the end of COBRA Continuation Coverage if you elect COBRA Continuation Coverage for the maximum time available to you. You can learn more about your options by visiting www.healthcare.gov.

Alternatives to COBRA Continuation Coverage

When you become eligible for COBRA Continuation Coverage, you may also become eligible for other coverage options that may cost less than COBRA Continuation Coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Exchange/Marketplace or you may be eligible for Medicaid. By enrolling in coverage through the Health Insurance Exchange/Marketplace or Medicaid, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. You can learn more about your options by visiting www.healthcare.gov.

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA Continuation Coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA Continuation Coverage due to a disability, 150%) of the cost to the Plan (including both employer and employee contributions) for coverage of a similarly situated Plan Participant who is not receiving COBRA Continuation Coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA Continuation Coverage and will most likely increase over time. You will be notified of COBRA premium changes.

First Payment for COBRA Coverage

If you elect COBRA Continuation Coverage, you do not have to send any payment with the election form. However, you must make your first payment for COBRA Continuation Coverage not later than 45 days after the date of your election. (This is the date your election form is postmarked, if mailed, or the date your election form is received by the individual at the address specified for delivery of the election form, if hand-delivered.) Your first payment must cover the cost of COBRA Continuation Coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. (For example, suppose your employment terminates on September 30, and you lose coverage on September 30. You elect COBRA Continuation Coverage on November 15. Your initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of your COBRA election.) You are responsible for making sure that the amount of your first payment is correct. You may contact the Plan Administrator to confirm the correct amount of your first payment.

The prescription drug claims incurred after you lose Plan coverage will not be processed and paid until you have elected COBRA Continuation Coverage and made the first payment for it. **If you do not make your first payment for COBRA Continuation Coverage in full within 45 days after the date of your election, you will lose all COBRA Continuation Coverage rights under the Plan.**

Monthly Payments for COBRA Coverage

After you make your first payment for COBRA Continuation Coverage, you will be required to make monthly payments for each subsequent month of COBRA Continuation Coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA Continuation Coverage is due on the first day of the month for that month's COBRA Continuation Coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA Continuation Coverage under the Plan will continue for that month without any break. **You will not receive periodic notices of payments due for these coverage periods, and you will not receive a bill. It is your responsibility to pay your COBRA Continuation Coverage premiums on time.**

Grace Periods for Monthly COBRA Premium Payments

Although monthly payments are due on the first day of each month of COBRA Continuation Coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA Continuation Coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. **If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA Continuation Coverage under the Plan.**

Questions

If you have questions about your COBRA Continuation Coverage, you should contact the Plan Administrator, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA"). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa**.** If you have questions about your rights under ERISA or the Patient Protection and Affordable Care Act or other laws affecting the Plan, you may contact the nearest Regional or District EBSA Office. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa.** For more information about the Health Insurance Exchange/Marketplace, you may visit www.healthcare.gov.

I**n order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members.** You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

COBRA Continuation Coverage Under the Trade Act of 2002

Certain employees and former employees whose employment is adversely affected by international trade through increased imports or a shift in production to another country and who are eligible for federal trade adjustment assistance (“TAA”) or alternative trade adjustment assistance (“ATAA”) are entitled to a second opportunity to elect COBRA Continuation Coverage. This opportunity applies to the employee or former employee and certain family members (if they did not already elect COBRA Continuation Coverage) during a special second election period of 60 days or less (but only if the election is made within six months after Plan coverage is lost).

COBRA Continuation Coverage elected during the second 60-day election period begins on the first day of the second election period and not on the date of the original loss of coverage.

If you are an employee or former employee and you qualify for TAA or ATAA, contact the Company promptly after qualifying for TAA or ATAA or you will lose any right that you may have to elect COBRA Continuation Coverage during a special second election period.

USERRA Continuation of Coverage

If you are absent from employment for more than 30 days by reason of service in the uniformed services, you may elect to continue Plan coverage for yourself and your Covered Dependents for up to 24 months, in accordance with the Uniformed Service Employment and Reemployment Rights Act ("USERRA"). Regardless of whether you continue health coverage during your absence, if you return to a position of employment with the Company, your health coverage and that of your Covered Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on you or your Covered Dependents in connection with this reinstatement, except as otherwise provided under USERRA. The procedures set forth above for electing COBRA Continuation Coverage apply to this election for continuation coverage. Contact the Company for additional information about USERRA continuation coverage.

HIPAA PRIVACY COMPLIANCE

The Plan understands and recognizes the confidentiality and sensitivity of your health information and is committed to protecting this information from inappropriate uses and disclosures. As required by HIPAA, the Plan has adopted certain privacy policies and procedures related to the use and disclosure of your protected health information ("PHI"). If there are material changes made to the Plan's practices and procedures regarding the use and protection of your PHI, you will receive a revised Notice. In addition, you may receive a copy of the Notice at any time by contacting the Plan's Privacy Officer, CBIZ Service Corp. at 216-447-9000.

If you have any questions about how the Plan protects your PHI and your question is not answered by reviewing the information in the Notice or in the Plan or this SPD, if you would like more information about the Plan's privacy practices, or if you want to make a complaint about the Plan's privacy activities, contact the Plan's Privacy Officer or any other individual(s) identified in the Notice.

What is PHI?

HIPAA defines PHI as information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual, or for which there is a reasonable basis to believe that the information can be used to identify the individual. PHI includes information of persons living or deceased.

Restrictions

HIPAA restricts the Plan Sponsor's ability to use and disclose PHI. The Plan Sponsor shall have access to PHI from the Plan only as permitted under the Plan or as otherwise required or permitted by HIPAA.

Enrollment/Waive Coverage

The Plan may disclose to the Plan Sponsor information about whether an individual is participating in the Plan, or is enrolled in or has waived participation in the Plan. Enrollment and disenrollment information held by the Plan Sponsor is held in its capacity as an employer and is not considered PHI.

Summary Health Information

The Plan may disclose Summary Health Information to the Plan Sponsor, provided that the Plan Sponsor requests the Summary Health Information for the purpose of (i) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (ii) modifying, amending, or terminating the Plan. "Summary Health Information" means information (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under the Plan; and (b) from which individual identifiers have been deleted. Summary Health Information is not considered PHI.

Plan Administration

The Plan may disclose PHI to the Plan Sponsor for Plan administration functions. Plan administration functions are those administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing, reviewing appeals and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor, and do not include any employment-related actions or decisions.

With respect to any PHI disclosed to it by the Plan (other than information that is disclosed pursuant to a Participant's signed authorization), the Plan Sponsor shall:

- not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- ensure that any agent to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
- not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures provided for;
- make a Participant's PHI available to the Participant in accordance with HIPAA's right of access;
- make PHI available for amendment, and incorporate any amendments to PHI, in accordance with HIPAA's requirements;
- make available the information required to provide an accounting of disclosures, in accordance with HIPAA's requirements;
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;
- if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that if such return or destruction

is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

- ensure that adequate separation between the Plan and the Plan Sponsor is established.

The Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than information disclosed pursuant to a Participant's signed authorization) on behalf of the Plan, it will:

- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- ensure that the adequate separation between the Plan and the Plan Sponsor (i.e., the firewall) is supported by reasonable and appropriate security measures;

- ensure that any agent to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and

- report to the Plan any security incident of which it becomes aware, as follows: the Plan Sponsor will report to the Plan, with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy electronic PHI or to interfere with systems operations in an information system containing electronic PHI; in addition, the Plan Sponsor will report to the Plan as soon as feasible any successful unauthorized access, use, disclosure, modification, or destruction of electronic PHI or interference with systems operations in an information system containing electronic PHI.

Separation Between the Plan and the Plan Sponsor

The Plan Sponsor shall allow only certain authorized personnel to have access to PHI. No other employees of the Plan Sponsor shall have access to PHI. The authorized personnel shall only have access to and use of PHI to the extent necessary to perform the Plan administration functions that the Plan Sponsor performs for the Plan. In the event that any authorized personnel does not comply with the privacy provisions of this section, he/she shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures.

Certification of the Plan Sponsor

The Plan is permitted to disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions required by HIPAA, and that the Plan Sponsor agrees to the conditions of disclosure set forth above.]

ADMINISTRATION OF THE PLAN

Amendment and Termination

The Plan Administrator has the right to amend the Plan at any time, without prior notice to Participants, provided that the amendment does not eliminate benefits to which a Participant has become entitled.

No amendment shall (i) increase the duties and liabilities of the Plan Administrator without the Plan Administrator's written consent, or (ii) divert Plan funds or assets (if any) from the exclusive purpose of paying for the benefits provided by the Plan for or on behalf of the Participants. Anyone claiming an interest under the Plan will be bound by any such amendment.

While the Plan Administrator expects the Plan to be continued, future conditions affecting the Company cannot be anticipated. Therefore, the Plan Administrator reserves the right to terminate the Plan or to discontinue permanently paying benefits under the Plan, without prior notice to the Participants. If the Plan is terminated, (a) Plan assets, if any, will be allocated in accordance with the relevant provisions of ERISA and the Code, (b) Plan coverage will terminate, and (c) the Plan shall continue until the Company has paid all proper claims for benefits outstanding as of the date of termination.

Authority to Construe and Apply Plan Documents; Standard of Judicial Review

To the full extent permitted by law, the Plan Administrator shall have the discretionary authority to:

- construe and interpret any uncertain, ambiguous or disputed term or provision in Plan and related documents; and
- decide all questions of law and fact concerning the Plan and related documents and their application (including, but not limited to, determining questions concerning eligibility and benefits).

The exercise of this discretionary authority shall be binding upon all interested parties, including, but not limited to, you, your Covered Dependents, your estate and your beneficiaries, and shall be subject to review only if it is arbitrary or capricious or otherwise inconsistent with applicable law. Any review of an exercise of this discretionary authority shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under the Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion, and further, constitutes agreement to the limited standard and scope of review described in this section.

Additional Powers and Duties of the Plan Administrator

The Plan Administrator shall have the following powers and duties:

- to require any person to furnish such reasonable information as the Company, the Plan Administrator or the Pharmacy Benefit Manager may request for the proper administration of the Plan as a condition to receiving any benefits under the Plan, and to rely on such information;
- to make and enforce such rules and regulations and prescribe the use of such forms as the Plan Administrator shall deem necessary for the efficient administration of the Plan;
- to decide on questions concerning the Plan and the eligibility of any employee or dependent to participate in the Plan, and to authorize payments from the Plan, in accordance with the provisions of the Plan;
- to manage the operation and administration of the Plan according to its terms and for the exclusive benefit of Plan Participants;

- to maintain (i) records and data necessary and desirable for the Plan's proper operation and administration, and (ii) governing documentation of the Plan for inspection by any Eligible Employee or Participant;

- to designate other persons to carry out any duty or power that would otherwise be a fiduciary or clerical responsibility under the terms of the Plan; and to retain such actuaries, accountants (including employees who are actuaries or accountants), consultants, third-party administration service providers, legal counsel, or other specialists, as the Plan Administrator may deem appropriate and necessary for the Plan's effective administration;

- to rely upon all tables, valuations, certificates, reports, and opinions furnished by any duly appointed actuary, accountant (including employees who are actuaries or accountants), consultant, third-party administration service provider, legal counsel, or other specialist, and shall be fully protected in respect to any action taken or permitted in good faith in reliance on such table, valuations, certificates, etc.

- to prepare and file Plan tax returns, annual reports, financial statements, and other documents required by law or under the Plan's terms;

- to appoint a committee to assist the Plan Administrator either generally or specifically in performing its obligations.

No Enlargement of Employment Rights

Nothing contained in the Plan is to be construed as a contract of employment between the Company and you, nor shall the Plan be deemed to give you the right to be retained in the employ of the Company, or to limit the right of the Company to employ or discharge you or to discipline you, for any reason or for no reason.

No Guarantee of Tax Consequences

Neither the Employer, the Plan Administrator, nor Plan Sponsor makes any warranty or other representation as to whether any payment received under the Plan will be treated as excludable from your gross income for federal or state income tax purposes. It is your obligation to determine whether each payment under the Plan is excludable from your gross income for federal and state income tax purposes.

Right to Offset Future Payments

In the event of an erroneous payment or payment amount to or on behalf of a Participant, the Plan may reduce future payments payable to or on behalf of such Participant by the amount of the error. This right to offset does not limit the Plan's right to otherwise recover an erroneous payment in any other manner.

Right to Recover Payments

If the Plan reimburses a Participant in a total amount exceeding the amount necessary to satisfy the Plan's obligation, the Plan or the Company may recover the excess directly from the person to or for whom the payment was made. This right of recovery does not limit the Plan's right to recover an erroneous payment in any other manner.

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy 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 financial report.

Continue Group Health Plan Coverage

- Continue Plan coverage for yourself, your Covered Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Covered Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your federal COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored, 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.

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact 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 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 EBSA at 866-444-EBSA, logging onto www.dol.gov, or contacting the EBSA field office nearest you.

APPENDIX

OVERVIEW

Participating Network Pharmacies

The Plan provides you with access to an extensive national pharmacy network. The Plan has entered into contractual arrangements with various pharmacies throughout the country called "Participating Network Pharmacies." These Participating Network Pharmacies generally offer Participants access to prescription drugs at discounted rates in exchange for being able to participate in the network. Generally, Participating Network Pharmacies are available to help Participants with their short-term medications. (Participants will also have access to a mail order service for long-term or maintenance medications.) Participating Network Pharmacies are not limited to CVS retail stores. Upon request and without charge, you will be furnished with a list of Participating Network Pharmacies as a separate document. To find a Participating Network Pharmacy, you may also log on to www.caremark.com or contact CVS Caremark Customer Service at (888) 202-1654.

Deductible

A deductible is the amount you must pay under the Plan for covered expenses each Plan Year before the Plan begins to pay benefits. No prescription drug benefits (other than certain preventative expenses) are payable under the Plan until you satisfy the annual deductible. The amount of the deductible you must pay under the Plan is outlined on the schedule below.

Co-Payment

A co-payment is the flat dollar amount you pay each time you receive a prescription drug that is covered under the Plan. The amount of your co-payment under the Plan is set forth on the schedule below.

Coverage of Preventive Care Medications

Certain preventive care medications (specifically, evidenced-based items that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force) are required by law to be covered under the Plan. You will not be required to pay a deductible, co-payment or co-insurance payment when you obtain such preventive care medications from a Participating Network Pharmacy. Because the Plan's coverage of these preventive care medications is based on the recommendations of the United States Preventive Services Task Force, the particular medications that are subject to coverage will change over time as the recommendations of the United States Preventive Services Task Force change.

BENEFITS - GENERALLY

Your benefits under the Plan will differ depending on the type of prescription drug you take (for example, [generic vs. preferred vs. non-preferred vs. specialty]), how you buy it (for example at a pharmacy vs. through the mail), and the other cost-savings measures implemented by the Company.

Type of Drug

All prescription drugs that are covered under the Plan fit within one of the following categories:

- Tier 1 (Generic): A non-brand name drug that has the same active ingredients as a brand-name drug and is sold for substantially less than the brand-name drug. For a detailed list of the generic drugs covered under the Plan, you may call CVS Caremark Customer Service at (888) 202-1654 or visit www.caremark.com. This list is available at no charge.

- Tier 2 (Preferred): A drug that is on the list of preferred brand name drugs and requires you to pay less than you would pay for a non-preferred drug. Drugs in this category are based on a combination of factors, including safety, effectiveness and cost. For a detailed list of the preferred drugs covered under the Plan, you may call CVS Caremark Customer Service at (888) 202-1654 or visit www.caremark.com. This list is available at no charge.

- Tier 3 (Non-Preferred): A drug that is not on the list of preferred brand name drugs and requires you to pay more than you would pay for a preferred drug. For a detailed list of the non-preferred drugs covered under the Plan, you may call CVS Caremark Customer Service at (888) 202-1654 or visit www.caremark.com. This list is available at no charge.

- Specialty: Drugs that are used in the management of chronic or genetic diseases, including injectables, infused drugs or oral medications, or drugs that otherwise require special handling. For a detailed list of the specialty drugs covered under the Plan, you may call CVS Caremark Customer Service at (888) 202-1654 or visit www.caremark.com. This list is available at no charge.

The category to which a particular drug belongs may change periodically based on CVS Caremark's formulary. These changes may occur without notice to you. When a change occurs, you may be required to pay more or less for a covered prescription drug, depending on the category to which it is assigned. Because a drug's category may change periodically, you should call CVS Caremark Customer Service at (888) 202-1654 or visit www.caremark.com for the Plan's most current information.

Retail Purchases

The Plan allows you to fill prescriptions at a retail pharmacy. You should use a retail pharmacy when filling short-term prescriptions for medications such as antibiotics. Through a retail pharmacy, you are generally able to receive up to a 30-day supply of medication.

If you receive your prescription drug from a Participating Network Pharmacy, you should show the pharmacist your ID card at the time you submit your prescription. You will be required to pay the applicable amount identified on the schedule below at the time of purchase. The Plan will pay the remaining cost of the prescription drug if there is coverage for that prescription drug under the Plan.

If you fail to show your ID card at the time of purchase from a Participating Network Pharmacy, you may be required to pay the entire cost of the prescription drug at the time of your purchase. The Plan will pay its share of the cost of the drug once you submit a claim form to the Plan's Pharmacy Benefit Manager. You may obtain a claim form from the Plan's Pharmacy Benefit Manager (CVS Caremark) by calling (888) 202-1654. The claim form will include specific instructions on how and where to file the claim. The claim form must be mailed to the address indicated on the claim form.

Mail Order Service Purchases

The Plan allows you to fill certain prescriptions through its mail order service. You should use the Plan's mail order service when filling long-term maintenance medications. Maintenance medications are used to treat chronic illnesses such as heart conditions, allergies, high blood pressure, and arthritis. Through the mail order service, you are generally able to receive up to a 90-day supply of your medication. You should inform your prescribing physician that you have a mail order prescription drug program. That information will indicate to your prescribing physician that you can obtain a 90-day supply of your medication. To obtain a prescription through the Plan's mail order service, you must complete an order form and send it to CVS Caremark along with your prescription and your applicable payment amount. It may take up to 2-3 weeks to receive your prescription in the mail. You may later order refills on your prescription through the mail order service by calling (888) 202-1654 or by visiting www.caremark.com. This will reduce the time it takes to receive your refill.

Prior Authorization Requirement

Certain prescription drugs are subject to prior authorization from the Plan. This means that you must obtain approval through CVS Caremark before your medication will be covered under the Plan. The prior authorization criteria are developed in order to ensure safe, effective and appropriate utilization of selected drugs. Your prescribing physician will be required to confirm that you have met the required evidence-based criteria before the Plan will cover your prescription. You will be informed about any prior authorization requirement that applies to your prescription at the time of your purchase. In addition, you may determine whether a prior authorization will apply to your prescription by contacting CVS Caremark Customer Service at (888) 202-1654.

Generic Step Therapy

The Plan uses a step therapy program for certain classes of prescription drugs. This program requires you to utilize an effective generic medication before a more expensive alternative will be covered under the Plan. For a list of the medications that are subject to this program, you may contact CVS Caremark Customer Service at (888) 202-1654.

"Dispense as Written" Restriction

If you or your doctor chooses for you to receive a brand name Covered Medication when a generic drug is available (such as when the prescription contains a "dispense as written" restriction), you will be responsible for paying a penalty equal to the difference between the cost of the brand name drug and the cost of the available generic drug. This penalty will not apply towards any deductibles or out-of-pocket maximums. You will also be responsible for paying the applicable co-payment or co-insurance amount for your prescription, as outlined in the Benefits at a Glance schedule below.

If you or your doctor feel a brand name medication is medically necessary, your doctor may submit a Letter of Medical Necessity to the Exception Fax # (888) 487-9257.

Maintenance Choice/Retail 90 Network

You have the option of receiving long-term maintenance prescription drugs through the Plan's mail order service described above or at a local CVS retail pharmacy. This program provides you with the flexibility to decide which delivery system is most convenient to you. If you utilize a CVS retail pharmacy, you will have the opportunity to discuss your medication face-to-face with a pharmacist. You will pay the same

amount for your 90-day supply of maintenance medication whether you receive it at a local CVS retail pharmacy or through the Plan's mail order service.

Generic Substitution

The Plan uses a generic substitution program whereby Participating Network Pharmacies and the Plan's mail order service will substitute brand name drugs with generic equivalents, when generic equivalents are available and appropriate. This program will not be applied when the prescription contains a "dispense as written" restriction or when the Participant has requested that only the brand name drug be dispensed.

Specialty Guideline Management

The Plan has adopted the Specialty Guideline Management program, which evaluates the appropriateness of drug therapy for specialty medications according to evidence-based guidelines both before the initiation of therapy and on an ongoing basis. This program is available for all specialty conditions, and outreach is made to both the Participant and the prescriber to evaluate the therapy.

The Specialty Guideline Management program requires approval of treatment for select medicines. Under this program, there will be a review of clinical information for approval of treatment with these medicines. Decisions are based on nationally recognized guidelines and are administered by a CVS Caremark clinical specialist.

Advanced Control Specialty Formulary™

The Plan has adopted the CVS Caremark Advanced Control Specialty Formulary™ program that acts as a guide to encourage physicians to prescribe drugs that are clinically effective and are available at the lowest net cost without sacrificing treatment outcomes. Under this program, the Pharmacy Benefit Manager may exclude certain products. Generics will be considered the first line of prescribing. If there is no generic available, there may be more than one brand name medicine to treat a condition. The Pharmacy Benefit Manager may contact your doctor after receiving your prescription to request consideration of a drug list product or generic equivalent. This may result in your doctor prescribing, when medically appropriate, a different brand-name product or generic equivalent in place of your original prescription. You may be responsible for the full cost of non-formulary products that are removed from coverage. In most instances, a brand name drug for which a generic product becomes available will be designated as a non-preferred option upon release of the generic product into the marketplace. For specific information regarding your prescription benefit coverage and copayment information, you can visit www.caremark.com or contact CVS Caremark Customer Service at (888) 202-1654.

Specialty Connect™

The Plan has adopted the CVS Caremark Specialty Connect™ program. A Participant may take advantage of this program by dropping off or having a specialty prescription sent to any CVS retail pharmacy, or the Participant's doctor may send the prescription to the Plan's specialty mail order service. A Participant may then choose to pick up specialty medications at a CVS retail pharmacy, have them shipped to the Participant's home address, or have them shipped to a location of choice. Additionally, clinical services for Participants taking specialty drugs will be offered through the CVS Caremark CareTeams. The CareTeams are staffed by specialty pharmacy clinicians with up-to-date knowledge on evidence-based protocols. CareTeams will work to help improve Participants' adherence by educating them about taking

their medications correctly, reviewing proper medication storage and handling, and troubleshooting medication side effects.

Specialty Co-pay Card Program

The Plan has elected to participate in CVS Caremark's Specialty Co-pay Card Program. Under this program, some specialty medications may qualify for third-party co-payment assistance, which could lower your out-of-pocket costs for those products. The third-party co-payment assistance benefit is provided by the applicable drug manufacturer, with the applicable drug manufacturer agreeing to pay a portion of the co-payment (or co-insurance amount) that you would otherwise be required to pay under the terms of the Plan. The third-party co-payment assistance requires the use of a manufacturer's coupon (which you would use at the time you purchase the medication) or a manufacturer's rebate form (which allows you to recover amounts paid at the time you purchased the medication).

Your eligibility for third-party co-payment assistance is dependent on the applicable terms and conditions established by the manufacturer. Those terms and conditions are subject to change.

This program is offered as part of the Plan's exclusive specialty pharmacy network with CVS/Caremark's affiliate, CVS/Specialty. The list of specialty drugs eligible for third-party co-payment assistance is subject to change.

In order to receive third-party co-payment assistance from a manufacturer, you will first be required to pay the manufacturer's designated co-payment amount (or co-insurance amount). Generally, drug manufacturers do not require individuals to make a co-payment (or co-insurance payment) of more than $50.00 for a 30-day supply of the specialty medication under this program.

> For example, a certain manufacturer offers co-payment assistance whereby the manufacturer will cover up to $1,000.00 a month for the Participant's specialty medication, but the manufacturer requires the Participant to pay the first $5.00 of the Participant's applicable co-payment (or co-insurance amount) for the medication.
>
> Co-payment Scenario:
>
> - The cost of a particular specialty medication is $1,000.00 per month
> - The Participant's co-payment under the Plan for specialty medication is $100.00
> - The manufacturer requires the Participant to pay the first $5.00 of the applicable co-payment
> - The Participant pays the required $5.00
> - The manufacturer pays the remaining $95.00 of the Participant's co-payment obligation
> - The Plan pays the remaining $900.00 in cost for the specialty medication
>
> Co-insurance Scenario:
>
> - The cost of a particular specialty medication is $1,000.00 per month
> - The Participant's co-insurance amount under the Plan for specialty medication is 20% ($200.00)
> - The manufacturer requires the Participant to pay the first $5.00 of the applicable co-insurance amount
> - The Participant pays the required $5.00

- The manufacturer pays the remaining $195.00 of the Participant's co-insurance obligation
- The Plan pays the remaining $800.00 in cost for the specialty medication

Under the Specialty Co-pay Card Program, you will not receive credit toward your out-of-pocket maximum for any co-payment or co-insurance amounts that are paid by a third party through a manufacturer's coupon or rebate. Furthermore, any amounts that are paid by a third party through a manufacturer's coupon or rebate will not count towards your deductible.

Specialty Starter Fill Program

If you begin taking a specialty medication for a condition listed below, that medication may be subject to the Specialty Starter Fill Program. The Specialty Starter Fill Program targets new specialty utilizers on high cost therapies that have poor tolerability and high discontinuation rates. The Specialty Starter Fill Program provides a short term fill to ensure that a new-to-therapy patient can tolerate a medication. A participant will receive a partial medication fill (a 14 or 15 day supply) for the first 3 months of therapy. Your copay or coinsurance will be prorated based on the supply you receive. After 3 months, if you demonstrate tolerance while on the medication, the program requirements are met. You may then fill a full month supply for all subsequent fills.

Current therapies included in the Specialty Starter Fill Program:

- Oral Oncology
- Hepatitis B
- Parkinson's Disease Psychosis
- Hematological Disorders

Under this program, certain specialized resources will be provided to you at no cost. A Patient Service Representative will contact you to verify your medication and scheduled shipment. The rejection for the quantity limitation will occur during the first adjudication of one of the targeted medications. At this point, the 14 or 15 day supply will be dispensed and members can reach out to the Specialty pharmacy for further questions. This program is offered as part of the Plan's exclusive specialty pharmacy network with CVS/Caremark's affiliate, CVS/Specialty. The list of specialty drugs eligible for this program is subject to change.

BENEFITS AT A GLANCE

DRUG CATEGORY	IN-NETWORK RETAIL PHARMACY		CVS CAREMARK MAIL ORDER		MAINTENANCE CHOICE PROGRAM
	You Pay	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**
Tier 1 (Generic)	$10 (after Rx Deductible)	100% after you meet the Annual Prescription Drug Deductible and pay a $10 Copay	$25 (after Rx Deductible)	100% after you meet the Annual Prescription Drug Deductible and pay a $25 Copay	$25 (after Rx Deductible)
Tier 2 (Brand preferred)	$30 (after Rx Deductible)	100% after you meet the Annual Prescription Drug Deductible and pay a $30 Copay	$75 (after Rx Deductible)	100% after you meet the Annual Prescription Drug Deductible and pay a $75 Copay	$75 (after Rx Deductible)
Tier 3 (Brand non-preferred)	$50 (after Rx Deductible)	100% after you meet the Annual Prescription Drug Deductible and pay a $50 Copay	$125 (after Rx Deductible)	100% after you meet the Annual Prescription Drug Deductible and pay a $125 Copay	$125 (after Rx Deductible)
Preventive Medicines					
Your plan includes a Generics Only Preventive Drug Therapy List. Generic medications on this list are not subject to the deductible and are available at a $5 copay at retail and at mail for a $12.50 copay. You can access the Preventive Drugs Therapy List at www.Caremark.com.					
Deductible					
The deductible amount that you must satisfy each Plan Year before you will receive any prescription drug benefits under the Plan				$100 per individual / $300 per family	
Day Supply Limit		**Retail Pharmacy**		**Mail Order**	
The maximum amount you can receive per prescribed order		30-day supply, [except Maintenance Choice Program which allows for a 90-day supply]		90-day supply	
Refill Limit		**Retail Pharmacy**		**Mail Order**	
The maximum amount you can receive per refill order		30-day supply, [except Maintenance Choice Program which allows for a 90-day supply]		90-day supply	
Use For:		Short-term medications or immediate prescription drug needs [except Maintenance Choice Program]		Long-term, maintenance, and injectable medications	

ADDITIONAL COVERAGE

Care Outside the United States

Prescription drugs purchased outside of the United States are generally not covered under the Plan. However, if you are outside of the United States and need to purchase prescription drugs due to an emergency, such medication will be covered [as if you had received it from a Participating Network Pharmacy.] In such circumstances, you will need to purchase the drug, obtain a receipt (be sure the receipt is translated into English) and submit a claim form to CVS Caremark for reimbursement from the Plan.

New Drugs

New drugs are developed and introduced into the marketplace daily. As the FDA approves these new drugs for use in the United States, the Plan Sponsor will work with CVS Caremark to determine whether a particular new drug will be covered under the Plan and whether any coverage restrictions or limitations will apply.

Over-The-Counter (OTC) Drug Coverage

Some over-the-counter drug products, like Aspirin and Folic Acid Tablets, may be subject to coverage under the Plan when purchased either at a retail location or through the mail order service. In order to receive Plan coverage for OTC products, you will need a written prescription or a telephone prescription from your prescribing physician. The pharmacist will process the OTC product in accordance with the terms of the Plan. This coverage requires you to pay the amount you would otherwise be charged for a covered generic drug. To confirm if an over-the-counter drug is covered you may log on to www.caremark.com or contact CVS Caremark Customer Service at (888) 202-1654.

EXCLUSIONS FROM COVERAGE

Certain expenses that you or your Covered Dependents incur for medications are not covered under the Plan. For a list of excluded drugs, you may log on to www.caremark.com/druglist or call the telephone number on the back of your ID card for more information.

PLEASE NOTE: If you are prescribed a medication that is excluded from coverage, please work with your pharmacist and physician to determine an alternative medication for you. You have the right to appeal the drug's exclusion from your Plan. If your appeal is approved, the excluded drug will be covered under your Plan at a non-preferred coverage tier. Refills of the excluded drug will also be covered at a non-preferred coverage tier.