Summary Plan Description for the Prescription Drug Plan
Effective January 1, 2025

This booklet is a Summary Plan Description (SPD) for the Spectrum Brands, Inc. prescription drug benefit administered by CVS Caremark Corporation ("CVS Caremark"). It is intended to give a general description of the pharmacy benefits under that benefit effective January 1, 2025. The prescription drug benefits offered are covered under the federal law known as the Employee Retirement Security Act of 1974 (also referred to as "ERISA"). If there is any information in this SPD that is not in the Plan document or the insurance contracts, then this SPD governs. If there is a conflict in language that exists between this SPD and the official Plan document, or insurance contracts, the Plan documents or insurance contracts govern. To request a copy of the official Plan document, please contact the Spectrum Brands' Benefits Team at 800-881-2562 or benefits@spectrumbrands.com.

The Company expressly reserves the right to amend, suspend, discontinue, or terminate any of its benefits plans, or to change any statement made in this SPD, at any time. These modifications or terminations may be made for any reasons Spectrum Brands, Inc. or its representatives deem appropriate, or as a result of changes in the laws that govern the Plan.

The Company's decision to amend, suspend, discontinue, or terminate the plans may be due to changes in federal or state laws governing welfare or pension benefits, the requirements of the Internal Revenue Code or the Employee Retirement Income Security Act of 1974, as amended, (ERISA), Company policy, or any other reason.

The Plan Administrator has the sole discretionary authority to determine eligibility for, and the amount of, benefits and to take any other actions with respect to questions arising in connection with the plans, including the construction and interpretation of the terms of the plans. The Plan Administrator may delegate any of its duties and responsibilities to one or more persons or entities. Such delegation of authority must be in writing and must identify the delegate and the scope of the delegated responsibilities. All decisions, determinations and interpretations of the Plan Administrator are conclusive and binding on all persons.

This SPD does not constitute an implied or express contract or guarantee of employment. Similarly, your right to benefits under the Plan should not be interpreted as an implied or express contract or guarantee of employment. Spectrum Brands, Inc. employment decisions are made without regard to benefits to which you are entitled upon employment.

The Company cannot advise you regarding tax, investment or legal considerations relating to the Plan. Therefore, if you have questions regarding benefit planning, you should seek advice from a personal advisor (e.g., legal counsel, tax advisor, investment advisor).

Table of Contents

Introduction

The Spectrum Brands, Inc. Welfare Benefit Plan provides important financial protection against the cost of medical care. An important part of this financial protection is prescription drug coverage.

About this Document

Prescription Drug Plan

This document is the Summary Plan Description (SPD) for the Prescription Drug Plan, administered by CVS Caremark Corporation ("CVS Caremark"). You are eligible for this prescription drug coverage if you are a:

- Regular, full-time employee who is regularly scheduled to work 30 hours per week.

You also must be enrolled for coverage in one of the following medical plans:

- Anthem Gold PPO
- Anthem Gold HSA
- Anthem Silver PPO

Your eligible spouse/domestic partner, and eligible dependent children (until end of the month in which they turn age 26), will also be covered for prescription drug benefits under this plan if they are enrolled in one of the medical plans listed above. Refer to the corresponding medical summary plan description, or you may contact 800-881-2562 or benefits@spectrumbrands.com for specific information about eligibility.

Overview of the Prescription Drug Plan

The Plan covers a wide range of prescription drugs through CVS Caremark, a pharmacy benefit managers (PBM). Your CVS Caremark prescription drug coverage enables you to purchase prescription drugs through a national network of retail pharmacies, including chain pharmacies, independent pharmacies, and CVS pharmacy stores. CVS Caremark Mail Service Pharmacy offers a mail order program through the CVS Specialty Pharmacy.

Contact Information

Questions about benefits and filing claims should be directed to Customer Care at the number on the back of your prescription ID card. You may also visit the CVS Caremark website at www.caremark.com. This personalized website is a central resource for prescription drug information for you and your family. You can price a prescription, find lower cost drug alternatives, order prescriptions, and check the status of your mail service prescription deliveries. You can also view your prescription history, get detailed information on prescription drug expenses paid by you and the plan, and find a participating pharmacy so you can make the most of your benefits program.

Find a Pharmacy

Once you are enrolled in a medical plan, you can register at the CVS Caremark website, www.caremark.com. Once logged in, click on "Find a Pharmacy". You may also contact a CVS Caremark

representative directly at the number on the back of your ID card for information. A listing of national pharmacy chains and local drugstores that participate with CVS Caremark also may be obtained from CVS Caremark website at www.caremark.com.

The Caremark website also allows you to:

- View and print your temporary prescription benefit card
- Sign up for automatic refills and renewals
- Find Savings and Opportunities to explore lower-cost options
- Sign up to receive notifications by www.cvsspecialty.com, phone or text message
- Access the latest health and wellness information

For questions about your benefits and filing claims, you may also write to:

CVS Caremark
P.O. Box 52196
Phoenix, AZ 85072-2196

Enrollment

You are automatically enrolled in the Prescription Drug Plan when you enroll in one of the Spectrum Brands, Inc. medical plans listed in "Prescription Drug Plan Coverage" under "About this Document." Generally, the benefit elections you make will be in place for the entire plan year, unless you have a qualified Change in Status event. Refer to the corresponding medical summary plan description, or you may contact the Spectrum Brands' Benefits Team at 800-881-2562 or benefits@spectrumbrands.com for detailed information about enrollment and qualified Change in Status events. Any qualified changes to your medical plan enrollment will have a similar impact on your prescription drug plan enrollment. For example, if you get married and add a dependent to the medical plan, that dependent will also have coverage in the prescription drug plan.

Cost of Coverage

Spectrum Brands, Inc. shares the cost of providing medical benefits for you and your dependents. Contributions for prescription drug coverage are included with your medical plan contributions, regardless of which medical plan you choose. Your portion of the cost of your Spectrum Brands, Inc. medical (including prescription drug) coverage is deducted from your paycheck on a pre-tax basis; that is, before federal – and, in some cases, state – income taxes and FICA taxes are withheld.

If you elect to cover a domestic partner or domestic partner's child, the value of premium contributions made by Spectrum Brands, Inc. is considered taxable income for you. Your contributions toward coverage for your domestic partner must be made on a post-tax basis.

You will be notified of any changes in the plan or the cost of plan coverage before they take effect.

When Coverage Begins

If you enroll in one of the Spectrum Brands medical plans listed in "About this Document," your coverage will take effect on the same date as your coverage begins under the medical plan.

Identification (ID) Cards

You will be provided with a prescription ID card from CVS Caremark. It generally takes about 7 to 10 business days to receive your ID card after you enroll for the first time in a medical option. If you lose your ID Card, you can obtain a replacement card by going to www.caremark.com or by calling Customer Care at 844-431-4885. You may also obtain a digital ID card via www.caremark.com on the member portal.

Administrative Information

The Prescription Drug Plan Administered by CVS Caremark Corporation

Legal Name of Plan	Spectrum Brands, Inc. Welfare Benefit Plan
Plan Type	Pharmacy Plan
Plan Year	January 1 – December 31 All plan information is maintained on a calendar year basis
Type of Financing/Administration	Self-insured
Method of Funding	The Plan is a self-funded plan, and benefits are payable solely from the Plan Sponsor's general assets. The Plan Sponsor, as Plan Administrator, is responsible for all claims decisions and the payment of the claims.
Plan Administrator/Sponsor and Agent for Service of Legal Process	Spectrum Brands, Inc. 3001 Deming Way Middleton, WI 53562 800-566-7899 benefits@spectrumbrands.com The Plan Administrator has the sole authority to: Interpret plan provisions; Exercise discretion in the interpretation and administration of the plan; Make the final determination of a benefit claims appeal
Claims Administrator	CVS Caremark P.O. Box 52136 Phoenix, Arizona 85072-2136
Employer Identification Number	22-2423556
Plan Number	501
Eligibility	**Employees:** you are eligible for this prescription drug coverage if you are a: Regular, full-time employee who is regularly scheduled to work 30 hours per week. You also must be enrolled for coverage in one of the following medical plans: • Anthem Gold PPO • Anthem Gold HSA • Anthem Silver PPO

	Dependent: • Legal spouse/domestic partner, • Dependent children (until the end of the month they attain age 26) • Legally adopted children • Domestic Partner Children • Foster Children • Children for whom the employee assumes legal guardianship • Stepchildren • Children who are mentally or physically impaired and totally dependent on the Employee for support, past the age of 26 or older. ○ To be eligible for continued coverage past the age of 26, certification of the impairment is required within 31 days of attainment of age 26. A certification form is available from the Employer or from the Claims Administrator (Anthem) and may be required periodically. You must notify the Claims Administrator and/or the Employer if the Dependent's marital or tax exemption status changes and they are no longer eligible for continued coverage. Refer to the ELIGIBILITY section of the medical summary plan description for more detailed information on eligibility. Or you may contact 800-881-2562 or benefits@spectrumbrands.com for specific information about eligibility.
Description of circumstances resulting in disqualification, ineligibility or denial or loss of benefits	Refer to the "WHEN COVERAGE ENDS" section of the medical summary plan description for more detailed information on eligibility. Or you may contact 800-881-2562 or benefits@spectrumbrands.com for next steps.
Waiting Period	None – Spectrum Brands, Inc, offers benefits as of the employee's date of hire

How the Prescription Drug Plan Works

The Prescription Drug Plan covers a broad range of prescription medications. To help maintain health care quality and manage costs, the Plan encourages the use of generic-equivalent drugs. It also encourages the use of medications included in the CVS Caremark prescription drug "formulary," although the decision as to which medication to prescribe rests solely with your physician.

Three Coverage Levels

There are three levels of coverage for prescription drugs purchased under the CVS Caremark program:

1. *Tier 1 (Typically Generic)* – These are drugs that are not under patent protection but contain the same active ingredients and are subject to the same U.S Food and Drug Administration (FDA) standards as their brand-name counterparts. Generic drugs may differ in size, color, or shape, but the FDA requires that the active ingredients have the same strength, purity, and quality as the brand-name alternatives. Because the cost of generic drugs is often much less than brand name drugs, your cost is lowest when you use them. For more information about generic drugs, go to www.caremark.com.
2. *Tier 2 (Typically Preferred Brand Drugs)* – These are commonly prescribed brand name drugs that are included in the CVS Caremark formulary. As part of the formulary, the Claims Administrator has negotiated discounts for these drugs. The Plan shares the cost savings with you by requiring a lower co-insurance when you purchase these drugs than you would pay for a non-preferred brand. If your doctor prescribes a drug that is not in the formulary, discuss the CVS Caremark formulary with your doctor and see if another drug might be equally effective for your specific condition.
3. *Tier 3 – (Typically Non-preferred Brand Drugs)* – These are brand name drugs that are not included in the CVS- Caremark formulary. These drugs are covered by the Plan, but they cost both you and the Plan more than a generic or preferred brand drug would cost.

What is a formulary?

A formulary, or Prescription Drug List (PDL), is a clinically based drug list of FDA-approved prescription medications. An independent PDL Management Committee established by CVS Caremark reviews the drugs on the formulary based on safety and efficacy. This Committee is made up of distinguished health care professionals, including pharmacists and doctors from various medical specialties. The formulary is updated quarterly. You will be notified if you are impacted by a formulary change, for example, if a generic becomes available and the drug you are taking becomes a non-preferred brand.

A summary of formulary medications is available at www.caremark.com or by calling the number on the back of your prescription ID card.

What is Covered?

The Plan covers prescription drugs that are approved by the Federal Drug Administration (FDA) and ordered by your physician. To assist you in managing the overall cost of your prescriptions, while making sure you have access to the medication you need, CVS Caremark may require prior authorization of the medication, limit the quantity dispensed, or limit the availability based on age. If you have questions about the following programs, please contact CVS Caremark for more information.

Managed Drug Limitations

CVS Caremark develops limitations to ensure safe and appropriate medication use. The list below includes those drugs subject to Managed Drug Limitations (MDLs). Regardless of what is prescribed by your physician, the amount dispensed will be based on the recommended limitation. For more information, call CVS Caremark Customer Care at the number on the back of your prescription ID card.

- Extended relief opioid analgesics
- Immediate relief opioid analgesics
- Acetaminophen/Aspirin/Ibuprofen containing opioid analgesics (Brand and Generic)
- Dermatitis products: Prudoxin, Zanalon

Prior Authorization

Some medications are covered by the Plan only for certain uses, ages or in certain quantities. In these cases, the pharmacy will let you know if additional information is required before your prescription can be covered.

If you are taking one or more of the drugs listed below, you can avoid delays and interruptions in your therapy by asking your doctor to call the CVS Caremark Prior Authorization Department at 800-294-5979. The request will be evaluated to determine if you still qualify for Plan coverage of the prescribed therapy. If you do not meet the criteria standards and still wish to take the medication, you will be responsible for the entire cost of the drug. Examples of drugs on the prior authorization list, which may be updated periodically throughout the year, include but are not limited to:

- Extended relief opioid analgesics
- Immediate relief opioid analgesics
- Acetaminophen/Aspirin/Ibuprofen containing opioid analgesics (Brand and Generic)
- Transmucosal Immediate-Release Fentanyl products: Abstral, Actiq, Fentora, Onsolis, Lazanda and Subsys
- Irritable Bowel Syndrome Products: Lotronex, Amitiza, Linzess, Viberzi
- Compounded Drug Products
- Anti-Fungal Products: Sporanox, Sporanox Oral Solution, Ciclopirox Topical Solution 8%, Penlac, Onmel, Lamisil Oral Granules, Lamisil Tabs, Jublia, Kerydin
- Acne Products: Absorica, Amnesteem, Atralin, Avita, Claravis, Differin, Fabior Myorisan, Retin-A, Retin-A Micro, Sortret, Tazorac (all topical), Tretin-A, Veltin, Zentane, Ziana
- Topical Anti-inflammatory Products: Solaraze, Klofensaid II, Pennsaid, Voltaren Gel
- Dermatitis Products: Prudoxin, Zonalon
- Cardiovascular Products: Entresto

- Sexual Disorder Products: Addyi
- Contraceptive Products: Depo-Provera contraceptive injection
- Testosterone Replacement Products: Testopel, Androderm, Androgel, Axiron, Fortesta, Natesto, Striant, Testim, Vogelxo, Depo-Testosterone
- Sleep Disorder Products: Nuvigil, Provigil, Xyrem
- Auto-Immune Disorder Products: Duexis/Vimovo,
- Diabetes Products: Fortamet, Glumetza
- Allergy Products: Orlair, Grastek, Ragwitek
- Topical Corticosteroid Products
- Vitamin D Analogs
- Protopic

Step Therapy

Step therapy requires that a cost-effective generic alternative be tried first before targeted-single source brands are covered. The list below includes those drug classes subject to Step Therapy. This list is subject to change and for the most up-to-date list, please contact CVS Caremark Customer Service at the number on the back of your prescription ID card. Examples of drugs on the step therapy list, which may be updated periodically throughout the year, include but are not limited to:

Step Therapy	
Drug Class	**Drugs Requiring Step Therapy**
Acetaminophen/Aspirin/Ibuprofen containing opioid analgesics (IR and ER Opioids)	APAP/benzyhydrocodone APAP/hydrocodone APAP/oxycodone APAP/tramadol APAP/caffeine/dihydrocodeine IBU/hydrocodone IBU/oxycodone
Dermatology Products	Prudoxin Zonalon Doxepin Rosacea Products (Brand Products Only) Oxiconazole
Antidiabetic GLP/GIP-1 Smart Logic (includes step therapy and prior authorization for some)GLP-1	Adlyxin Bydureon Byetta Ozempic Rybelsus Trulicity Victoza Mounjaro
CGRP Products	Aimovig Ajovy Emgality Vyepti

For the most up to date plan information, please refer to www.caremark.com.

Covered Medications

The Plan covers prescription medications, including but not limited to:

- All drugs prescribed by a physician that require a prescription either by federal or state law, except drugs excluded by the Plan;
- All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity;
- Insulin;
- Diabetic supplies, including insulin needles and syringes;
- Contraceptives, including:
  - – Depo-Provera/Depo-SubQProvera, up to a 90-day supply
  - – Diaphragms, cervical caps
  - – IUDs
  - – Plan B contraceptive emergency kit, retail pharmacy only;
- Relenza/Tamiflu for treatment of influenza;
- Drugs to treat impotency, except Yohimbine, subject to quantity limits and available to males only age 18 and over;
- Inhaler assisting devices;
- Pediatric fluoride vitamin drops (quantity limited to 50-day supply at retail; 90-day supply mail order);
- Prenatal vitamins; and
- Topical Vitamin A derivatives for treatment of mild to moderate acne (e.g., Retin-A, Altinac, Avita (all forms), up to age 45 without prior authorization)

Contact CVS Caremark at the number on the back of your prescription ID card for more information about whether certain medications are covered under the plan.

What You Pay

Whenever you purchase a prescription, you pay towards the cost of the drug. The amount you pay out-of-pocket will depend on the following:

- Whether you have satisfied your annual deductible under the medical plan;
- Whether the medication is a generic or a brand name drug;
- Whether the medication is part of the CVS Caremark formulary (preferred) or is a non-formulary (non-preferred) drug;
- Whether you purchase the prescription in a retail pharmacy or by mail; and
- Whether or not you are purchasing the medication regularly to treat a chronic condition.

<u>Annual Deductible</u>

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving covered benefits. The amounts you pay towards your Annual Deductible will accumulate over the course of the calendar year.

In-Network prescription drugs are not subject to an Annual Deductible for the Gold and Silver PPO plans. For

the Gold HSA plan, your prescriptions will apply to your Annual Deductible. Please note that certain preventive medication is covered by the plan prior to meeting the Annual Deductible.

Co-Payment

Once you satisfy your Annual Deductible, whenever you purchase a prescription, you will pay a co-payment towards the cost of the drug. The amount you pay out of pocket will be based on the criteria outlined above.

Co-insurance

Once you satisfy your Annual Deductible, whenever you purchase a prescription, you will pay a co-insurance towards the costs of the drug. The amount you pay out of pocket will be based on the criteria outlined above.

RETAIL PHARMACY	Anthem Gold PPO	Anthem Gold HSA	Anthem Silver PPO
Typically Generic (Tier 1)	$10	20% ($40 max)	$10
Typically Preferred Brand (Tier 2)	$45	25% ($70 max)	$50
Typically Non-Preferred (Tier 3)	$70	35% ($110 max)	$100
Typically Specialty (Tier 4)	20%		
Preventive Rx	100% Covered (Deductible waived)		
Maximum Day Supply*	31 Days		
MAIL ORDER/MANDATORY MAINTENANCE CHOICE (90 Day Supply for (routinely/regularly used) Maintenance Medications	Anthem Gold PPO	Anthem Gold HSA	Anthem Silver PPO
Typically Generic (Tier 1)	$20	20% ($80 max)	$20
Typically Preferred Brand (Tier 2)	$90	25% ($140 max)	$100
Typically Non-Preferred (Tier 3)	$140	35% ($220 max)	$120
Typically Specialty (Tier 4)	20%		
Preventive Rx	100% Covered (Deductible waived)		
Maximum Day Supply	90 Days		

***You may purchase up to a 90-day supply of maintenance medication at a retail CVS Pharmacy. Please note that the ability to fill a prescription up to 90 days at a retail pharmacy is subject to federal and state regulations. The copayment and coinsurance amounts above for mail order are also applicable to the Retail 90 program.**

The Retail Pharmacy Program

The Retail Pharmacy Program includes over 68,000 CVS Caremark pharmacies nationwide. In addition,

there are national and local drugstores that participate as part of the CVS Caremark network to make prescriptions available through the Retail Pharmacy Program.

What is a participating pharmacy?

A participating retail pharmacy is a national pharmacy chain or local drugstore that has entered into an agreement with CVS Caremark to provide prescription medications as part of the CVS Caremark pharmacy network. When you use a participating pharmacy, you pay only your co-payment or co-insurance, once you have satisfied your Annual Deductible, toward each eligible prescription. To locate a participating pharmacy, visit www.caremark.com.

When you fill a prescription at a network retail pharmacy, you pay only your retail prescription drug co-payment or co-insurance for generic or brand name drugs once you have satisfied your Annual Deductible (only for the Gold HSA). You may purchase up to a 90-day supply of medication at a retail CVS Pharmacy. Please note that the ability to fill a prescription up to 90 days at a retail pharmacy is subject to federal and state regulations.

If you wish to fill a prescription at a local pharmacy that does not participate in the CVS Caremark network, you will be required to pay 100% of the cost of your prescription.

Summary of Your Retail Prescription Drug Benefits

Using a CVS Caremark Participating Pharmacy

To obtain a prescription at a CVS Caremark retail participating pharmacy, follow these steps:

1. Ask your doctor to write a prescription for a 30-day supply of medication.
2. Present your prescription ID card, along with your prescription, to the pharmacist.
3. Verify that the pharmacist has the most up-to-date information about you and your covered dependents.
4. Pay your share of the cost based on the type of prescription you order.
5. Sign and receive your prescription.

If You Use a Non-Participating Pharmacy

If you use a pharmacy that does not participate in the CVS Caremark network, you will be reimbursed at a lower contracted rate minus your co-insurance. Claim forms are available at www.caremark.com.

Specialty Pharmacy (Typically Tier 4)

If You Need Specialty Medications

Specialty medications are drugs used to treat complex medical conditions, such as cancer, growth hormone deficiency, hemophilia, immune deficiency, and multiple sclerosis. If you require Specialty Prescription Drugs, CVS Caremark will direct you to the CVS Specialty Pharmacy to provide those Specialty Prescription Drugs. For more information, visit www.cvsspecialty.com or call Customer Care at the number on the back of your prescription ID card.

Please refer to the Specialty Guideline Management (SGM) Therapy and Drug Overview on www.caremark.com to find more details about the which classes of drugs qualify.

True Accumulation

Some specialty medications may qualify for third-party copayment assistance programs that could lower your out of-pocket costs for those products. For any such specialty medication where third-party copayment assistance is used, you will not receive credit toward the maximum out-of-pocket or Annual Deductible for any co-payment or co-insurance amounts that are applied to a manufacturer coupon or rebate.

PrudentRx Solutions for Specialty Medications

PrudentRx assists by helping you enroll in manufacturer copay assistance programs. Medications on the PrudentRx Program Drug List are included in the program and will be subject to a 30% co-insurance, after satisfaction of any applicable deductible. However, if you are participating in the PrudentRx Solution, which includes enrollment in an available manufacturer copay assistance program for your specialty medication, you will have a $0 out-of-pocket responsibility for prescriptions covered under the PrudentRx Solution, unless you have a health savings account (HSA). For those with HSAs: (i) for drugs listed on the plan's High Deductible Health Plan Preventive Drug List, you will have a $0 out-of-pocket responsibility for prescriptions covered under the PrudentRx Solution; and (ii) for all other drugs, you will have a $0 out-of-pocket responsibility for prescriptions covered under the PrudentRx Solution after your deductible has been satisfied.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, specialty medications. The PrudentRx Solution will assist you in obtaining copay assistance from drug manufacturers to reduce your cost share for eligible medications thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, which is done in compliance with HIPAA.

If you currently take one or more specialty medications included in the PrudentRx Program Drug List or start a new medication covered under the PrudentRx Solution, you will receive a welcome letter from PrudentRx that provides information about the PrudentRx Solution. Call PrudentRx at 800-578-4403 to register for any manufacturer copay assistance program available for your specialty medication as some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications. Eligible members who fail to enroll in an available manufacturer copay assistance program or who opt out of the PrudentRx Solution will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx Solution.

The PrudentRx Program Drug List may be updated periodically.

Payments made on your behalf, including amounts paid by a manufacturer's copay assistance program, for medications covered under the PrudentRx Solution will not count toward your plan deductible or out-of-pocket maximum (if any), unless otherwise required by law. Also, payments made by you for a medication that does not qualify as an "essential health benefit" under the Affordable Care Act, will not count toward your out-of-pocket maximum (if any), unless otherwise required by law. A list of specialty medications that are not considered to be "essential health benefits" under the Affordable Care Act is available. An exception process is available for determining whether a medication that is not an

"essential health benefit" under the Affordable Care Act is medically necessary for a particular individual.

CVS Caremark by Mail

CVS Caremark's Mail Service Program is a pharmacy where prescription drugs are legally dispensed by mail. If you need long-term medication to treat a chronic condition, this mail order program may be a more cost-effective alternative. By using the Mail Service Program, you may obtain prescribed medication required on a non-emergency, extended use basis, for up to a 90-day supply. Mail order medications are mailed directly to your home, and there is no charge for standard shipping.

> What is a 90-day supply?
>
> A 90-day supply of medication is the amount of medication you take each day for 90 days. For example, if you take one pill each day, your prescription would be for 90 pills. If you take two pills each day, your prescription would be for 180 pills. A prescription for 30 days, plus two refills does not equal one prescription written for 90 days. Talk with your doctor to be sure the prescription is written accurately.

Summary of Your Mail Service Benefits

Limitations

There are certain limitations to the mail service program. These include:

- Certain controlled substances and several other prescribed medications may be subject to federal and state regulations concerning dispensing limitations and/or to the judgment of the pharmacist. Contact CVS Caremark if you have questions about your state's dispensing regulations.

Using the CVS Mail Service Program

The mail service program may be less costly for you than ordering at a retail pharmacy, and your prescriptions are conveniently delivered to your home. However, there will be times when you need a prescription immediately. To be sure you have the option of getting a prescription filled at your local pharmacy, ask your doctor for two prescriptions: one for a 30-day supply, and the other for the balance up to a 90-day supply that you can use in the mail service program.

Here are some step-by-step instructions for using the mail service:

For an initial prescription

1. Ask your doctor to write two prescriptions:
    a. One for a 30-day supply to be filled immediately at a local participating pharmacy.
    b. One for a 90-day supply, plus refills, to be ordered through the CVS Mail Service Program.
2. Complete a Mail Service Order Form and send it to CVS Caremark, along with your original 90-day prescription(s) and the appropriate copayment for each prescription. You can obtain a Mail Service Order Form online at www.caremark.com.
3. Send your materials to the CVS Mail Service Program at:

Fax to 800-378-0323

Or ePrescribe to:
CVS Caremark Mail Service Pharmacy NCPDP
ID: 0322038
9501 E Shea Blvd
Scottsdale, AZ 85260

4. Look for your prescription(s) in your mailbox about 7 to 10 days after CVS Caremark receives your order.

For Refills

You can order prescription refills through the automated refill service or online at www.caremark.com. To ensure that you receive your prescription(s) on time, it is recommended that you place your order when you have about a 14-day supply of medication remaining.

Your medication, plus instructions for obtaining refills, will arrive by mail about 7 to 10 days after your order is received. You can request for the mail order prescription to be delivered to a local retail CVS Pharmacy.

How many refills can I get?

- Refills can be made up to the number of times specified by your physician when you place your initial order.
- Refills can be made for up to one year from the date of your first order (except for controlled substances) based on the refill information supplied by your physician.

Refills by Phone

1. Call the toll-free number on your prescription refill label received in your prior order to order refills or inquire about an order already placed. The automated telephone refill service is available 24 hours a day, seven days a week. When you call, you will need to have the following information ready:
    a. Member number (on your prescription ID card and on the refill label provided with a previous order)
    b. Prescription number for each prescription to be refilled
    c. Credit card number and expiration date, unless you have selected the Autocharge option.

Refills by Mail/Internet

1. Call automated system at Customer Care at 855-299-3258.
2. Refill your prescription online at www.caremark.com.

Products Not Covered

The following exclusions and limitations apply to prescriptions purchased through the Plan's Prescription Drug Program. If you have questions, please contact CVS Caremark.

Medications that are **not** covered:

- for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received;
- any Prescription Drug for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether payment or benefits are received, except as otherwise provided by law;
- available over the counter that do not require a prescription order or refill by federal or state law before being dispensed unless the Plan Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a prescription order or refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision;
- compounded into their final form by the dispensing pharmacist, Physician, or other health care provider when comprised of components that are available in over-the-counter form or equivalent;
- dispensed by a non-Network Pharmacy, employees will pay for the full retail price at the non-Network Pharmacy;
- in excess of any supply limits (days' supply or quantity limit);
- new drugs and/or new dosages, until they are reviewed and assigned to a tier by the Preferred Drug List (PDL) Management Committee through CVS. The PDL Management Committee decides what tier (generic, preferred, non-preferred) the specific drug should be placed. Their objectives are to specify drugs of choice and alternatives, based on safety and efficacy; minimize therapeutic redundancies; and to maximize cost-effectiveness;
- prescribed, dispensed or intended for use during an Inpatient Stay;
- prescribed for appetite suppression, and other weight loss products;
- prescribed to treat infertility;
- contraceptive implants
- Blood Glucose monitoring watch
- Prescription Drugs, including new Prescription Drugs or new dosage forms, that Spectrum Brands, Inc. determines do not meet the definition of a Covered Health Service;
- typically administered by a qualified Provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception;
- used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless CVS Caremark and Spectrum Brands have agreed to cover an Experimental and Investigational or Unproven treatment

- used for cosmetic purposes;
- vitamins, except for the following which require a prescription:
    - prenatal vitamins;
- Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);
- Prescription Drugs that contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug;
- Prescription Drugs that contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug.
- IV Injectables
- Generic Fluocinonide

How Claims Are Paid

If you are using a pharmacy that participates in the CVS Caremark pharmacy network, your claim for benefits under the Prescription Drug Plan will be processed automatically when you submit your prescription. If you are using a pharmacy that does not participate in the CVS Caremark pharmacy network, you must first pay for your prescription, then file a claim for reimbursement. Claims should be filed as soon as possible, but no later than one year from the date the claim was incurred. Claim forms are available at www.caremark.com.

To expedite your claim payment, follow these steps:

1. Complete the Member/Subscriber, Patient Information and Pharmacy Information sections of the form.
2. Tape your itemized receipt that shows the reimbursable amount paid by the participant to the back of the form. Do not staple! An itemized receipt must include all the items listed on the back of the form.
3. Read the Acknowledgement section carefully, then sign and date that section of the form.
4. Submit a separate form for each pharmacy and for each patient.
5. Submit the completed form by mail:

    CVS Caremark
    P.O. Box 52136
    Phoenix, Arizona 85072-2136

If Your Claim is Denied

The prescription drug plan recognizes four categories of health benefit claims:

Urgent Care Claims - Claims for which the application of non-urgent care timeframes could seriously jeopardize the life or health of the patient to regain maximum function, or, in the judgment of a physician with knowledge of the patient's condition, would subject the patient to severe pain that cannot be adequately managed otherwise. The Plan must defer to an attending provider to determine if a claim for benefits is urgent.

Pre-service Claims – Claims must be decided before a patient will be afforded access to health care (e.g. preauthorization process).

Post-service Claims – Claims involving the payment or reimbursement of costs for medical care that has already been provided

Concurrent Care Claims – Claims where the plan has previously approved a course of treatment over a period or a specific number of treatments, and the plan later reduces or terminates coverage for those treatments.

Adverse Benefit Determination – If the Plan does not fully agree with your claim, you will receive an "adverse determination" – a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- An individual being ineligible to participate in the Plan;
- Utilization review;
- A service being categorized as experimental or investigational or not medically necessary or appropriate;
- A concurrent care decision; and
- Certain retroactive terminations of coverage, whether there is an adverse effect on any particular benefit at that time.

An adverse benefit determination for prescription drug claims includes a rescission of coverage (generally a retroactive cancellation of coverage) under the Plan, whether in connection with the rescission there is an adverse effect on any particular benefit at that time. However, the Plan will not rescind coverage under the prescription drug option for a participant or covered dependent unless the participant or covered dependent performs an act, practice or omission that constitutes fraud (as defined by the Plan) or intentionally misrepresents a material fact with respect to the medical or prescription drug coverage.

If You Receive an Adverse Benefit Determination

The Claims Administrator will provide you with written notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination;
- References to the specific plan and/or summary plan description provisions on which the benefit determination is based;
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary;
- A description of the plan's internal appeal and external review procedures that may be available to you and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination;
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request;
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- If the adverse benefit determination concerns a claim involving urgent care, a description of the

expedited review process applicable to the claim;
- Sufficient information to identify the claim, including the date of service, the provider, the claim amount (if applicable), the diagnosis, treatment and denial codes and their meanings, and the standard, if any, used for deciding the claim; and
- The availability of health insurance consumer assistance or a Public Health Service ombudsman, including contact information, to assist you in seeking plan benefits.

Initial Benefit Determination

Urgent Care Claims

The Claims Administrator/Insurer will notify you of the Plan's determination, whether adverse or not, as soon as possible, taking into account medical requirements, but not later than 72 hours after receipt of the claim, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claims Administrator/Insurer will notify you as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. Notification of the improper filing may be made orally unless the claimant requests written notification. You will be afforded a reasonable amount of time, considering the circumstances, but not less than 48 hours, to provide the specified information. The Claims Administrator/Insurer will notify you of the Plan's benefit determination as soon as possible, but no later than 48 hours after the earlier of the Plan's receipt of the specified information or the end of the period afforded you to provide the specified additional information.

Pre-Service Claims

The Claims Administrator/Insurer will notify you of the Claims Administrator/Insurer's determination, whether adverse or not, within a reasonable period, but not later than 15 days after receipt of the claim. This period may be extended by 15 days provided the Claims Administrator/Insurer determines that an extension is necessary due to matters beyond control of the Plan and notifies you, within the initial period of the circumstances requiring the extension and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically request the required information.

If the claim is improperly filed, the Claims Administrator/Insurer will notify you as soon as possible, but not later than five (5) days after receipt of the claim by the Plan, of the specific information necessary to complete the claim. Notification of the improper filing may be made orally unless you request written notification. You will be afforded at least 45 days from the receipt of the notice within which to provide the specified information.

Post-Service Claims

For non-urgent, post-service prescription drug claims, the Plan has up to 30 days following receipt of the claim to evaluate and respond to claims for benefit covered by ERISA. This period may be extended by 15 days provided the Claims Administrator/Insurer or its delegate determines that an extension is necessary due to matters beyond control of the Plan and notifies you, within the initial period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision. In addition, the notice of extension must include the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. You

will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Concurrent Care Claims

Concurrent care claims may fall under any of the other three categories, depending on when the request is made. If you request an extension of ongoing treatment in an urgent care situation, the Claims Administrator/Insurer will notify you within 24 hours of your request, provided your request is made at least 24 hours before the end of the approved treatment. Non-urgent claims will be treated as either pre-service or post-service claims.

Appealing an Adverse Benefit Determination (Initial Appeal)

The Plan will comply with additional claim and appeals rules required under the applicable provisions of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act (Health Care Reform).

Coverage for you, your spouse and your or your spouse's dependent children will continue, pending the outcome of an internal appeal. This means that a plan cannot terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

In the event of an adverse benefit determination, the claimant will receive written notice of the determination. The notice will include:

- The specific reason for the denial;
- The specific provisions of the Plan on which the determination is based;
- A description of any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the Plan's review procedures and the time limits applicable to such procedures;
- A statement of your right to bring a civil action under section 502(a) of ERISA following and adverse benefit determination on review (after the internal review process);
- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule guideline, protocol or other similar criteria, or a statement that a copy or such information will be made available free of charge upon request;
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, either an explanation of the scientific or clinical judgement used in the decision, or a statement that an explanation will be provided free of charge upon request;
- For adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided in writing or orally within the timeframe for the expedited process, as long as written notice is provided no later than three (3) days after the oral notice;
- The notice will include information sufficient to identify the claim involved. This includes
    - The date of service,
    - The health care provider,
    - The claim amount (if applicable), and
    - The denial code;
- The notice will also include a description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included; and

- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

If you receive an adverse benefit determination, you are entitled to a full and fair review of the claim and the adverse benefit determination. You or your authorized representative has 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

Your appeal should include the following information:

- Name of the person the appeal is being filed for
- CVS Caremark Identification Number
- Date of birth
- Written statement of the issue(s) being appealed, and
- Written comments, documents, records, or other information relating to the

claim. Appeal and supporting documentation should be mailed or faxed to:

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

You may also contact CVS Caremark at the number on the back of your prescription ID card, which may also be used by Physicians to submit urgent appeal requests.

You have the right to:

- Submit written comments, documents, records, and other information relating to the claim for benefits whether submitted in connection with your initial claim.
- Request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as "relevant" to your claim if it:
    - Was relied upon in making the benefit determination;
    - Was submitted, considered or generated while making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination;
    - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination;
    - Constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.
- A review that considers all comments, documents, records, and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination.
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination nor by that person's subordinate.
- The Claims Administrator will ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination,

promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits.

- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a treatment, drug or other item is experimental). The Claims Administrator will ensure that health care professionals consulted are not chosen based on the experts' reputation for outcomes in contested cases but chosen based on professional qualifications.
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision.
- In the case of a claim for urgent care, an expedited review process in which:
    - You may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination.
    - All necessary information, including the plan's benefit determination on review, will be transmitted between the plan and you by telephone, facsimile, or other available similarly prompt method.
- You will also be provided, free of charge, any new or additional evidence considered, relied upon, or generated by the plan or at the plan's direction in connection with your claim. This material, if any, will be provided to you as soon as possible and sufficiently in advance of the deadline for the determination of the appeal to give you an opportunity to respond prior to the deadline.

Prior to making a benefit determination on review, the Claims Administrator/Insurer must provide you with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. This evidence will be provided at no cost to you and will be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Prior to issuing a final internal adverse benefit determination on review based on new or additional rationale, the rationale will be provided at no cost to you. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Additionally, if your claim is an Urgent Care Claim, or a claim requiring an ongoing course of treatment, you may begin an expedited external review before the Plan's internal appeals process has been completed.

Second Level Appeals

If you are dissatisfied with a first level appeal decision, you may file a second level appeal with CVS Caremark within 60 days of receipt of the level one appeal decision. CVS Caremark will notify you of the

decision not later than 30 days after the appeal is received.

If your Second Level Appeal is denied after review by Caremark, that denial will be considered a Final Adverse Benefit Determination.

You will be notified electronically or in writing. Such notice will include the information set forth under "Notification of the Outcome of the Appeal."

If you do not agree with the Final Internal Adverse Benefit Determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable, or to pursue a voluntary External Review.

Notification of the Outcome of an Appeal

The Claims Administrator will notify you, in writing, of the decision following receipt of your request for appeal of a denied claim. Ordinarily, a decision regarding your appeal will be reached within:

- Seventy-two hours after receipt of your request for review of an urgent care claim.
- Fifteen days after receipt of your request for review of a pre-service claim.
- Sixty days after receipt of your request for review of a post-service claim.

In certain cases, the Plan may obtain a limited extension of time if the notice of the extension is provided to the claimant before the end of the initial decision-making period.

In case of an adverse benefit determination, you will receive written notice containing the following information:

- The specific reason(s) for the adverse benefit determination on review;
- References to the specific plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;
- A statement describing the external review procedures that may be available to you or any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA;
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination or a statement that a copy of this information will be provided free of charge to you upon request;
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- For adverse benefit determinations, the notice will include information enough to identify the claim involved. This includes:
    - The date of service,
    - The health care provider
    - The claim amount (if applicable), and
    - The denial code (if any);
- The notice will also include a description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;

- For adverse benefit determinations, the notice will provide identification of the experts whose advice was obtained on behalf of the Plan to make the determination, without regard to whether the advice was relied on in making the determination; and
- The availability of health insurance consumer assistance or a Public Health Service ombudsman, including contact information, to assist you in seeking plan benefits.

You and your plan may also have the right to other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

If the Claims Administrator fails to follow the claims appeals procedures as outlined above, you will have the right to bring a civil action in federal court, or to pursue a voluntary External Review. See "Exhaustion of Internal Appeals Process" for information.

Exhaustion of Internal Appeals Process

Generally, you are required to complete all appeal processes of the Plan before being able to obtain a voluntary External Review or bring an action in litigation. However, if the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan's internal appeal requirements ("Deemed Exhaustion") and may proceed with External Review after the first level or second level appeal, or may pursue any available remedies under §502(a) of ERISA or under state law, as applicable.

External Review

External Review

"External Review" is a review of an Adverse Benefit Determination or a Final Internal Adverse Benefit Determination by an Independent Review Organization/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable. A "Final External Review Decision" is a determination by an ERO at the conclusion of an External Review.

You must complete all the levels of standard appeal described above before you can request External Review, other than in a case of Deemed Exhaustion.

The notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination that you receive from CVS Caremark will describe the process to follow if you wish to pursue an External Review and will include a copy of the Request for External Review Form. You must submit the Request for External Review Form to CVS Caremark within 4 months of the date you received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

Request for External Review

The External Review process under this Plan gives you the opportunity to receive review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to applicable law. Your request will be eligible for External Review if the following are satisfied:

- CVS Caremark, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law; or
- The standard levels of appeal have been exhausted; or
- The appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An Adverse Benefit Determination based upon your eligibility is not eligible for External Review.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for External Review, you will be informed in writing of the steps necessary to request an External Review. An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, CVS Caremark and the Plan unless otherwise allowed by law.

Preliminary Review

Within five (5) business days following the date of receipt of the request, CVS Caremark must provide a preliminary review determining: you were covered under the Plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeals process (unless Deemed Exhaustion applies), and you have provided all paperwork necessary to complete the External Review.

Within one (1) business day after completion of the preliminary review, CVS Caremark must issue to you a notification in writing. If the request is complete but not eligible for External Review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

If the request is not complete, such notification will describe the information or materials needed to make the request complete and CVS Caremark must allow you to perfect the request for External Review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

Referral to ERO

CVS Caremark will assign an ERO accredited as required under federal law, to conduct the External Review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for External Review and will provide an opportunity for you to submit in writing within ten (10) business days following the date of receipt, additional information that the ERO must consider when conducting the External Review. Within one (1) business day after making the decision, the ERO must notify you, CVS Caremark, and the Plan.

The ERO will review all the information and documents timely received. In reaching a decision, the assigned ERO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending health care professional's recommendation;

- Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you, or your treating provider;
- The terms of your Plan to ensure that the ERO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by CVS Caremark, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available, and the clinical reviewer or reviewers consider appropriate.

The assigned ERO must provide written notice of the Final External Review Decision within 45 days after the ERO receives the request for the External Review. The ERO must deliver the notice of Final External Review Decision to you, CVS Caremark, and the Plan.

After a Final External Review Decision, the ERO must maintain records of all claims and notices associated with the External Review process for six (6) years. An ERO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Legal Action

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum unless it is beginning within one year of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. If your health benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.

When Coverage Ends

- Membership for you and your enrolled family members may be continued as long as you are employed by the employer and meet eligibility requirements. It ceases if your employment ends, if your no longer meet eligibility required, if the plan ceases, or if you fail to make any required contributions towards the cost of your coverage. In any case, your coverage would end at the expiration on the period covered by your last contribution.
    - If your employment ends, the last day of the month from your separation date (for

example, if your last day worked at Spectrum Brands is November 11th, you will have coverage until through November 30th).

Your eligible dependent's coverage will automatically terminate on the earliest of the following dates:

- Coverage of an enrolled child ceases at the end of the month in which the child attains age 26.
- Coverage of an enrolled impaired child at or over age 26 ceases if the child is no longer totally or permanently impaired.
- Coverage for a spouse/domestic partner ceases as the date of divorce or death.
- The date your insurance ceases
- The last day of the month the dependent ceases to be eligible for dependent insurance;
- The last day of the month CVS Caremark receives notice from Spectrum Brands, Inc. to end your coverage, or the date requested in the notice, if later.

If you or your dependent's prescription drug coverage ends, you may be able to continue that coverage at your own expense under a federal law known as COBRA, the Consolidated Omnibus Budget Reconciliation Act or 1985. See the Summary Plan Description for the medical plan under which you are enrolled for additional information.

- The date the Plan is terminated;
- The last day of the month your employment with Spectrum Brands, Inc. ends;
- The last day of the month you cease to be in a class of eligible employees or cease to qualify for insurance;
- The last day of the month CVS Caremark receives notice from Spectrum Brands, Inc. to end your coverage, or the date requested in the notice, if later.

Rescission

In general, Spectrum Brands, Inc. is not allowed to rescind (i.e. retroactively cancel or terminate) your (or your dependents) Plan coverage once you (or your dependents) become covered under the Plan. However, your (and/or your dependent's) coverage under the Plan may be rescinded (i.e. cancelled or discontinued with a retroactive effective date) if you (and/or your dependent) perform an act, practice or omission that constitutes fraud, or make an intentional misrepresentation of material fact as prohibited under the terms of this Plan. For example, if Spectrum Brands, Inc. determines that you have enrolled an individual who does not meet the Plan's requirements as stated in this SPD or as stated in the enrollment materials, your enrollment of such plan ineligible individuals will be treated as an intentional misrepresentation of a material fact, or fraud, and Spectrum Brands, Inc. reserves the right to rescind your (and/or your dependent's) plan coverage. If Spectrum Brands, Inc. seeks to rescind coverage for fraud or an intentional misrepresentation of a material fact, Spectrum Brands, Inc. will provide at least 30 days advance written notice to each participant who would be affected before coverage is rescinded. Your (and/or your dependent's) coverage also may be terminated retroactively for failure to pay the required premiums or contributions on a timely basis, or in certain other limited circumstances without Spectrum Brands, Inc. having to provide 30 days advance written notice.

Continuation of Coverage

Continuing Coverage during FMLA

Under the Family and Medical Leave Act of 1993 as amended (FMLA), you may be entitled to up to 12 weeks of unpaid, job-protected leave during each calendar year for the following:

- The birth of your child, to care for your newborn child, or for placement of a child in your home for adoption or foster care;
- To care for your spouse, child or parent with a serious health condition;
- For your own serious health condition; or
- To take care of any urgent matters for your spouse, child or parent who is on active duty or who has been notified of an impending call or order to active duty in the U.S. Armed Forces.

Additionally, you may be entitled to unpaid, job-protected leave each year to care for your spouse, child, parent or next of kin who incurs a serious injury or serious health condition during active military service in the U.S. Armed Forces. Please refer to the Spectrum Brands' Leave of Absence Policy (reach out to HR for this document) for more information around military leave.

To be eligible for FMLA leave, you must have at least one year of service and have worked at least 1,250 hours over the previous 12 months (these are your regular scheduled working hours).

Paying for Health Care Coverage during FMLA

If you take a leave of absence that qualifies for FMLA, prescription drug coverage may continue as long as you pay the regular employee portion of the cost of your health coverage during your leave. At your election:

- You may continue payroll deductions if you are continuing to receive payroll compensation from Spectrum Brands, Inc., for example, receiving salary continuation benefits or using accumulated vacation to cover a portion of your leave; or
- You may pay premiums each month during your leave. Note that your monthly contributions during the unpaid leave are made on an after-tax basis.
- If you are on an unpaid leave of absence greater than 60 days, you may make monthly medical contributions on an after-tax basis to Spectrum Brands, Inc. via a third-party administrator.

Prescription drug coverage is included with your medical plan contributions, so it is important to arrange for payment of contributions before your leave begins to ensure continuation of your benefits.

If you lose coverage during an FMLA leave because you did not make the required contributions, you may re-enroll when you return from your leave. Your coverage will start again on the first day after you return to work provided you make your required contributions.

If you do not return to work at the end of your FMLA leave, or your employment is terminated while you are on FMLA leave, you may be entitled to purchase COBRA continuation coverage for medical. If you continue your medical coverage under COBRA, prescription drug coverage will automatically be continued.

Please contact the Spectrum Brands' Benefits Team at 800-881-2562 or benefits@spectrumbrands.com for more information, or to request copies of Spectrum Brands, Inc. leave policies.

Continuing Coverage during Military Leave

The Plan will comply with the requirements of all the terms of the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). 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 dependents in accordance with the USERRA.

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the reserve components of the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, you may elect to continue coverage under the Plan by notifying the Spectrum Brands' Benefits Team at 800-881-2562 or benefits@spectrumbrands.com in advance and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a colleague's behalf. If your Military Service is for a period less than 31 days, you may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

You may continue coverage under the USERRA for up to the lesser of:

- The 24-month period beginning on the date of your absence from work; or
- The day after the date on which you fail to apply for, or return to, a position of employment.

Regardless of whether you continue health coverage, if you return to a position of employment, your health coverage and that of your dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on you or your dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred or aggravated during the performance of military service. You should contact the Plan Administrator if you have questions about your rights to continue health coverage under the USERRA.

Please contact the Spectrum Brands' Benefits Team at 800-881-2562 or benefits@spectrumbrands.com for more information about USERRA and how it affects your benefits.

Other Important Information about The Plan

Qualified Medical Child Support Order (QMCSO)

The term "eligible dependent" also includes any child for whom you are required to provide health coverage under a Qualified Medical Child Support Order (QMCSO), as determined by the Plan Administrator. In general, QMCSOs are orders under state law requiring a parent to provide health care support to a child – for example, in the case of divorce. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your federal income tax return and children who do not reside with you; however, a child who no longer meets Plan eligibility requirements (due to age, for example) cannot be added under a QMCSO.

Coverage will be made available according to a valid order served on Spectrum Brands, Inc., or its agent for service of legal process. A QMCSO cannot require the Plan to provide benefits that are not normally

available to you and your dependents. When an order is received by Spectrum Brands, Inc., or its agent for service of legal process and determined to be valid, Spectrum Brands, Inc. will notify affected participants and each child covered by the order. As directed by the order, each child covered by the order will be added to your coverage, and your payroll contributions will be adjusted to reflect the addition of your children.

Participants and beneficiaries under the Plan can obtain, without charge, a copy of the Plan's QMCSO procedures by contacting the Spectrum Brands' Benefits Team at 800-881-2562 or benefits@spectrumbrands.com.

When You Become Eligible for Medicare

You will receive a Certificate of Creditable Coverage that indicates that the prescription drug coverage offered to you by Spectrum Brands, Inc. provides benefits that are at least as good as the coverage provided to you under Medicare Part D. When you are eligible for, and decide to enroll in, Medicare, your prescription drug coverage will be provided under a Medicare Part D plan. You will need to provide your Certificate(s) to Medicare to avoid paying a penalty charge for Part D coverage. The Certificate of Creditable Coverage describes the purpose of the Certificate and how penalty charges are assessed.

For more information about Medicare Part D, you may request a free booklet, "Your Guide to Medicare Prescription Drug Coverage" (CMS Pub. No. 11109), at www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227).

Your Right to Privacy

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you and is available by contacting the Spectrum Brands' Benefits Team at 800-881-2562 or benefits@spectrumbrands.com.

This Plan, and the Plan Sponsor, will not use or further disclose information that is protected by HIPAA ("protected health information" or PHI) except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your PHI, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, in certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

The Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, if you have any questions about the privacy of your health information, or if you wish to file a complaint under HIPAA, please contact the Spectrum Brands' Benefits Team at 800-881-2562 or benefits@spectrumbrands.com.

Company Reimbursement Rights

This section applies whenever another party (including your own insurer under an automobile or other policy) is legally responsible or agrees to compensate you or your dependent, by settlement, verdict, judgment, arbitration award or otherwise, for an illness or injury. In that case, you or your dependent (or the legal representatives, estate or heirs of either you or your dependent), must promptly reimburse the Plan for any prescription drug benefits it paid relating to that illness or injury, up to the full amount of the compensation received from the other party (regardless of how that compensation may be characterized and regardless of whether you or your dependent have been made whole). If the Plan has not yet paid prescription drug benefits relating to that illness or injury, the Plan may reduce or deny future prescription drug benefits based on the compensation received by you or your dependent.

Prescription drug benefits relating to such illness or injury will not be payable by the Plan until you sign and return a statement, provided by the Plan, acknowledging your obligation to reimburse the Plan under this provision. (That obligation will arise upon the payment of any Plan benefits relating to the illness or injury, whether you sign such a statement). Any payment made by the Plan in the absence of a signed statement will not constitute a waiver of any rights of the Plan under this section or under applicable law.

As a condition to participating in and receiving benefits under this Plan, you and your dependent agree to cooperate with the Plan and its agents and agree to sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement. You and your dependent also agree to provide any relevant information and take such actions as the Plan or its agents reasonably request to assist the Plan in making a full recovery of the reasonable value of the benefits provided, including encouraging the full cooperation of any counsel retained by you or your dependent. You and your dependent agree not to take any action that prejudices the Plan's right of reimbursement.

In order to secure the rights of the Plan under this section, you or your dependent hereby: (1) grant to the plan a first priority lien against the proceeds of any such settlement, verdict, judgment, arbitration award, or other amounts received by or on behalf of you or your dependent; and (2) assign to the Plan any benefits you or your dependent may have under any automobile policy or other coverage, to the full extent of the Plan's claim for reimbursement.

The reimbursement required under this provision will not be reduced to reflect any costs or attorneys' fees incurred in obtaining compensation. The Plan Administrator may, however, in its sole discretion, agree separately in writing to reduce the amount of reimbursement otherwise required under this section to account for special circumstances.

The Plan Administrator has the discretionary authority to interpret the terms of this section. The Prescription Drug Plan’s Claims Administrator has the right to intervene in any suit or legal proceeding to protect these rights.

Subrogation

When you or your covered dependent (“you”) are injured or become ill because of the actions or inactions of a third party, the plan may cover your eligible prescription drug expenses. However, to receive coverage, you must notify the plan that your illness or injury was caused by a third party within a reasonable time, but no more than 90 calendar days after you knew or should have known of the actions or inactions of the third party that caused your injury or illness, and you must follow special plan rules.

This section describes the plan's procedures with respect to subrogation and right of recovery (also referred to as "reimbursement").

Subrogation means that if an injury or illness is someone else's fault, the plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party related to the illness or injury.

You must pay the plan back first, in full, out of such funds for any health care expenses the plan has paid related to such illness or injury. You must pay the plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses.

Furthermore, you must pay the plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury.

By accepting plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree:

- to notify the plan and obtain its consent no later than 30 days before settling claims with any third party responsible for your illness or injury;
- to notify any third party responsible for your illness or injury of the plan's right to reimbursement for any claims related to your illness or injury;
- to hold any reimbursement or recovery received by you (or your dependent, legal representative, or agent) in trust on behalf of the plan to cover all benefits paid by the plan with respect to such illness or injury and to reimburse the plan promptly for the benefits paid, even if you are not fully compensated or made whole for your loss;
- that the plan has an equitable lien on all monies paid (or payable) to you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;
- that the plan may appoint you as constructive trustee for any and all monies paid (or payable) to you or for your benefit by any responsible party or other recovery to the extent the plan paid benefits for such sickness or injury;
- that the plan has the right of first reimbursement against any recovery or other proceeds of any claim against the other person (whether the participant or dependent is made whole) and that the plan's claim has first priority over all other claims and rights;
- to reimburse the plan in full up to the total amount of all benefits paid by the plan in connection with the illness or injury from any recovery received from a third party, regardless of whether the recovery is specifically identified as a reimbursement of medical expenses. All recoveries from a third party, whether by lawsuit, settlement, insurance, or otherwise, must be turned over to the plan as reimbursement up to the full amount of the benefits paid;
- that the plan's claim is not subject to reduction for attorneys' fees, costs, or damages under the "common fund" doctrine or otherwise;
- that, in the event that you elect not to pursue your claim(s) against a third party, the plan shall be equitably subrogated to your right of recovery and may pursue your claims;
- to assign, upon the plan's request, any right or cause of action to the plan;

- not to take or omit to take any action to prejudice the plan's ability to recover the benefits paid;
- to cooperate in doing what is necessary to assist the plan in recovering the benefits paid or in pursuing any recovery or reimbursement;
- to forward any recovery to the plan within ten days of disbursement by the third party or to notify the Plan as to why you are unable to do so; and
- to the entry of judgment against you and, if applicable, your dependent, in any court for the amount of benefits paid on your behalf with respect to the illness or injury to the extent of any recovery or proceeds that were not turned over as required and for the cost of collection, including but not limited to the plan's attorneys' fees, costs, or damages.

Additionally, the plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds.

The plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- money from a third party that you, your guardian or other representatives receive or are entitled to receive;
- any constructive or other trust that is imposed on the proceeds of any settlement, verdict, or other amount that you, your guardian, or other representatives receive; or
- any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian, or other representatives.

As a plan participant, you are required to:

- Notify the plan within 10 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
- Provide all information requested by the plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.

If the subrogation provisions conflict with subrogation provisions in an insurance contract that governs the benefits at issue, the subrogation provisions in the insurance contract will control. If the right of recovery provisions in these subrogation provisions conflict with right of recovery provisions in an insurance contract that govern the benefits at issue, the right of recovery provisions in the insurance contract will control. Notwithstanding anything to the contrary, no provision in any governing document or contract will be interpreted to limit the plan's right to seek subrogation or reimbursement from you, your covered dependent, or the dependent, legal representative, or agent of you or your covered dependent.

Right of Recovery

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these excess payments from any individual (including you), insurance company or other organization to whom the excess payments were made or to withhold payment, if necessary, on future benefits until the overpayment is recovered.

If excess payments were made for prescription drug benefits or services rendered to your dependent(s), the Plan has the right to withhold payment on your future benefits until the overpayment is recovered.

Further, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise all available legal rights, including its right to withhold payment on future benefits, until such overpayment is recovered.

Plan Continuance

The Company expects and intends to continue this Prescription Drug Plan. However, the Company reserves the right to amend, suspend or terminate all or any portion of the Plan. The Company's rights include the right to obtain coverage and/or administrative services from additional or different insurance carriers, third party administrators, etc. at any time, and the right to revise the amount of employee contributions. Employees will be notified of any material modifications to the Plan.

If Spectrum Brands, Inc. discontinues the plan for any reason and does not replace the coverage with comparable benefits, plan participants will receive written notice. If the Plan were to be terminated, there would be no plan assets that would need to be distributed.

If the plan ends, claims for eligible services incurred before the termination date will be paid, provided benefits would have been payable before the plan ended.

Your Rights Under ERISA

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. These people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a plan benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and you 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 to pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in state or Federal court, but only after you have exhausted the Plan's claims and appeals procedures. The requirement to exhaust the Plan's claims and appeals procedures applies for all purposes including the recovery of benefits under the Plan, the enforcement of rights under the terms of the Plan and the clarification or rights to future benefits under the terms of the Plan. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact 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 (EBSA), 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 DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 866-444-3272S.

Definitions

Throughout this SPD, a number of words and phrases will be used that have a special meaning when used to describe the Prescription Drug Plan. Here is an explanation of those special terms to help you better understand your benefits.

Brand-name is a Prescription Drug that is either:

- manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- identified by CVS Caremark as a Brand-name Drug based on available data resources including, but not limited to, First DataBank, that classify drugs as either Brand-name or Generic Drugs based on a number of factors.

You should know that all products identified as "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand name by the Claims Administrator.

Chronic medical condition means a condition, such as high blood pressure or high cholesterol, which can be managed effectively through the ongoing use of prescription medications.

Co-insurance means the percentage of the cost of Preferred Brand Name and Non-Preferred Brand Name drugs you pay up to a co-insurance maximum per prescription.

Formulary or Preferred Drug List means a list of commonly prescribed brand name and generic medications that are selected by CVS Caremark based on their clinical effectiveness, safety, and cost.

Generic Drugs are Prescription Drugs

- chemically equivalent to a Brand-name Drug; or
- identified by CVS Caremark as a Generic Drug based on available data resources including, but not limited to, First DataBank, that classify drugs as either Brand-name or Generic Drugs based on a number of factors.

You should know that all products identified as "generic" by the manufacturer, pharmacy, or your Physician may not be classified as a Generic by the Claims Administrator.

Maintenance Medication means medications that are prescribed to treat conditions of a long-term or chronic nature, such as diabetes, arthritis, and high blood pressure.

Medically Necessary means a treatment, procedure, service, or supply, including prescription drugs, that the plan administrator determines, in the exercise of its discretion:

- Is appropriate and consistent with diagnosis; and
- Is in accord with generally accepted medical practice; and
- Could not have been left out without adversely affecting the covered person's condition or quality of medical care.

A treatment, procedure, service, or supply must meet all the criteria listed above to be considered medically necessary and to be eligible for coverage under this plan. In addition, the fact that a health care provider has prescribed, ordered, or recommended a treatment, procedure, service, or supply does not, in itself, mean that it is medically necessary as defined above.

Non-preferred Brand Drugs are brand name drugs that are not included in the CVS Caremark formulary but are available to you at a higher cost than Preferred Brand drugs.

Participating Pharmacy means a local retail pharmacy that has entered into an agreement with CVS Caremark to dispense drugs to persons covered under the Plan, but only:

- While the agreement remains in effect; and
- When such a pharmacy dispenses a prescription drug under the terms of the agreement with CVS Caremark, the Claims Administrator.

Pharmacy Benefit Manager (PBM) means an organization, such as CVS Caremark, that manages the pharmaceutical program and benefits for an employer.

Preferred Brand Drugs are commonly prescribed brand name drugs that are included in the CVS Caremark formulary and are available at negotiated discounts, so you pay less for them.

PDL Management Committee - see Prescription Drug List (PDL) Management Committee.

Prescription Drug - a medication, product or device that has been approved by the Food and Drug Administration and that can under federal or state law, only be legally dispensed using a prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of this Plan, Prescription Drugs include:

- inhalers (with spacers);
- insulin;
- the following diabetic supplies:
    - insulin syringes with needles;
    - blood testing strips - glucose;
    - urine testing strips - glucose;
    - ketone testing strips and tablets;
    - lancets and lancet devices;
    - insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets; and
    - glucose monitors

Prescription Drug Cost - the rate the Claims Administrator has agreed to pay its Network Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Network Pharmacy.

Prescription Drug List (PDL) - a list that categorizes into categories medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which category a particular Prescription Drug has been assigned by contacting CVS Caremark at the toll-free number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that CVS Caremark designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

Specialty Prescription Drug - Prescription Drug that is generally high cost, self-injectable biotechnology

drug used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drugs through the Internet at caremark.com or by calling the number on the back of your prescription ID card.

Usual and Customary Charge – the usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.