SUMMARY PLAN DESCRIPTION

for the Prescription Drug Benefits

HDHP/HSA 2 Medical Plan

under the XL America, Inc. Health and Welfare Plan

Effective January 1, 2021

Contents

INTRODUCTION

AXA XL provides medical and prescription drug benefits to its eligible employees. Prescription drug benefits are provided to employees and their dependents who are covered for medical benefits under the Open Access Plus (OAP) HSA/HDHP2 Medical option (the "HDHP2 Medical plan") offered under the XL America, Inc. Health and Welfare Plan (the "Plan").

The medical benefits provided under the HDHP2 Medical plan are described in one or more separate booklets. This summary is intended to describe pharmacy prescription drug benefits under the HDHP2 Medical plan. This summary, when combined with the AXA XL Wrap Summary Plan Description (SPD), is intended to serve as the summary plan description with respect to pharmacy prescription drug benefits under the HDHP2 Medical Plan, as required by the Employee Retirement Income Security Act (ERISA).

Prescription drug benefits described in this summary are provided through pharmacies under administrative service only contracts with service providers. A directory of participating pharmacies is provided at no cost to you. You may also access a list of participating pharmacies at www.Caremark.com or you can call CVS Caremark at 1-844-462-0196. For TDD assistance, please call 1-800-863-5488.

For additional information regarding the benefits provided under the Plan, please contact the Plan Administrator identified on page 15. AXA XL reserves the right to change, amend, suspend, or terminate the Plan, any or all of the benefits under the Plan, in whole or in part, at any time and for any reason at its sole discretion.

Note that by adopting and maintaining these benefits, AXA XL has not entered into an employment contract with any employee. Nothing in the legal Plan documents or in the SPD gives any employee the right to be employed by AXA XL or to interfere with AXA XL's right to discharge any employee at any time.

ELIGIBILITY

Eligible Employees

Generally, you are considered an "eligible employee" and are eligible for prescription drug benefits if you are enrolled for Medical benefits under HDHP2 Medical plan.

Please refer to the Medical SPD for specific eligibility requirements for employees.

Eligible Dependents

Your dependent is eligible for prescription drug benefits if he or she is enrolled as a dependent for Medical benefits under HDHP2 Medical plan.

Please refer to the Medical SPD for specific eligibility requirements for dependents.

You are required to provide proof of your dependents' eligibility upon request. False or misrepresented eligibility information may cause both your coverage and your dependents' coverage to be irrevocably terminated (retroactively to the extent permitted by law), and could be grounds for employee discipline up to and including termination.

Qualified Medical Child Support Orders

The Plan may be required to provide prescription drug coverage for your child due to a Qualified Medical Child Support Order (QMCSO) even if you have not enrolled the child. A QMCSO is any judgment, decree or order, including a court approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible under the Plan, and that the plan administrator determines is qualified under the terms of ERISA and applicable state law. 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 don't reside with you. However, children who are not eligible for coverage under the Plan, due to their age for example, cannot be added under a QMCSO.

ENROLLMENT

New Employees

To be covered for prescription drugs, you must enroll for Medical benefits under the HDHP2 Medical plan.

Please refer to the Medical SPD for enrollment information.

WHEN COVERAGE ENDS

Your prescription drug coverage will terminate when you are no longer enrolled in the HDHP2 Medical plan.

Specific rules regarding when Medical coverage (and with it, prescription drug coverage) ends is found in the SPD describing the plan option in which you are enrolled.

Coverage for your spouse and other dependents terminates when your coverage terminates. Their coverage will also cease for other reasons specified in the SPD describing the Medical plan option in which they are enrolled.

For children covered pursuant to a QMCSO, coverage will end as of the date that the child is no longer covered under a QMCSO.

Depending on the reason for termination of coverage, you and your covered spouse and dependent child(ren) might have the right to continue health coverage temporarily under COBRA or under a conversion right under a particular benefit plan.

COBRA

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances (called "qualifying events") when coverage would otherwise end. The right to COBRA coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children who lose coverage for certain specified situations. If you elect COBRA for your medical coverage, you will automatically be covered under COBRA for prescription drug coverage. No separate election for prescription drug coverage is required or allowed. The COBRA premium you pay for medical coverage includes prescription drug coverage. For more information on your COBRA rights and obligations, please refer to the COBRA section of the SPD describing the medical plan in which you are enrolled.

PRESCRIPTION DRUG BENEFITS

Definitions

Co-payment/Co-insurance: A portion of the total cost of the claim that must be paid by the member.

Date of Service: Date on which a prescription is filled or dispensed.

Days Supply: The number of days payable by the plan for the dispensed drug.

Direct Claim: A reimbursement process whereby the member pays 100% of the prescription drug cost at the time of purchase and then submits a paper claim for reimbursement.

Federal Legend Drugs: A drug that requires a prescription; these drugs can be identified by the presence of "Federal Legend" on the label.

Formulary: A list of brand name and generic commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings. CVS Caremark continually reviews drugs on the standard formulary and will either add newly available products or exclude products that do not meet clinical requirements. If you are impacted by a formulary change, you will be contacted by CVS Caremark. You can contact CVS Caremark at 1-844-462-0196 to determine if the brand-name drug you are taking is on the formulary. You can also locate this information at www.caremark.com or on the CVS Mobile App. If a drug you are taking is not on the formulary, you may want to discuss alternatives with your doctor or pharmacist. Using drugs on the formulary will keep your costs and the Plan's costs lower.

Generic drug: A medication that contains the same active ingredient and is manufactured according to the same strict federal regulations as its brand-name counterpart. Medication that is chemically equivalent and therapeutically equivalent to a brand medication, but manufactured at a lower cost. The Food and Drug Administration (FDA) requires generic medications to meet the same standards as Multi Source (brand) medications. Generic medications may differ in color, size, or shape, but the Food and Drug Administration requires that they have the same strength, purity, and quality as their brand-name counterparts. A generic medication can be produced once the manufacturer of the brand-name medication is required to allow other manufacturers the opportunity to produce the medication.

Brand-name drug (brand drug): A medication that is available only from its original manufacturer or from another manufacturer that has a licensing agreement to make the drug with the brand-name manufacturer. These medications are marketed under a recognized brand name. A brand-name drug may have a generic equivalent once the manufacturer is required to allow other manufacturers the opportunity to make the medication.

In-Network Retail Claims: Claims processed by pharmacies that participate in the CVS Caremark National Network and are included in the member's pharmacy network.

Maintenance Medication: Medications prescribed for long-term use, (i.e., maintenance medication taken for long-term prevention such as: high-blood pressure sufferers or diabetics). Please note that some "long term" medications are not on the maintenance list due to certain regulations (for example: opioids).

Multi Source (Brand) Drug: Brand Name Drug that has a FDA Approved generic equivalent substitute available.

Network Pharmacy: A retail pharmacy that has an agreement currently in effect with CVS Caremark for this Plan to dispense Prescription Drugs to Participants.

Out-Of-Network Claims: Claims processed by pharmacies that do not participate in CVS Caremark's national pharmacy network.

Over the Counter (OTC Medication): Medication that does not require a prescription.

Prior Authorization: Process by which a medication or benefit that is not preferred under the member's plan may be covered on an exception basis with the appropriate medical exception.

Benefits Highlights

	Short-Term Medicines *CVS Caremark Retail Pharmacy Network (up to a 30 day supply)*	**Long-Term Medications** *CVS Caremark Mail Service Pharmacy or CVS Pharmacy Locations (up to a 90 day supply)*	**Out of Network**
Generic Drugs	20% for a 30-day supply of a generic medicine	20% for a generic medicine	40% for a generic medicine
Preferred Brand-Name Drugs	30% for a 30-day supply of a preferred brand-name medicine	30% for a preferred brand-name medicine	50% for a preferred brand-name medicine
Non-Preferred Brand-Name Drugs	40% for a 30-day supply of a non-preferred brand-name medicine	40% for a non-preferred brand-name medicine	60% for a non-preferred brand-name medicine
Refill Limit	One initial fill plus one refill for long-term medications at any retail pharmacy, then you must use Maintenance Choice	None	
Specialty Drugs	$0 Copay if enrolled in PrudentRx copay card program, 30% coinsurance if not enrolled in PrudentRx (30% coinsurance will not apply to the annual out-of-pocket maximum)		No Specialty Benefit
Annual Deductible	$2,500 per individual / $5,000 per family		
Maximum Out-of-Pocket	$5,000 per individual / $10,000 per family		
Medications on the preventive generics drug list, medications on the ACA preventive services list and non-OTC diabetic medications and supplies bypass the deductible and have a $0 member cost share			

** Please Note: when a generic is available, but the pharmacy dispenses the brand-name medication for any reason, you will pay the difference between the brand-name medication and the generic plus the brand copayment.*

Member Services

Visit CVS Caremark website - www.caremark.com - to view your plan design and co-payment information, search for details on prescription medications, locate a participating pharmacy near you, and manage your home delivery prescriptions. For additional plan inquiries, you may call Member Services directly at 1-844-462-0196. For future reference, this number is listed on the back of your CVS Caremark ID card.

Covered Expenses

- Federal Legend Drugs
- State Restricted Drugs
- Insulin
- Diabetic Supplies/Insulin Needles, Syringes
- Needles and Syringes to be used with covered Federal Legend Drugs
- Contraceptives
- Fertility Agents
- Drugs to Treat Impotency, for males only age 18 and over

Visit www.Caremark.com to check coverage for a specific medication

Medications

Generic Medications

Generic drugs may have unfamiliar names, but they are safe and effective. Be assured that generic drugs and their brand-name counterparts:

- Have the same active ingredients
- Are manufactured according to the same strict federal regulations

Generic drugs may differ in color, size, or shape, but the U.S. Food and Drug Administration requires that the active ingredients have the same strength, purity, and quality as the brand-name alternatives.

Prescriptions filled with generic drugs often have a lower co-payment. Therefore, you may be able to get the same health benefits at a lower cost. You should ask your doctor or pharmacist whether a generic drug would be right for you. You may be able to receive the same high-quality medication but reduce your expenses.

Generic medications contain the same active ingredients as brand-name medications, are just as safe and effective, and meet the same U.S. Food and Drug Administration standards for quality, strength and purity. However, generic drugs normally cost substantially less than their brand name counterparts. Therefore, generic drugs offer a simple and safe alternative to help reduce your medication costs. Ask your doctor to see if a generic drug could treat your condition.

Formulary and Non-Formulary Medications

The Formulary is a guide for you and your doctor to refer to when filling out your prescriptions. If there is no generic medication available for your condition, there may be more than one brand name for you and your doctor to consider. CVS Caremark provides a list of formulary brand name medications to help you and your doctor decide which medications are clinically appropriate and cost effective.

If a drug you are taking is not on the formulary, you may want to discuss alternatives with your doctor or pharmacist. Using drugs on the formulary will keep your costs lower.

A current drug list is available online or upon request by calling Member Services. To avoid paying higher co-payments associated with non-preferred drugs, please take this list with you when you visit your doctor so he or she can refer to it when prescribing medications for you and your eligible family participants.

A prior authorization process (i.e. review of medical necessity) is available in the event there are no drugs on the Standard Formulary that meet your needs. A component of the formulary requires some specialty medications to be reviewed for their preferred vs. non-preferred status

Coverage limits

Your plan may have certain coverage limits. For example, prescription drugs used for cosmetic purposes may not be covered, or a medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period.

If you submit a prescription for a drug that has coverage limits, your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will give you or your doctor a toll-free number to call. If you use The CVS Caremark Pharmacy, your doctor will be contacted directly.

When a coverage limit is triggered, more information is needed to determine whether your use of the medication meets your plan's coverage conditions. CVS Caremark will notify you and your doctor in writing of the decision. If coverage is approved, the letter will indicate the amount of time for which coverage is valid. If coverage is denied, an explanation will be provided, along with instructions on how to submit an appeal.

Prior Authorization

Your prescription drug program provides coverage for some drugs only if they are prescribed for certain uses. For this reason, some medications must receive prior authorization before they can be filled. If the prescribed medication must be pre-authorized, your pharmacist will inform you. The Pharmacist may initiate the review process or you may ask your Physician to call a special toll-free phone number that will be supplied by your pharmacist. It typically takes two business days. The patient and physician will be notified when the review process is completed. If the medication is not approved, you will have to pay the full cost of the prescription.

You will be required to get prior authorization from your doctor before receiving Type 2 diabetes medications Glumetza, Fortamet, and the associated high-cost Metformin ER generics. Members will be instructed to try the generic of Glucophage XR before being allowed to use one of the high-cost metformin ER generics. In addition, there is a similar process for Proton Pump Inhibitor medication Zegerid and its generics. Generic proton pump inhibitors such as omeprazole and lansoprazole are the preferred lower cost alternatives. Your prescribing doctors should be aware of the prior authorization requirements for Glumetza, Fortamet, Zegerid, and their respective generics.

Prior Authorization for Compound Drugs

Compounding is the combining, mixing, or altering of ingredients to create a customized medication that is not otherwise commercially available and in final form does not meet FDA standards. Most compound ingredients are excluded. However, medically necessary compound drugs may be covered if approved Prior authorization for all covered compound drugs over $300 is required.

Preventive Medications

The Patient Protection and Affordable Care Act (PPACA) makes certain preventive medications and supplements available to you at no cost, including certain women's contraceptives, pediatric multivitamins, and smoking cessation medications. You pay $0 for qualifying PPACA preventive medications regardless of which medical plan you choose. The preventive drug list is available by calling CVS Caremark at 1-844-462-0196.

Members also have access to a list of preventive generic prescription drugs that are available without having to meet the deductible and at no cost to you. The Preventive Drug List is available by visiting the AXA XL Benefits website or calling CVS Caremark at 1-844-462-0196. Preventive drugs as defined by the PPACA (health care reform law) will continue to be covered in full ($0 cost) and are not subject to the deductible.

Preventive Generics Drug List for HDHP participants

The HDHP2 medical plan requires you to pay the full cost of your medical services and prescription medications until you have reached the plan deductible. After you meet the deductible, you pay only the coinsurance and your plan pays the rest.

However, by taking advantage of the drugs on the Preventive Generics Drug List – AXA XL, you will have no out of pocket cost, even if you have not yet met your annual plan deductible. These medications are intended to help prevent disease or help manage existing conditions to try and avoid future complications. For example, generic preventive medications for HDHP participants may be taken for the treatment of high cholesterol, hypertension, diabetes, cancer, respiratory issues, and more.

The Preventive Drug List is available by visiting the AXA XL Benefits website or by calling CVS Caremark at 1-844-462-0196. For those who are not taking a drug on this list but may benefit from moving to an equivalent that is the drug list, you can discuss alternative treatment options with your doctor that may provide the same clinical benefits and save you money.

For certain conditions, if you are enrolled in the OAP, HSA 1 or HSA 2 plan, and you fill a prescription from the preventive generics drug list, there is $0 cost to you.

Vaccines

As part of the Patient Protection and Affordable Care Act (health care reform law), the list of fully covered vaccines include both seasonal strains of influenza and common preventable diseases at no cost to you or your family.

Specialty Drugs

Specialty drugs are often used to treat chronic, complex medical conditions that require additional patient support to ensure optimal adherence.

Many specialty drugs require special handling, storage, and administration and follow very specific FDA guidelines to ensure the product is clinically effective. Specialty drugs can come in generic or brand-name form, are taken for a long period of time, and are often more expensive than non-specialty medications. All specialty medications will be exclusively processed by CVS Caremark Specialty Pharmacy. Information can be found at cvsspecialty.com.

How it works:

Programs for specialty medications under the AXA XL plan are designed to help prescribers select the most clinically effective therapy through well-supported treatment options and clinical support.

Specialty medications will be subject to a prior authorization process, and all specialty medications are dispensed by the CVS Specialty pharmacy. **All specialty medications must go through the prior authorization process even if they are preferred drugs.**

If you are a new member and currently obtain your specialty medications through another specialty pharmacy, contact Caremark directly to discuss the transition of your medications to be processed exclusively through CVS Caremark. In addition, medications for the certain conditions will be reviewed for their preferred or non-preferred status within the plan's formulary prior to being dispensed, including, (but not limited to): Multiple sclerosis, autoimmune, fertility, hepatitis C (interferons), growth hormone, pulmonary arterial hypertension, osteoarthritis, hematology, osteoporosis, chronic myeloid leukemia, and transplant.

- When/if you present a new prescription for a preferred specialty medication under one of these drug classes, you must submit a request for a prior authorization review to ensure it is clinically appropriate.
- When/if you present a prescription for a non-preferred specialty medication under these drug classes, you must submit a request for a prior authorization review to ensure it is clinically appropriate.
- CVS Caremark will notify both the prescriber and member if the drug is approved.

PrudentRx Copay Program for Specialty Medications

In order to provide a comprehensive and cost-effective prescription drug program for you and your family, AXA XL has contracted with PrudentRx to offer the PrudentRx Copay Program for certain specialty medications. The PrudentRx Copay Program assists members by helping them enroll in manufacturer copay assistance programs. Medications in the specialty tier will be subject to a 30% co-insurance. However, enrolled members who get a copay card for their specialty medication (if applicable), will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program.

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 Copay Program will assist members in obtaining copay assistance from drug manufacturers to reduce a member's 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, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible members will be automatically enrolled in the PrudentRx program, but you can choose to opt out of the program. You must call 1-800-578-4403 to opt-out. Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications – in that case, you must speak to someone at PrudentRx at 1-800-578-4403 to provide any additional information needed to enroll in the copay program. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. If you do not return their call, choose to opt-out of

the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer you will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx program.

If you or a covered family member are not currently taking, but will start a new medication covered under the PrudentRx Copay Program, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx program. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Copay Program.

The PrudentRx Program Drug List may be updated periodically by the Plan.

Copayments for these medications, whether made by you, your plan, or a manufacturer's copay assistance program, will not count toward your plan deductible.

Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, member cost share payments for these medications, whether made by you or a manufacturer copayment assistance program, do not count towards the Plan's out-of-pocket maximum. A list of specialty medications that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is medically necessary for a particular individual.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Copay Program.

Opioid Management Program

This program is designed to help ensure safe and appropriate use of opioids by limiting the use of pain medication and controlled substances to FDA-approved amounts. You will be able to fill a prescription for the amount approved by the FDA, but not for a higher quantity. If there is a medical necessity to increase the quantity beyond the FDA limit, you and your physician may apply for post-limit prior authorization to obtain additional medication. Note: These limits do not apply to individuals diagnosed with cancer or end-of-life hospice or palliative care.

Benefit ID Cards

CVS Caremark will provide an initial benefit ID card upon enrollment in the plan. Present your ID card when filling a prescription at the pharmacy. Should you need additional or replacement ID cards, please contact Member Services, your Caremark Mobile App or visit www.Caremark.com to either request a new card or print a temporary card. The Caremark mobile app also has an electronic version of your ID card.

Filling Prescriptions

There are two ways to fill prescriptions: at a network retail pharmacy or using the mail order service:

- At a network pharmacy (30-day supply)
- Mail order for maintenance (long-term) medication. Alternatively, you can fill your maintenance medications at CVS pharmacies with a 90-day supply.

Retail Network Pharmacy

When you purchase covered Drugs from a CVS Caremark pharmacy, you should present your prescription order and Prescription Drug Program Identification Card to the Pharmacist. The Pharmacist will use a computerized system to confirm your eligibility for benefits and determine the cost of your prescription, including the share of the cost you will be asked to pay.

You can purchase up to a 30-day supply of your Prescription drug through a participating pharmacy. CVS Caremark network pharmacies include national chains such as CVS, Walgreens, Rite-Aid, and most other retail pharmacies. To find a local pharmacy, visit www.caremark.com or contact CVS Caremark Customer Care 1-844-462-0196.

You may fill your maintenance medications at a retail CVS pharmacy, and receive a 90-day supply. Note that this only applies to CVS pharmacies and not any other retail pharmacies, even if in the network. Or you may send your maintenance prescriptions through the convenient Mail Order Pharmacy described below.

For OAP participants, the mail order copay is the same regardless of which method you use: home delivery or CVS retail pick-up. For those in the CDHP, you can expect to pay the same discounted amount for 90-day supply at retail and at mail order.

Non-Network Retail Pharmacies

In an emergency situation, where there is no CVS pharmacy, you may be reimbursed by CVS Caremark should you visit a non-network pharmacy. However, it is to your advantage to visit a CVS Caremark network pharmacy. The non-network pharmacies will require you to pay for the full cost of the drug at the time of purchase, not just your co-payment amount. You must then complete a direct reimbursement claim form and forward it to CVS Caremark with a copy of your receipt. Direct reimbursement claim forms are available on the website or by calling Member Services. You will be reimbursed for the cost of the medication charged by the non-network pharmacy, minus your co-pay. Compound medications are not covered through this process.

Mail Order Pharmacy

The Mail Order Pharmacy is a convenient and cost-effective means of receiving prescription drugs. By mailing in a prescription or having a doctor fax in the Prescription, Participants can receive up to a 90-day supply.

You have two options for filling your 90 day supply:

- Receive your 90-day supply of maintenance medication through the CVS Caremark Mail Service Pharmacy
- Receive your 90-day supply of maintenance medication at the local retail CVS pharmacy

In order to fill your prescription through the CVS Caremark Mail Order Pharmacy Program, mail your prescription, order form and payment to CVS Caremark. You may also ask your doctor to fax your prescription to 1-800-378-0323 or call 1-844-462-0196.

To order refills, call the automated refill system at 844-462-0196, or visit www.caremark.com. Refills are normally delivered within 3 to 5 days.

As you manage your prescriptions, please be aware that each and every prescription is filled and checked by highly qualified registered pharmacists to ensure that quantity, quality and strength are accurate. A patient profile is maintained on file to ensure that there are no adverse reactions with other prescriptions you are receiving from retail and/or mail order pharmacies. If any questions arise regarding potential drug interactions or other adverse reactions, CVS Caremark's pharmacists will contact either you or your doctor prior to dispensing the medication.

Maintenance Choice for Long-Term Medications

Maintenance Choice offers you choice and savings when it comes to filling long-term prescriptions. You have two ways to save:

CVS Caremark Mail Service Pharmacy:

- Enjoy convenient home delivery
- Receive your medications in private, tamper-resistant and (when needed) temperature-controlled packaging
- Talk to a pharmacist by phone

CVS Pharmacy:

- Pick up your medication at a time that is convenient for you
- Enjoy same-day prescription availability
- Talk with a pharmacist face-to-face

The following chart provides detailed steps to help enjoy all the benefits of Maintenance Choice.

If You Would Like	**Then…**
To continue with mail service	You don't have to do anything. CVS Caremark will continue to send your medications to the location of your choice.
To pick up at CVS Pharmacy	You can do so quickly and easily. Choose the option that works best for you: ▪ Register or log into www.caremark.com to select a CVS Pharmacy location for pick up ▪ Visit your local CVS Pharmacy and talk to the pharmacist ▪ Call the toll-free number on the back of your Prescription Card.
To sign up for mail service for the first time	You can do so easily online or by phone. ▪ Register or log into www.caremark.com, select *Request a new prescription* ▪ Call Customer Care at 1-844-462-0196.
More Information	Use the phone number on the back of your Prescription Card to call CVS Caremark toll-free.

Before you reach your 30–day fill and your out-of-pocket cost increases, we will contact you to help you get started with Maintenance Choice. They will also help you get a 90-day prescription from your doctor so you can choose to fill it through mail service or at a CVS Pharmacy.

CVS Maintenance Choice All Access:

If you take a maintenance medication, you are required to fill your 90-day supplies at CVS Pharmacy or CVS Caremark Mail Service Pharmacy. A maintenance drug is any medication taken on a regular basis for an extended period of time (i.e., for three months or more) such as those used to treat diabetes, high cholesterol or hypertension. There will be two 30-day supply grace fills allowed before you are required to fill maintenance medications in 90-day supplies at CVS Pharmacy or CVS Caremark Mail Service Pharmacy. By filling your 90-day supplies at CVS Pharmacy or CVS Caremark Mail Service Pharmacy, you're getting your medications at the lowest possible cost and meeting the requirements of your plan. You can also have your 90-day supplies delivered from a local CVS Pharmacy along with short-term medications (such as antibiotics). Choose On-Demand Delivery to get it within four hours for a small fee*. Or choose 1-2 day delivery to get it in 1-2 days from USPS, with no-cost shipping**. To request either delivery service, call your CVS Pharmacy or download the CVS Pharmacy app. If you need to transfer prescriptions from another pharmacy, you can do it online with just a few clicks at Caremark.com/MoveMyMeds.

*Most prescriptions eligible for delivery with qualifying health plans. Orders must be placed by 4 p.m. or four hours before pharmacy closing, whichever is earlier, to ensure delivery within same day. Order cut-off times and delivery fees apply. Delivery is limited to certain locations within a 10-mile radius of CVS Pharmacy locations, and as allowed by and in accordance with state guidelines and regulations. Participating locations only. Either the member or an agent of the member must be present at the delivery address to receive a prescription package. Your delivery is provided at a special rate as part of your prescription benefit plan. You will be notified of the fee before you prepay for your delivery order. Other restrictions apply, see www.cvs.com/RxDelivery or ask pharmacy staff for details.

**Most prescriptions eligible with qualifying health plans. Delivery period does not include Sundays or USPS holidays. Order cut-off times and delivery fees apply. Participating locations only. Delivery not available to every address. Delivery prices may vary from store prices. Coupons/promotions may not be available with delivery orders. Other restrictions apply. Ask pharmacy staff for details. Your delivery is provided at a special rate as part of your prescription benefit plan. You will be notified of the fee before you prepay for your delivery order. Other restrictions apply, see www.cvs.com/RxDelivery or ask pharmacy staff for details.

Expenses Not Covered CVS Caremark

If any expense not covered is contrary to any law to which the plan is subject, the provision is hereby automatically changed to meet the law's minimum requirement. No payment will be made under any portion of the plan for:

- Non-Federal Legend Drugs, Federal Legend Non-Drugs, and Non Federal Legend Non-Drugs, except as noted in the Covered Expenses section
- Cosmetic Drugs
- Periodontal Products
- Investigational Drugs
- Glucowatch Products
- Nutritional Supplements and Combo Nutritional Products
- Ostomy Supplies
- Compounded Medications of which at least one ingredient is a legend drug, except as noted in the Prior Authorization for Compound Drugs section
- Durable medical equipment
- Drugs administered in Hospitals

Certain new drugs and new indications for existing drugs, approved by the U.S. Food and Drug Administration (FDA) after the plan effective date, that exceed a minimum cost-effectiveness threshold established by the plan[1], unless the drug has been granted breakthrough therapy designation by the FDA. The plan threshold establishes a minimum value standard for prescription drugs measured by the benefit to patients through lengthening life or improving the quality of life.

Visit www.Caremark.com to check coverage for a specific medication

Note that, even if an expense is not covered by the Plan, you may obtain excluded drugs and supplies at your own expense.

CLAIMS PROCESS

Filing a Claim

Any participant or beneficiary under the Plan (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure. A claimant can obtain the necessary claim forms from the Claims Administrators. When the Claims Administrator receives your claim, it will be responsible for reviewing the claim and determining how to pay it on behalf of the Plan.

You may designate an authorized representative to handle the claim, or any subsequent appeal, on your behalf. To designate an authorized representative to act on a participant's or beneficiary's behalf with respect to a benefit claim, you (or your spouse or child) must submit a written request on a form approved by the Plan Administrator, which the participant or beneficiary signs and which authorizes the representative to act on their behalf with respect to

[1] *$100,000 per additional quality-adjusted life year for drugs not indicated in rare conditions and $150,000 per additional quality-adjusted life-year for drugs indicated in rare conditions*

the benefit claim. If a party is not properly designated as an authorized representative under Plan, the Plan Administrator will not communicate with that party with respect to any benefit claim or other exercise of a participant's or beneficiary's rights under the Plan. With respect to any urgent, pre-service, or concurrent care claim (discussed below), a participant's or beneficiary's treating physician or other health care professional may act as an authorized representative in exercising a participant's or beneficiary's rights under the Plan. The Plan will also recognize a court order giving a person authority to submit claims on a participant's or beneficiary's behalf. Any attempted assignment of benefits by a participant or beneficiary to a health care provider is void, and does not constitute a designation of an authorized representative for purposes of the Plan.

In general, when you need to file a claim use the addresses listed on the applicable claims form, or below. When your claim is received by the Claims Administrator, it will be reviewed and the Claims Administrator will determine how to pay your claim on behalf of the Plan. Claims forms are available from the Claims Administrator.

This section provides general information about the claims and appeals procedure applicable to the Plan under ERISA. The Plan will comply with additional claim and appeal rules if required under Health Care Reform. You will be notified if any of these new rules impact your claim.

Claim-Related Definitions

Claim

Any request for plan benefits made in accordance with the plan's claims-filing procedures, including any request for a service that must be pre-approved.

The Plan recognizes four categories of health benefit claims:

Urgent Care Claims

"Urgent care claims" are claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise. The Plan must defer to an attending provider to determine if a claim is urgent.

Pre-service Claims

"Pre-service claims" are claims for approval of a benefit if the approval is required to be obtained before a patient receives health care (for example, claims involving preauthorization or referral requirements).

Post-Service Claims

"Post-service claims" are claims involving the payment or reimbursement of costs for health care that has already been provided.

Concurrent Care Claims

"Concurrent care claims" are claims for which the Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments. A concurrent care claim may be treated as an "urgent care claim," "pre-service claim," or "post-service claim," depending on when during the course of your care you file the claim. However, the Plan must give you sufficient

advance notice of the initial claims determination so that you may appeal the claim before a concurrent care claims determination takes effect.

Adverse Benefit Determination

If the Plan does not fully agree with your claim, you will receive an "adverse benefit 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 characterized as experimental or investigational or not medically necessary or appropriate; and
- A concurrent care decision.

Initial Claim Determination

For each of the Plan options, the Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974 (ERISA). The period of time the Plan has to evaluate and respond to a claim begins on the date the Plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue.

The timeframes on the following pages apply to the various types of claims that you may make under the Plan, depending on the benefit at issue.

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

- The specific reasons for the adverse determination;
- The specific plan provisions on which the determination is based;
- A request for 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 an adverse benefit determination on review;
- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of 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, an explanation of the scientific or clinical judgment 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 orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice;
- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);
- A statement that diagnosis and treatment codes (and their meanings) will be provided upon request;

- A description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
- In addition to the description of the Plan's internal appeal procedures, a description of the external review processes; 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.

Benefit Determinations

Determinations on prescription drug benefits will be made by CVS Caremark in accordance with the Plan. You may request coverage beyond your plan's standard benefit offering, or if you are dissatisfied with a benefit determination made by CVS Caremark, you may appeal the determination in writing.

CVS Caremark
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ. 85072-2084
Fax: 1-866-689-3092

Appealing a Claim

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the time frames described below. The request must be made in writing, except for urgent care claims which you may file orally or in writing, and should be filed with the appropriate Claims Administrator. If you don't appeal on time, you lose your right to later object to the decision.

Medical coverage for you and your dependents will continue pending the outcome of an internal appeal. This means that the Plan will not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

The Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the Plan. In either case, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

You will be able to review your file and present evidence as part of the review. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. You also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the

Plan in connection with your adverse benefit determination. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

The Claims Administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure there is no conflict of interest with regard to the individual making the decision. 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. The Claims Administrator will ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications.

Prior to making a benefit determination on review, the Claims Administrator 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 Medical claim. This evidence will be provided at no cost to you, and will be given before the determination in order to give you a reasonable opportunity to respond. Prior to issuing a final internal adverse benefit determination on review based on a new or additional rationale, the rationale will be provided at no cost to you. It will be given before the determination in order to give you a reasonable opportunity to respond.

If the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to your Medical benefit claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may seek an external review or pursue legal remedies (as discussed below) without waiting for further Plan action. However, this will not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, you may resubmit your claim for internal review and you may ask the Plan to explain why the error is minor and why it meets this exception.

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

The Claims Administrator will provide you with written notification of the Plan's determination on review, within the time frames described in this SPD. For urgent care, all necessary information, including the benefit determination on review, will be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the Plan on which the 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 the claim for benefits;
- A description of your right to bring a civil action under ERISA following an adverse determination on review;
- A description of the voluntary appeals procedure under the Plan, if any, and your right to obtain additional information upon request about such procedures;
- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or

a statement that a copy of such information will be made available free of charge upon request; and
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

For Medical claim adverse benefit determinations, the notice will also include:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);
- A statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- A description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
- In addition to the description of the Plan's internal appeal procedures, a description of the external review processes; 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.

Unless the right to an external review applies under the Medical benefit plan, all decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

Appeals process for all claims other than member submitted paper claims:

In the event you receive an adverse determination following a request for coverage of a prescription benefit claim, you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. To initiate an appeal for coverage, you or your authorized representative (such as your physician), must provide in writing, your name, member ID, phone number, the prescription drug for which benefit coverage has been denied and any additional information that may be relevant to your appeal.

This information should be mailed to:

CVS Caremark
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ. 85072-2084
Fax: 1-866-689-3092

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request. The notice will include the specific reasons for the decision and the plan provisions on which the decision is based. You have the right to receive, upon request and at no charge, the information used to review your appeal.

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. To initiate a second level appeal, you or your authorized representative (such as your physician), must provide in writing, your name, member ID, phone number, the prescription drug for which benefit coverage has been denied and any additional information that may be relevant to your appeal. This information should be mailed to CVS Caremark at the address above. A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for

appeal. You have the right to receive, upon request and at no charge, the information used to review your second level appeal. The decision made on your second level appeal is final and binding.

If you are not satisfied with the decision of the second level appeal, you also have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) if your second level appeal is denied.

In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. An urgent care claim is any claim for treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed. If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim, of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 48 hours of receipt of the information.

You have the right to request an urgent appeal of an adverse determination if you request coverage of a claim that is urgent. Urgent appeal requests may be oral or written. You or your physician may call or send a written request to CVS Caremark FAX: 1-866-689-3092. In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. This coverage decision is final and binding. You have the right to receive, upon request and at no charge, the information used to review your appeal. You also have the right to bring a civil action under section 502(a) of ERISA if your final appeal is denied.

Appeals process for member submitted paper claims:

Your plan provides for reimbursement of prescriptions when you pay 100% of the prescription price at the time of purchase. This claim will be processed based on your plan benefit. You will receive an explanation of benefits within 30 days of receipt of your claim. If you are not satisfied with the decision regarding your benefit coverage, you have the right to appeal this decision in writing within 180 days of receipt of notice of the initial decision. To initiate an appeal for coverage, you or your authorized representative (such as your physician), must provide in writing, your name, member ID, phone number, the prescription drug for which benefit coverage has been reduced or denied and any additional information that may be relevant to your appeal. This information should be mailed to CVS Caremark at the address above or Faxed to: 1-866-689-3092. A decision regarding your appeal will be sent to you within 30 days of receipt of your written request. The notice will include the specific reasons for the decision and the plan provision on which the decision is based. You have the right to receive, upon request and at no charge, the information used to review your appeal.

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. To initiate a second level appeal, you or your authorized representative (such as your physician), must provide in writing, your name, member ID, phone number, the prescription drug for which benefit coverage has been reduced or denied and any additional information that may be relevant to your appeal. This information should be mailed to CVS Caremark at the address above or faxed to: 1-866-689-3092. A decision regarding your request will be sent to you in writing within 30

days of receipt of your written request for appeal. The decision made on your second level appeal is final and binding.

If you are not satisfied with the decision of the second level appeal, you also have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) if your second level appeal is denied.

Acts of Third Parties

When you or your coverd dependent 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, and you must follow special Plan rules. Refer to the SPD describing the plan option in which you are enrolled for the Plan's procedures with respect to subrogation and right of recovery.

Recovery of Overpayment

Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these expenses from any individual (including you, and the insurance company or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

Non-assignment of Benefits

Plan participants cannot assign, pledge, borrow against, or otherwise promise any benefit payable under the Plan before receipt of that benefit. However, benefits will be provided to a participant's child if required by a Qualified Medical Child Support Order. In addition, subject to the written direction of a Plan participant, all or a portion of benefits provided by the Plan may, at the option of the Plan, and unless a participant requests otherwise in writing, be paid directly to the person rendering such service. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan and AXA XL to the extent of such payment.

Misstatement of Fact

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

ADMINISTRATIVE INFORMATION

Below is key information you need to know about your benefit plans:

Plan Name	XL America, Inc. Health and Welfare Plan
Plan Number	501
Plan Sponsor	AXA XL 70 Seaview Avenue Stamford, CT 06902
Employer Identification Number	06-1516268
Plan Administrator	AXA XL 70 Seaview Avenue Stamford, CT 06902
Agent for Service of Legal Process	Plan Administrator
Plan Year	January 1 through December 31
Plan Type	Welfare benefit plan providing prescription drug benefits.
Source of Contributions	The cost of medical coverage (including prescription drug coverage) is shared by AXA XL and its enrolled employees. AXA XL contributes the difference between the amount employees contribute and the amount required to pay benefits under the Plan. The Plan Administrator will notify employees annually as to what the employee contribution rates will be. AXA XL in its sole and absolute discretion, shall determine the amount of any required contributions under the Plan and may increase or decrease the amount of the required contribution at any time. Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract shall be applied first to reimburse AXA XL for their contributions, unless otherwise provided in that group insurance contract or required by applicable law.

Plan Document

This document is intended merely as a summary of the official Plan document(s). In the event of any disagreement between this summary and the official Plan document(s), as they may be amended from time to time, the provisions of the Plan document(s) will govern.

Plan Amendment and Termination

AXA XL reserves the right to amend the Plan in whole or in part or to completely discontinue the Plan at any time. For example, AXA XL reserves the right to amend or terminate benefits, covered expenses, benefit copays, lifetime maximums, and reserves the right to amend the Plan to require or increase employee contributions. AXA XL also reserves the right to amend the Plan to implement any cost control measures that it may deem advisable.

Any amendment, termination or other action by AXA XL will be done in accordance with AXA XL's normal operating procedures. Amendments may be retroactive to the extent necessary to comply with applicable law. No amendment or termination shall reduce the amount of any benefit otherwise payable under the Plan for charges incurred prior to the effective date of such amendment or termination.

In the event of the dissolution, merger, consolidation or reorganization of AXA XL, the Plan shall terminate unless the Plan is continued by a successor to AXA XL

If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to AXA XL to the extent permitted under applicable law, unless otherwise stated in the applicable Plan document.

Plan Administration

AXA XL is responsible for the general administration of the Plan, and will be the fiduciary to the extent not otherwise specified in this SPD, the Plan document or in a Benefit Booklet. AXA XL has the discretionary authority to construe and interpret the provisions of the Plan and make factual determinations regarding all aspects of the Plan and its benefits, including the power to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the Plan, and to remedy ambiguities, inconsistencies or omissions. Such determinations shall be conclusive and binding on all parties. A misstatement or other mistake of fact will be corrected when it becomes known, and AXA XL will make such adjustment on account of the mistake as it considers equitable and practicable, in light of applicable law. Neither the Plan Administrator, nor AXA XL will be liable in any manner for any determination made in good faith.

AXA XL may designate other organizations or persons to carry out specific fiduciary responsibilities for AXA XL in administering the Plan including, but not limited to, the following:

- Pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the Plan, including the processing and payment of claims under the Plan and the related recordkeeping,
- The responsibility to prepare, report, file and disclose any forms, documents, and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan, and
- The responsibility to act as Claims Administrator and to review claims and claim denials under the Plan to the extent an insurer or administrator is not empowered with such responsibility.

AXA XL will administer the Plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated.

Questions

If you have general questions regarding your medical coverage, please contact the Plan Administrator. However, if you have specific questions concerning your prescription drug coverage, such as what's covered or excluded, please Contact CVS Caremark. You may also use the contact information on the back of your CVS Caremark ID card.

ERISA

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

Receive Information about Your Plan and Benefits

You can:

- Review at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, insurance contracts, Benefit Booklets, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. There is no charge for this review.
- Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including Benefit Booklets and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any is required to be prepared by ERISA. The Plan Administrator is required by law to furnish each participant with a copy of any required summary annual report (SAR).

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse and/or dependent child(ren) if there is a loss of coverage under the Plan because of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description for the medical plan option in which you are enrolled and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a 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 (if any) from the Plan and do not receive them within 30 days, you may file suit in

a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.