

Prescription Drug Benefits Summary

Illumina, Inc.

Effective: January 1, 2026

Prescription Drug Benefits Summary

Illumina's (the "Plan Sponsor") Prescription Drug Plan (the "Plan") is administered by CVS Caremark.

If you enroll in the medical plan, you automatically have prescription drug coverage.

This benefits summary outlines the provisions of the Plan in effect as of January 1, 2026. Please read the information in this benefit summary carefully and share it with your family. Keep this in a convenient location so you can refer to it whenever necessary, and, when notified when changes are made to the benefit plans. Please keep those notifications with this benefit summary.

All benefits and coverages described in this benefits summary are effective as of January 1, 2026 and are subject to the terms of the plan document under which the Plan is provided. If there is any conflict between this benefit summary and the plan documents, the plan documents will always govern.

Illumina reserves the right to amend any of the programs and arrangements described in this benefits summary (including changing the method of providing benefits and curtailing or reducing future benefits) or to terminate at any time for any reason, any or all the programs and arrangements herein described.

Neither this benefits summary nor the benefits described herein constitute a contract of employment or a guarantee of employment between Illumina and any employee.

Illumina intends to continue this Plan, but reserves the right, in its sole discretion, to change, interpret, withdraw, or add Benefits, or to end the Plan, as permitted by law, without your approval, subject to any collective bargaining agreements, if applicable.

The Plan will take effect on January 1, 2026. Coverage under the Plan starts at 12:01 a.m. and ends on December 31, 2026 at 12:00 midnight in the time zone of the Plan Sponsor's location.

On its effective date, the benefits summary replaces and overrules any prior version that the Plan Sponsor may have previously issued to you.

Contents

Prescription Drug Benefits Summary2

How the Prescription Drug Program Works4

 Eligibility.....4

 Enrolling, Making Changes when Coverage Ends, and Continuation Rights4

Your Member Identification Card (ID)5

Your Prescription Drug Coverage6

 Brand-Name and Generic Drugs.....7

 Using a Retail Network Pharmacy.....8

 Filling Long-Term Prescriptions.....8

 Using a Retail Non-Network Pharmacy9

 Specialty Pharmacy9

 Accumulator Adjustment Program for Specialty Medications10

 PrudentRx Program10

 Clinical Coverage Review and Drug Limitations11

 Compound Prior Authorization12

 Opioid Management Program12

 Preventive Services12

 Cost Saver13

 What is Covered?13

 What is Not Covered?14

Right of Appeal.....15

 Other Resources.....16

If You Are Covered by More than One Plan.....17

 Does This Plan Have the Right of Recovery?17

General Information and Disclaimers about Your Prescription Drug Plan Coverage18

Your Rights under ERISA.....19

How the Prescription Drug Program Works

Eligibility

Who Is Eligible for Coverage?

The Plan Sponsor determines who is eligible to enroll and who qualifies as a Plan participant. This includes determining eligibility for Employees and their Dependents (e.g., spouses, domestic partners, children).

For more information, including the specific eligibility parameters for Employees and their Dependents, as well as any requirements to verify eligibility of your Dependents, see the Aetna Summary Plan Description (SPD).

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.

Enrolling, Making Changes when Coverage Ends, and Continuation Rights

When Do You Enroll and When Does Coverage Begin?

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

Please refer to the Medical SPD (and Wrap ERISA SPD, if applicable) for enrollment requirements and information as well as information related to coverage effectiveness (e.g., when coverage begins, ends).

Making Changes During the Year

Please refer to the Medical SPD (and Wrap ERISA SPD if applicable) for when coverage can be changed midyear (e.g., due to midyear change-in-status events, leaves of absence).

When Coverage Ends

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

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

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 qualified medical child support order (QMCSO), coverage will end as of the date that the child is no longer covered under the 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.

For more details on when coverage ends, see the Aetna SPD.

Continuation of prescription drug coverage

If your coverage ends under the Prescription Drug Plan, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Plan Sponsors that are subject to the terms of COBRA. Contact your plan administrator to find out if your Plan Sponsor is subject to the provisions of COBRA. If subject to COBRA, more details regarding your rights and responsibilities are available under the Aetna SPD.

Your Member Identification Card (ID)

When you enroll in a medical plan, you will automatically receive an ID card from Aetna with CVS Caremark information included. You must present your ID card to the network pharmacy every time you get a prescription filled to be eligible for network benefits. The network pharmacy will calculate your claim online. You will pay any Copayment Amount directly to the network Pharmacy. You do not have to complete or submit claim forms. The network pharmacy will take care of claim submission.

The card offers a convenient way of providing important information specific to your coverage including, but not limited to, the following:

- Your Subscriber identification number. This unique number identifies you as a participant in the prescription drug program with CVS Caremark.
- The Group number is RX25FN
- The BIN number is 004336
- The PCN number ADV

The above information identifies your prescription drug program with CVS Caremark.

CVS Caremark's Customer Service Toll-Free Number is 1-833-728-2550.

Any time a change in your family takes place, it may be necessary for a new ID card to be issued to you. Fraudulent, unauthorized, abusive, or intentionally improper use of ID cards by any participant may result in sanctions being applied to all participants covered under your coverage including but not limited to:

- Denial of benefits.
- Cancellation of coverage under the Plan for all participants under your coverage.
- Limitation on the use of the Identification Card to one designated Participating Pharmacy of your choice.
- Recovery from you or any of your covered Dependents of any benefit payments made.
- Prior authorization of drug purchases for all participants receiving benefits under your coverage.
- Notice to proper authorities of potential violations of law or professional ethics.

Fraudulent, unauthorized, abusive or intentionally improper use of ID cards issued to you and your covered Dependents may include: use of the ID card before your effective date (or after your termination of coverage under the Plan); obtaining drugs for resale or use by someone other than the person for whom the Prescription Order is written (even if the person is covered under the Plan); obtaining Covered Drugs without a Prescription Order or through the use of a forged or altered Prescription Order; circumventing the quantity limitations of the Plan; using Prescription Orders for the same drugs from multiple Providers; and using the same Prescription Order at multiple pharmacies.

Your Prescription Drug Coverage

The Plan is managed by CVS Caremark and covers prescription drugs that are approved by the U.S. Food and Drug Administration (FDA). When you need to fill a prescription, you can:

- Go to a network pharmacy, or
- Use the mail order delivery service, or
- Go to a non-network pharmacy.

Below is a summary of the prescription drug coverage under each medical option.

Prescription Drug Plan	PPO	HDHP
Annual Plan Deductible	N/A individual N/A family	\$1,700 individual \$3,400 family
Annual Out-of-Pocket Maximum (integrated with medical)	\$3,000 individual \$6,000 family	\$4,000 individual \$6,550 family

Prescription Drug Plan	PPO	HDHP
Retail from a Network Pharmacy (up to 31-day supply)	Generic: \$10.00 Preferred brand: \$30.00 Non-preferred brand: \$50.00	After meeting the medical plan deductible ² , you pay: Generic: \$5.00 Preferred brand: \$20.00 Non-preferred brand: \$40.00
Retail 90 from a Network Pharmacy¹ (up to 90-day supply)	Generic: \$20.00 Preferred brand: \$60.00 Non-preferred brand: \$100.00	After meeting the medical plan deductible ² , you pay: Generic: \$10.00 Preferred brand: \$40.00 Non-preferred brand: \$80.00
Mail Order Pharmacy¹ (up to a 90-day supply)	Generic: \$20.00 Preferred brand: \$60.00 Non-preferred brand: \$100.00	After meeting the medical plan deductible ² , you pay: Generic: \$10.00 Preferred brand: \$40.00 Non-preferred brand: \$80.00
Specialty Medications^{3, 4} (up to 31-day supply)	30%	After meeting the medical plan deductible ² , you pay: 30%

1. 90-day prescriptions may be filled at CVS Pharmacy, Costco, Kroger affiliates and CVS Caremark Mail Order pharmacy.
2. The HDHP Plan includes a "Preventive Drug List," which is a list of medications to which the plan's deductible does not apply.
3. If a member enrolls in PrudentRx for Specialty Medications, medications will be covered at \$0 cost share.
4. If a specialty medication is not on the PrudentRx Drug List, the applicable retail or mail order cost-share will apply.

Medical and prescription drug costs count toward a single out-of-pocket maximum. Once you reach the annual out-of-pocket maximum, you do not have to pay anything further for your covered medications for the rest of the year. There is one combined annual out-of-pocket maximum for both medical benefits and prescription drug benefits.

Brand-Name and Generic Drugs

Generic drugs have the same active ingredients in the same dosage form and strength as their brand-name counterparts. The color and shape may differ between the generic and the brand drug; however, the active ingredients must be the same for both. The U.S. Food and Drug Administration (FDA)

approves both brand and generic drugs and requires generics to have the same active ingredients and be absorbed in the body the same way as brand-name drugs. These requirements assure that generic drugs are as safe and effective as brand drugs. The formulary (the list of preferred drugs) chosen by the Plan contains only FDA-approved generic medications.

The formulary changes from time to time as new clinical information becomes available. To determine the status of any drug on the Plan's formulary, go to www.caremark.com or contact customer service at 1-833-728-2550. A medication's inclusion on the formulary is no guarantee of effectiveness. Similarly, if a medication is not on the formulary, it does not mean it is not effective, but rather that a clinically equivalent and more cost-effective alternative is available and on the formulary.

Using a Retail Network Pharmacy

Network pharmacies have agreed to accept lower, negotiated fees than non-network pharmacies. When you need to fill a prescription, go to a network pharmacy and present your prescription drug ID card. To find a network pharmacy near you or to see if your pharmacy is part of the network, go to www.caremark.com or contact CVS Caremark's customer service at 1-833-728-2550 .

- Short-term prescriptions are covered through a retail pharmacy
- If a pharmacy's price is less than the coinsurance or copay you would pay for that drug, you'll pay the lower price. For example, if the actual cost of a generic medication is \$3.50, but your copay is \$10.00, you will pay \$3.50.

Filling Long-Term Prescriptions

Some examples of long-term maintenance drugs are those used to control or treat:

- Arthritis
- High cholesterol
- Diabetic conditions, and
- High blood pressure.

Mail Order

With this service, you can order up to a 90-day supply of maintenance drugs and have them delivered to your home.

In order to fill your prescription through CVS Caremark Mail Order, ask your doctor to send an electronic prescription to CVS Caremark Mail Service Pharmacy; or request that CVS Caremark contact your doctor and get the process started for you by calling CVS Caremark at 1-833-728-2550. To start online, visit www.caremark.com and select *Start Rx Delivery by Mail*.

CVS Maintenance Choice Program

The CVS Maintenance Choice Program is a money-saving feature that makes it easy for you to pick up a 90-day supply of your maintenance medication at all CVS Pharmacies, Costco, and Kroger affiliates. You pay less for each 90-day supply than you would pay for three 30-day supplies. You will also make fewer trips to the pharmacy and you only need to make one payment every three months.

To begin using the CVS Maintenance Choice Program, get a 90-day prescription from your physician for your maintenance medication.

Contact Member Services at 1-833-728-2550 or visit www.caremark.com to find the nearest participating Maintenance Choice pharmacy.

Using a Retail Non-Network Pharmacy

If you purchase your prescription drugs through a non-network pharmacy or do not show your prescription drug identification (ID) card at a network pharmacy, you will have to pay for the prescription and then file a claim form for reimbursement. The Plan will pay benefits based on the amount it would have paid to a network pharmacy. You will pay the difference between what the non-network pharmacy charges and the Plan's benefit payment.

Claim forms are available at www.caremark.com. You can mail your completed claim form to the address listed on the form.

If you have any questions about filing a claim, call Member Services at 1-833-728-2550 or visit www.caremark.com to submit your claim online.

Specialty Pharmacy

Complex conditions, such as anemia, hepatitis C, multiple sclerosis, asthma, cancers and rheumatoid arthritis, are treated with specialty medications. Specialty medications can be injectable medications administered either by you or a healthcare professional and they often require special handling. If you use specialty medications, you'll have access to the services offered by CVS Specialty Pharmacy at 1-866-782-2779 or www.cvsspecialty.com. CVS Specialty Pharmacy provides not only your specialty medicines, but also personalized Pharmacy care management services including:

- Safe, prompt delivery. CVS Specialty Pharmacy will schedule and quickly ship all your specialty medications, including those that require special handling such as refrigeration.
- Personalized care. You'll have access to a team of specialty-trained pharmacists, nurses and patient-care representatives who are trained in your condition.
- Supplies. Most supplies, such as syringes, needles and sharps containers, will be provided with your medication.

- Support – 24/7. CVS Specialty's specialty-trained pharmacists and nurses are available around the clock to answer your questions. The CVS Specialty team can assist in managing side effects.
- Refill reminders. CVS Specialty will contact you regularly to schedule your next refill and see how your therapy is progressing. For convenience, some specialty medication refills can be ordered online, safely and securely, through www.cvsspecialty.com.
- Drug safety monitoring. As a CVS Caremark pharmacy, CVS Specialty pharmacies can access your prescription information on file at all CVS Caremark pharmacies to monitor for potential drug interactions and side effects of your medications.
- Online support and resources through www.cvsspecialty.com including condition-specific information and the specialty Pharmacy drug list.

Accumulator Adjustment Program for Specialty Medications

The CVS Caremark True Accumulation Program disallows coupon dollars from manufacturer copay assistance programs for Specialty medications from applying to your annual accumulators (out-of-pocket maximum and deductible, if applicable).

PrudentRx Program

The PrudentRx Copay Program assists you by helping you enroll in manufacturer copay assistance programs. Medications on the PrudentRx specialty drug list and exclusively dispensed by CVS Caremark's specialty network are included in the program and will be subject to a 30% coinsurance. However, if you enroll in the PrudentRx Copay Program, you will receive a copay card for your specialty medication (if applicable), and you will have a zero dollar (\$0) cost share for your prescriptions covered under the Program.

PrudentRx will assist you in obtaining copay assistance from drug manufacturers to reduce your cost share for eligible medications thereby reducing your out-of-pocket expenses.

For HDHP, all medications on the PrudentRx Program Drug List qualify as Essential Health Benefits under the Affordable Care Act (ACA). 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. Payments made by you for all medications covered under the PrudentRx Solution will count toward your deductible and ACA out-of-pocket maximum.

If you currently take one or more specialty medications included on the PrudentRx Program Drug List, or are prescribed one in the future, you will be contacted by PrudentRx, and they will assist you in enrolling in manufacturer copay assistance for 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.

If you opt out of the PrudentRx Copay Program, or do not affirmatively enroll in any copay assistance, you will be responsible for 30% coinsurance on specialty medications that are eligible for the PrudentRx program. Copayments for these medications, whether made by you, your plan, or a manufacturer's copay assistance program, will not count toward your plan deductible (if applicable). Also, 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 your or a manufacturer copayment assistance program, do not count towards the Plan's out of pocket maximum.

The PrudentRx Program Drug List may be updated periodically and may be found online at www.caremark.com.

Clinical Coverage Review and Drug Limitations

Prior Authorization

Some drugs may require pre-authorization. If the necessary pre-authorization is not obtained, the drug may not be covered. If a pharmacist tells you that a prescription requires pre-authorization, CVS Caremark will need to communicate with the doctor to be sure that the medicine is right and will verify that the Plan covers the drug.

When a prescription requires pre-authorization, the doctor can contact CVS Caremark to prescribe a different medicine that is covered by the Plan or start a pre-authorization on your behalf. Only the prescriber can give CVS Caremark the information needed to determine if the drug may be covered. If the medicine is approved, you will pay the normal copay. If the medication is not covered but you want to take it, you will pay the full price of the medicine.

Step Therapy

Your plan uses utilization management programs that require you try one or more drugs before another drug will be covered.

Step Therapy is a program for people who take prescription medicine regularly to treat a long-term condition, such as arthritis, asthma or high blood pressure. It lets you get the treatment you need affordably. First-line medicines are the first step.

- First-line medicines are generic and lower-cost brand-name medicines approved by the U.S. Food & Drug Administration (FDA). They are proven to be safe, effective and affordable. Step therapy suggests that a patient try these medicines first because, in most cases, they provide the same health benefit as more expensive drugs, but at a lower cost.
- Second-line medicines are the second and third steps. Second-line drugs typically are brand-name drugs. They are best suited for the few patients who do not respond to first-line medicines. Second-line drugs are the most expensive options.

Quantity Limits

Quantity Limits are in place to make sure that you are getting the right amount of medication and that it is prescribed in the most efficient way. For example, your doctor may say, “take two 20mg pills each morning.” If that medication is also available in 40mg pills, CVS Caremark will notify the pharmacy about contacting the prescriber for one 40mg pill a day instead of two 20mg pills. In addition, if your doctor writes the original prescription for 30 pills (a 15-day supply), the new prescription for 30 pills will last a full month — and you will have just one copayment, not two.

Quantity Limits also make sure that your prescriptions do not exceed the amount of medication that the Plan covers. If the prescription is for too large a quantity, the pharmacist can fill the prescription for the amount that the Plan covers or contact the doctor to discuss other options, such as increasing the strength or getting a prior authorization for the quantity originally prescribed.

Compound Prior Authorization

The Plan currently participates in CVS Caremark’s Compound Prior Authorization Program. Prior Authorization is required for compounded prescriptions that cost more than \$300.

Opioid Management Program

CVS Caremark’s Opioid Management Program limits the quantity of opioids, requires step therapy, and is designed to (i) help improve management of opioid use; and (ii) reduce potential misuse/abuse. It is aligned with the Guideline for Prescribing Opioids for Chronic Pain issued by the Centers for Disease Control and Prevention (CDC). The Opioid Management Program uses the CDC criteria of Morphine Milligram Equivalent (MME) to limit the quantity of opioid products. Prior authorization requests can be made if your doctor believes the dose should exceed the MME within the CDC recommendation. The Opioid Management Program is not intended to be applicable to cancer treatment or palliative end-of-life care.

Preventive Services

The Patient Protection and Affordable Care Act (PPACA) contains a provision to make certain preventive services available without cost-sharing to the member. Any plan exclusions, formulary, or utilization management status would be overridden by the adoption of one or more of the following categories. The CVS Caremark standard drug coverage recommendations include information regarding suggested patient demographics that would be applicable to each drug therapy. The following preventative items and services are covered at no cost to you under your pharmacy plan.

- Aspirin products
- Fluoride products

- Folic acid & prenatal vitamins
- Tobacco smoking cessation products
- Immunizations
- OTC contraceptives
- Prescription contraceptives
- Contraceptive devices – diaphragms, cervical caps, IUD, implants
- Bowel prep agents for colorectal cancer screening
- Breast cancer – primary preventive
- Statins
- Pre-exposure prophylaxis (PrEP) – prevention of HIV infection

Cost Saver

Your CVS Caremark benefits include Cost Saver, which is a tool that ensures that you always pay the lowest prescription drug price. If there is a lower price available outside of the insurance benefit (i.e., through a discount card like GoodRx), Cost Saver automatically applies that price and the amount you pay counts towards your annual deductible and out-of-pocket maximums. Some limitations apply.

What is Covered?

The Plan covers most prescription drugs approved by the U.S. Food and Drug Administration (FDA) for outpatient care. The following list includes covered prescription drugs. Certain over-the-counter medications may be covered when prescribed by a physician. For the most current information on the types of drugs covered under the Plan, please visit www.caremark.com or contact CVS Caremark's customer service at 1-833-728-2550.

This list may change at any time:

- Federal legend drugs (other than those identified as not covered).
- State restricted drugs.
- Medications of which at least one ingredient is a legend drug (other than those identified as not covered).
- Insulin.
- Needles and syringes.

- Certain over-the-counter medications and supplies, such as diabetic supplies, fluoride, contraceptives for women, and bowel evacuants when prescribed by a physician.
- Legend and over-the-counter smoking deterrents for participants age 18 and older.
 - Get a prescription for these products from your doctor, even if the products are sold over the counter (OTC).
- Oral contraceptives and devices.
- Contraceptive jellies, creams and foams if FDA-approved and prescribed by your physician.
- Emergency contraceptives.
- Immunization agents and vaccines.
- Certain self-injectables.
- Medications to treat impotency (subject to certain restrictions).

What is Not Covered?

The following are excluded under your prescription drug plan:

- Abortifacients.
- Allergy serums (injectable and non-injectable).
- Blood components (Hemophilia and hereditary angioedema are not included in this category).
- Bulk chemicals.
- Cosmetic alteration drugs (e.g. hair loss, anti-wrinkle, hair removal creams, Botox, Latisse, etc.)
- Diagnostic agents (unless brought in by drug coverage section).
- Digital therapies.
- General anesthetics.
- Multi-vitamins.
- Multi-vitamins with fluoride.
- Multi-vitamins with iron.
- OTC products (unless brought in by drug coverage section).
- Repackaged products.

- Surgical supply/medical devices (unless brought in by drug coverage section).
- Oral and injectable fertility medications.
- Homeopathics.
- Electrolyte replacement products.
- Nutritional supplements.
- Dietary management.
- Respiratory therapy supplies (nebulizers, peak flow meters, spacers)
- Vision agents.
- Traditional insulin pumps (disposable insulin pumps and supplies for personal use are covered).

Right of Appeal

Can I appeal this decision?

Yes. You, your provider, or an appointed representative like an attorney or family member can file a standard (non-urgent) or urgent appeal within 180 calendar days from the date of this decision. Otherwise, this decision will be final. Urgent appeals may be submitted by phone or in writing. Standard (non-urgent) appeals may be submitted in writing by fax or mail.

Appeal requests – Mail
Caremark, Inc.
Appeals Department, MC 109
P.O. Box 52084
Phoenix, AZ 85072-2084

Appeals requests – Fax
ATTN: Appeals Department
866.443.1172

Specialty appeal requests – Mail
CVS Caremark, Inc.
Specialty Guideline Management Appeals Department
800 Biermann Court Ste. B.
Mt. Prospect, IL 60056

Specialty appeals requests – Fax
ATTN: Appeals Department
855.230.5548

How long does the appeal process take?

Standard (non-urgent) appeals can take up to 30 calendar days from when your request is received. You will receive written notice of the decision.

What if my appeal is urgent?

In some cases, urgent appeals can be reviewed, and a decision could be made within 72 hours. Generally, you can request an urgent decision for these reasons:

- Life, health or ability to function would be in jeopardy based on layperson's judgement.
- You may be subject to severe pain without the treatment or care requested in the opinion of a clinician who is aware of your condition.

Other Resources

You and your plan may have other ways to get help with, resolve, or dispute this decision.

Where can I go for more help or to file a complaint?

U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Ave., NW Washington, DC 20210

(866) 4-USA-DOL (866-487-2365)
<http://www.dol.gov/ebsa/>

Can I have an External Review of this Decision?

A Plan member whose Claim Involving Medical Judgment or the rescission of coverage is denied may request, in writing, an External Review of such Claim within four months after receiving notice of the Final Internal Adverse Benefit Determination. The member's request should include the member's name, contact information including mailing address and daytime phone number, member ID number and a copy of the coverage denial. The member's request for External Review and supporting documentation may be mailed or faxed to CVS Caremark:

CVS Caremark
External Review Appeals Department, MC 109
P.O. Box 52084
Phoenix, AZ 85072-2084
866.443.1172 (fax)

If You Are Covered by More than One Plan

If you or a covered dependent has coverage under the Plan and coverage under another prescription drug plan, benefits under the Plan are coordinated with those provided by the other plan so that your combined coverage doesn't exceed the provider's fees for eligible expenses.

Does This Plan Have the Right of Recovery?

Overpayment and Underpayment of Benefits

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

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

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

Refund of Overpayments

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

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

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

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payment in connection with services provided to persons under other

plans for which CVS Caremark processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- Equal the amount of the required refund, or
- If less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.
- The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

General Information and Disclaimers about Your Prescription Drug Plan Coverage

Fraud or Intentional Misrepresentation of a Material 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.

If you or your dependent(s) receive benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation, you may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. If you make any intentional misrepresentation or use fraudulent means concerning eligibility for coverage, changing your existing coverage, or benefits under the Plan, your coverage (and your dependents' coverage) may be terminated irrevocably (retroactively to the extent permitted by law), and could be grounds for discipline up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

Source of Contributions

Your contribution amount under the Plan depends on the Medical benefit you select, the family members you choose to enroll, and the extent to which the Plan Sponsor shares in the cost. You can obtain current contribution rates by calling the Plan Sponsor.

Your contributions are subject to review and the Plan Sponsor reserves the right to change your contribution amount from time to time.

Employer Right to Rebates

For any refund, rebate, dividend, experience adjustment, or other similar payment under the prescription drug Plan benefit that the Plan Administrator receives, the funds shall be applied first to reimburse [Client Name] for their contributions and/or to pay reasonable Plan expenses, unless otherwise provided under Plan agreement or as required by applicable law.

Non-Assignment of Benefits

Generally, benefits under the Prescription Drug Plan may not be sold, transferred, pledged or assigned except as permitted by law. In certain situations, however, court orders (including qualified medical child support orders and qualified domestic relations orders) may require benefits to be provided for a certain individual or individuals, typically an employee's family member.

Change or Termination of the Plan

The Plan Sponsor reserves the right to amend, modify, suspend or terminate the Prescription Drug Plan in whole or in part, subject to applicable legal and contractual agreements, at any time and for any reason, regardless of your status at the time of the change.

A decision to terminate, amend or replace the Plan may be due to changes in federal law or state laws governing benefits, the requirements of the Internal Revenue Service (IRS) or ERISA or for any other reason. This may include elimination of or decreases in benefits, changes in Plan networks and/or increases in your required contributions for coverage. If the Plan is terminated or changed, you'll still be paid any benefits you were entitled to receive under the terms of Plan, up to the cancellation date or date of the change.

Employment Rights Not Implied

This benefits summary is for your information only; it is not a binding contract, nor does it impose any legal obligation upon the Plan Sponsor. The plan and the benefits described in this benefits summary do not imply or create a contract or guarantee of continued employment between the Plan Sponsor and any individual. Employment with the Plan Sponsor (or, if applicable any of its affiliated employers) is "at will" and may be terminated by either party at any time, with or without cause or notice, except as provided by the terms of any applicable collective bargaining agreement. This provision applies to all employees regardless of their hire date.

Participation in the prescription drug benefits doesn't give you a right to any benefit to which you're not entitled under the terms of the Plan.

Your Rights under ERISA

As a participant in the Prescription Drug Plan, you're entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants are entitled to each of the rights described here.

Receive Information about Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, upon request, 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, if any is required to be prepared under ERISA.

Continue Group Prescription Drug Plan Coverage

You may continue healthcare coverage for yourself, your spouse/domestic partner or your 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 the summary plan description for the Plan in which you are enrolled and the documents governing the Plan on the rules governing your COBRA 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 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, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a 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 from the Plan and don't 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 weren't sent because of reasons beyond the administrator's control. If you have a claim for benefits which is denied or ignored, in whole or in part and you have exhausted the claims procedures available to you under the Plan, 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 domestic relations order or a medical child support order, you may file suit in a federal court, after exhausting the Plan's claim and appeals procedures. If it should happen that Plan fiduciaries misuse the Plan's money, or if you're 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, after exhausting the Plan's claims and appeals procedures. The court will decide who should pay court costs and legal fees. If you're successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

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.