

CVS Caremark
Wellness Plan for Non-Enrolled Colleagues

MinuteClinic Wellness Services

Summary Plan Description

Effective June 1, 2014

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INTRODUCTION

In order to support the health and wellness of its employees, beginning June 1, 2014, CVS Caremark is implementing a wellness program – known as the CVS Caremark Wellness Plan for Non-Enrolled Colleagues (the “Wellness Program”) – that provides access to certain wellness and preventive care services at MinuteClinics for employees who are not enrolled in a CVS Caremark medical plan.

This document constitutes the Summary Plan Description and plan document for the Wellness Program. The Wellness Program is also a component plan under The CVS Caremark Welfare Benefit Plan.

WHEN COVERAGE BEGINS AND ENDS

Eligibility

The Wellness Program is available to “non-enrolled” employees – meaning employees of CVS Caremark or a related company or business division that participates in the Wellness Program (referred to herein as “CVS Caremark”) who are not enrolled in a CVS Caremark medical plan. This means that all employees of CVS Caremark who are not participating in a CVS Caremark group medical plan are eligible to participate in the Wellness Program, such as:

- CVS Caremark employees who are not eligible for CVS Caremark medical plan coverage, which may include part-time employees, seasonal and temporary employees employed by CVS Caremark (other than through an agency), and employees subject to collective bargaining agreements, and
- CVS Caremark employees who are eligible for CVS Caremark medical plan coverage but are not enrolled in such coverage.

If you are employed by MinuteClinic, LLC or a MinuteClinic entity, you are not eligible to participate in the Wellness Program.

In addition, an eligible employee does not include any individual who CVS Caremark regards, classifies or treats as a leased employee or staffing, payroll or temporary agency employee, independent contractor, or consultant, even if such person is later determined by a court, regulatory body, or administrative agency to be or have been a common law employee.

The Wellness Program is maintained for the benefit of eligible employees only. **Spouses, domestic or civil union partners and dependents are not eligible to participate in the Wellness Program.**

If you terminate employment with CVS Caremark, or your work status changes so that you are no longer classified as an eligible employee, you will no longer be eligible for the Wellness Program (other than through a valid election of COBRA continuation coverage, discussed below). You will become eligible for the Wellness Program benefits when you meet the eligibility requirements again.

If the Plan Administrator determines that a benefit was paid under the Wellness Program in error (for example, if you are provided coverage under the Wellness Program and you are not an eligible employee), you may be required to repay the cost of the improperly covered benefits to the Wellness Program.

When Coverage Begins

If you are an eligible employee as of June 1, 2014, your Wellness Program coverage will begin on that date.

If you become an eligible employee after June 1, 2014, your coverage will begin on the date you become an eligible employee.

Automatic Enrollment

If you are an eligible employee, you will automatically be enrolled in the Wellness Program at no cost to you.

Accessing Benefits

To take advantage of the Wellness Program benefits, you may visit your local MinuteClinic or visit the MinuteClinic website, www.minuteclinic.com, to find a clinic location near you and to learn about the available benefits.

MinuteClinic visits to access a benefit covered by the Wellness Program will be accommodated based on availability. You should follow the normal procedures for checking in for services at the MinuteClinic of your choice.

When Coverage Ends

Your coverage under the Wellness Program will end on the earlier of:

- The date you cease to be an eligible employee (for example, if you enroll in a CVS Caremark medical plan);
- The date that your employment with CVS Caremark terminates; or
- The date the Wellness Program is terminated.

Under some circumstances, you may be able to continue coverage through COBRA continuation coverage. See the COBRA Continuation Coverage section below.

COST OF COVERAGE

There are no CVS Caremark payroll deductions for coverage under the Wellness Program, and there are no charges to you for services covered under the Wellness Program.

If you have health insurance coverage, MinuteClinic will bill your health insurance coverage for the services provided under the Wellness Program. If there are any out-of-pocket costs under your health insurance plan for the Wellness Program benefits, the Wellness Program will cover such out-of-pocket costs. You will not be asked to provide payment upon visiting a MinuteClinic for any of the Wellness Program benefits described below.

WELLNESS PROGRAM BENEFITS

If you are an eligible employee, the Wellness Program covers the following services at MinuteClinic locations:

1. Flu Shots

The Wellness Program covers your annual flu shot at MinuteClinic.

2. MinuteClinic Weight Loss Program

The Wellness Program covers your participation in the MinuteClinic Weight Loss Program, as follows:

- An Initial Weight Assessment Visit at which a MinuteClinic health care practitioner will perform a risk assessment, check your vital signs and measure your body mass index and waist circumference.
- During the Initial Weight Assessment Visit, a MinuteClinic health care practitioner will also review your lifestyle, goals and physical health, and create a personalized plan to help you lose weight and improve your overall health.
- Membership to DASH for Health™, an online resource to help you stay on course in-between visits to MinuteClinic.
- Follow-up visits for personalized coaching and medical evaluation to help you on your weight loss journey. The number of follow-up visits will be determined by the MinuteClinic health care practitioner in his/her sole discretion and will be based on the health care practitioner's determination as to your individualized needs.

3. Comprehensive Health Screening

The Wellness Program provides a comprehensive health screening (“biometric screening”) at MinuteClinic that covers the following services:

- A₁c or blood glucose test
- Blood pressure check
- Body mass index (BMI)
- Cholesterol test
- Results and recommendations
- A copy of your visit records sent to your primary care provider, upon your request

4. MinuteClinic Smoking Cessation Program – *Start to Stop*[™]

The Wellness Program covers your participation in MinuteClinic's *Start to Stop*[™] smoking cessation program, as follows:

- A personal one-on-one consultation with a MinuteClinic health care practitioner
- A nicotine addiction assessment

- Customized smoking cessation plan and education
- A nicotine replacement recommendation or prescription* if deemed clinically appropriate by a MinuteClinic health care practitioner
**The cost of filling the prescription is not covered under the Wellness Program.*
- A copy of your visit records sent to your primary care provider, upon your request
- Follow-up visits for personalized coaching and medical evaluation to help you on your smoking cessation journey. The number of follow-up visits will be determined by the MinuteClinic health care practitioner in his/her sole discretion and will be based on the health care practitioner's determination as to your individualized needs.

Note: Although the above services are covered under the Wellness Program,

- ❖ the provision of any of these services is subject to the health care practitioner's judgment as to whether such service is advisable, and
- ❖ some of the above services may not be available to all eligible colleagues, due to clinical guidelines.

Questions concerning the Wellness Program should be addressed to:

CVS Caremark
P.O. box 1135
Woonsocket, RI 02895
Attention: FSS Benefits Administration
1-88-MY-HR-CVS (1-888-694-7287)

FILING CLAIMS AND APPEALS

If you are an eligible employee, you are automatically eligible for any of the covered services (listed above) offered at a MinuteClinic and will not need to file a claim for benefits. However, if the Wellness Program does not provide a particular service, the service will not be provided as a covered service under the Wellness Program and you will be responsible for any associated costs if you receive the service. Also, if the health care practitioner does not think that a particular test or service is advisable (for example, if a health care practitioner thinks you are not well enough for a flu shot), the health care practitioner may exercise his or her professional duty to decline to provide the requested service and will provide you with the reason for the decision not to provide the service.

If you have an unresolved issue with respect to your right to benefits covered under the Wellness Program you may make a formal claim for a benefit or eligibility determination by submitting a written claim no later than thirty (30) days after the date of your MinuteClinic visit (or, if your claim is based on being denied eligibility for Wellness Program coverage, thirty (30) days after the date on which access is denied) to the Claims Administrator at:

CVS Caremark HR/Benefits
One CVS Drive
Woonsocket, RI 02895
Attn: Wellness Manager

Your claim will be decided by the Claims Administrator within thirty (30) days after it is received. If necessary, this period may be extended up to an additional fifteen (15) days, but a representative from the Claims Administrator (or its delegate) will notify you in advance if the extension is needed, as well as the reason for the extension. If the extension is necessary because more information is needed from you, you will have forty-five (45) days to provide the additional information. If your claim involves a medical judgment question, the Claims Administrator (or its delegate) will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. Upon request, the Claims Administrator will provide you with the identification of any medical expert whose advice was obtained on behalf of the Wellness Program in connection with your claim.

Once the Claims Administrator has all the necessary information, he or she will notify you of the decision on your claim within thirty (30) days. (This period may be extended by up to fifteen (15) days following receipt of any additional information requested from you, as described above.) If your claim is denied, you will receive a written notice explaining why. The notice will include the specific reason(s) for the denial; reference to the specific plan provisions on which the determination is based; a description of any additional information needed for you to perfect the claim and an explanation of why such information is needed; a description of the review procedures for the Wellness Program, including your right to bring a civil action under Section 502(a) of ERISA following denial of an appeal; and a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the decision, or a statement that it will be provided without charge upon request. In addition, if the decision is based on medical necessity, you will receive an explanation that applies the terms of the Wellness Program to your medical circumstances or a statement that this will be provided without charge upon request.

Upon request, you and/or your authorized representative will be provided without charge, reasonable access to, and copies of, all documents that are relevant to any denial of benefits.

If you disagree with the reasons for your claim denial, you (or your authorized representative) have one hundred eighty (180) days from the date you receive the original denial to request a review on appeal. Your request must be made in writing and sent to the Claims Administrator, which is responsible for deciding appeals. The request should state the reasons why you want the claim reviewed. You should also include evidence or documentation to support your position.

Your appeal will be decided within forty-five (45) days by someone other than the person who decided your initial claim. However, if additional time is necessary to decide the appeal, you will be notified of the extension as explained above. You will be told if additional information is needed from you, and how long you have to provide it. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on appeal. If your claim is denied, you will receive written notice that contains the information described above with respect to the response to your initial claim, as well as a statement that you are entitled to receive, at no charge, the documents considered or submitted in connection with your appeal, and a description of any Wellness Program policies or guidance concerning the decision.

The decision of the Claims Administrator on appeal shall be final and binding.

You may not bring a lawsuit to recover benefits under the Wellness Program until you have exhausted the administrative process described in this section. No legal action may be brought at all unless brought no later than 90 days following a final decision on your claim for benefits. This statute of limitations on suits for all benefits shall apply in any forum in which you may initiate such suit.

COBRA CONTINUATION COVERAGE

Introduction

COBRA is a federal law that allows you to continue your health care coverage under the Wellness Program under certain circumstances. The rules described below contain important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Wellness Program. *This notice generally explains COBRA continuation coverage, when it may become available to you, and what you need to do to protect the right to receive it.*

What is COBRA Continuation Coverage

COBRA continuation coverage is continuation of the Wellness Program coverage when coverage would otherwise end because of a “qualifying event” – here, a termination of employment other than termination for gross misconduct. If you are an eligible employee who experiences a qualifying event (termination of employment other than for gross misconduct), you will be provided a notice of your right to elect COBRA continuation coverage. If you elect COBRA continuation coverage, you must pay for COBRA continuation coverage.

How is COBRA Continuation Coverage Provided

If you are eligible for and properly elect COBRA continuation coverage, you will continue to be able to use the Wellness Program for a period of up to 18 months following your last day of employment as an eligible employee. You must elect COBRA continuation coverage within 60 days after the later of (1) the date you would otherwise lose Wellness Program coverage and (2) the date you are sent a notice about your eligibility to elect continuation coverage. If you elect to continue coverage through the Wellness Program, your coverage will generally begin on the date you would otherwise have lost coverage (*i.e.*, the date you terminate employment).

You will be required to pay the COBRA premiums for COBRA continuation coverage. The COBRA premiums will not exceed 102% of the cost of coverage under the Wellness Program.

Disability Extension of 18-Month Period of COBRA Continuation Coverage

The 18-month period referenced above may be extended to twenty-nine (29) months if the Social Security Administration determines that you are disabled within the first sixty (60) days of COBRA continuation coverage. To be eligible for this extension, you must provide proof that you have been determined to be disabled by the Social Security Administration. You must provide a copy of the Social Security Administration disability determination to the COBRA

Administrator within sixty (60) days of the later of (1) the Social Security Administration's determination or (2) the date on which the qualifying event occurs, and, in all cases, before the end of the 18-month period of COBRA continuation coverage. Failure to notify the COBRA Administrator or to provide the Social Security Administration disability determination will result in forfeiting the right to the extension of coverage.

If the Social Security Administration determines that you are no longer disabled, you must notify the COBRA Administrator of such determination at the address listed below. This notification must be made within thirty (30) days of the determination that you are no longer disabled. In the event you fail to provide timely notice of your cessation of disability and continue to incur claims under the Wellness Program, you will be required to pay to the plan all claims incurred after the later of (1) the conclusion of your first eighteen (18) months of COBRA continuation coverage; and (2) the cessation of your disability.

When COBRA Continuation Coverage Ends

COBRA continuation coverage will end before the maximum continuation period ends if:

- You become covered under a CVS Caremark medical plan;
- You fail to pay the COBRA premiums for COBRA continuation coverage;
- You become entitled to Medicare on a date after the date of your COBRA election;
- You notify the COBRA Administrator or the Plan Administrator that you wish to cancel coverage during the COBRA period;
- Your actions would result in the termination of coverage for a similarly situated active employee, such as fraudulent claims submission; or
- If you have extended COBRA continuation coverage due to disability and you are determined by the Social Security Administration to be no longer disabled (coverage will not terminate before the end of the initial 18-month period).

If You Have Questions Regarding Your COBRA Coverage

Questions regarding your COBRA continuation coverage rights under the Wellness Program should be addressed to the COBRA Administrator at:

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

Keep the COBRA Administrator Informed of Address Changes

In order to protect your rights, you should keep the COBRA Administrator informed of any changes in your address. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

YOUR RIGHTS UNDER ERISA

As a participant in the Wellness Program, which will be referred to as the “Plan” for the remainder of this booklet, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

Continue Plan Coverage

- Continue coverage under COBRA if there is a loss of coverage under the Plan as a result of a qualifying event. You will have to pay for such coverage. Review this Summary Plan Description/plan document on the rules governing your COBRA continuation coverage rights.

Prudent Action by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon those who are responsible for the operation of your employee benefit plans.

The people who operate the Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including CVS Caremark, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a Plan 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 the Plan document or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until

you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court after you have exhausted the Plan's claims procedures. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in 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 the court finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

GENERAL PLAN INFORMATION

Plan Name: The name of the Plan is the CVS Caremark Wellness Plan for Non-Enrolled Employees; the Plan is a component plan under The CVS Caremark Welfare Benefit Plan.

Type of Plan: The Plan is a welfare (health) benefit plan.

Plan Number: 510

Plan Year: The fiscal year that runs from June 1 to May 31.

**Employer
Identification
Number (EIN):**

05-0340626

Plan Sponsor:

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

The Plan Sponsor also includes CVS Caremark affiliates that participate in the Plan. By writing the Plan Administrator at the address listed below, you can receive information as to whether a particular affiliate is a sponsor of the Plan and, if so, the affiliate's address.

CVS Caremark offers the Plan to its eligible employees as a benefit of employment, but neither sponsorship of the Plan by CVS Caremark or any of its affiliates nor participation in its benefits shall be deemed to enlarge an employee's employment rights or confer any right to be retained in the employ of CVS Caremark or any of its affiliates.

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

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

The Plan Administrator is the "named fiduciary" of the Plan and has the exclusive discretionary authority to interpret the Plan and to construe the terms of the Plan and all facts surrounding claims under the Plan (such as questions of eligibility and benefits). Accordingly, benefits under the Plan will be paid only if the Plan Administrator decides in her discretion that an applicant is entitled to benefits. The Plan Administrator's decisions are final and binding on all parties. The Plan Administrator can delegate her authority and responsibility to others, including the discretionary authority to make eligibility and benefits decisions.

Neither CVS Caremark nor the Plan Administrator shall be liable for the acts or omissions of the MinuteClinic health care practitioners providing services under the Plan. Nothing in this booklet shall be construed as giving CVS Caremark or the Plan Administrator the right to control the professional judgment or actions of the health care practitioners with respect to any services covered or rendered under the Plan.

Agent for Service of Legal Process:

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

Service of legal process may also be made on the Plan Administrator.

Funding:

CVS Caremark pays the costs of the Plan to the extent not covered by eligible employees' other health insurance. These costs are paid from its general operating assets.

Claims Administrator: The Claims Administrator receives, processes, pays and reviews claims for the benefits under the Plan. The Claim Administrator is the CVS Caremark HR/Benefits department. Communications to the Claims Administrator should be directed as follows:

CVS Caremark HR/Benefits Department.
One CVS Drive
Woonsocket, RI 02895
Attn: Wellness Manager

COBRA Administrator: Aon Hewitt
myHR
P.O. Box 563927
Charlotte, NC 28256
(888) 694-7287

**Future of the
Plan:**

The continued maintenance of the Plan is completely voluntary on the part of CVS and neither its existence nor its continuation will be construed as creating any contractual right to or obligation for its future continuation. While CVS expects to continue the Plan indefinitely, CVS reserves the right at any time and for any reason, in its sole discretion, to curtail benefits under, otherwise amend, modify, or terminate the Plan or any portion thereof without notice, including, without limitation, those portions of the Plan outlining the benefits provided or the classes of employees or dependents eligible for benefits under the Plan. The Plan may be amended, modified or terminated by the Board of Directors of CVS Caremark Corporation, by the Management Planning and Development Committee or, in certain circumstances, by the Senior Vice President and Chief Human Resources Officer of CVS Pharmacy, Inc. All amendments or modifications to the Plan shall be in writing, and any oral statements or representations made by any individual or entity that purport to alter, modify, amend or are inconsistent with the written terms of the Wellness Program shall be invalid and unenforceable and may not be relied upon by any individual or entity.

In the event the Plan is amended, modified or terminated, any claims submitted after the effective date of amendment, modification or termination are payable in accordance with the then relevant Plan documents. However, no amendment, modification or termination can reduce or otherwise affect any claim for a benefit you became entitled to before the effective date of amendment, modification or termination. In the event the Plan terminates, you will be informed of any termination rights you may have.