PLAN DOCUMENT AND

SUMMARY PLAN DESCRIPTION

Prescription Drug Benefit under the

HALO BRANDED SOLUTIONS, INC. WELFARE BENEFIT PLAN

Note to Plan Sponsor:

As the plan sponsor, you are required to issue a Summary Plan Description (SPD) to all plan participants within 90 days of coverage and upon request. The SPD must meet certain content requirements under the Employee Retirement Income Security Act of 1974 (ERISA). This template is designed to include the content that is required to be in an SPD. The employer or plan sponsor should review and complete the information in the template and provide it to plan participants.

In addition, as the plan sponsor, you are also responsible for ensuring that the plan is maintained pursuant to a written plan document. In addition to serving as the SPD, this template also constitutes the plan document required by ERISA.

Note that this template is not intended to ensure full compliance with ERISA or ERISA's SPD delivery requirements. VPS provides this template as a convenience. VPS does not represent that this template meets the requirements of ERISA or any other applicable law. Please consult your own attorney to determine whether you have complied with ERISA and other applicable laws.

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Introduction

Overview

The prescription drug benefit ("Prescription Drug Benefit") is a benefit offered under the ***HALO BRANDED SOLUTIONS, INC. WELFARE BENEFIT PLAN*** (the "Plan"), which is an employer-sponsored health and welfare employee benefit plan. The Prescription Drug Benefit is governed under ERISA.
This booklet, together with the documents incorporated by reference, serve as the "summary plan description" and formal plan document for the Prescription Drug Benefit for purposes of ERISA. The summary plan description for the medical benefits ("Medical SPD") provided to you by Employer is incorporated by reference into this document unless otherwise noted. An amendment to one of these documents constitutes an amendment to the Plan.

Unless otherwise noted, if there is a conflict between a specific provision under this document and the Medical SPD, the terms of this document control. If this document is silent, the terms of the Medical SPD control.

Any capitalized terms not defined herein shall have the meanings given to such terms in the Medical SPD.

Employer reserves the right to change, amend, suspend, or terminate any or all of the benefits under this Plan, in whole or in part, at any time for any reason at its sole discretion.

Plan Contact Information

Questions concerning the Prescription Drug Benefit can be directed to the Plan Administrator or the Claims Administrator listed in the Administrative Information section of this document.

Administrative Information

Plan Name & Number	***HALO BRANDED SOLUTIONS, INC. WELFARE BENEFIT PLAN*** **(501)**
Plan Sponsor	***HALO BRANDED SOLUTIONS INC.*** **1500 HALO WAY STERLING, IL 61081 815-548-9006**
Employer Identification Number	**03-0509520**
Plan Administrator & Agent for Service of Legal Process	***HALO BRANDED SOLUTIONS INC.*** **1500 HALO WAY STERLING, IL 61081 815-548-9006**
Claims Administrator	CVS Caremark For contact information, see Article 3, "Filing Claims and Appeals"
Plan Year	**SEPTEMBER 1 – AUGUST 31**
Plan Type	This Summary Plan Description and Plan Document describes the prescription drug benefits under the Plan.
Administration & Funding	The Prescription Drug Benefit is self-funded and is administered by the Claims Administrator.
Source of Contributions	Contributions will be paid out of the Employer's and any Participating Employer's general assets and through contributions paid by Eligible Employees,

	in the amounts determined by the Employer in its discretion.

Glossary

Claims Administrator	A third party that makes claims determinations under the Plan pursuant to a contractual arrangement with the Employer. The Claims Administrator does not insure any benefits under the Plan. The Claims Administrator is listed in the "Administrative Information" section.
COBRA	The Consolidated Omnibus Budget Reconciliation Act, which provides continuation coverage for certain benefits when an Eligible Employee or Eligible Dependent has experienced a loss of coverage due to a qualifying event.
Eligible Dependent	A dependent of an Eligible Employee who meets the eligibility requirements described in Article 1 of this SPD.
Eligible Employee	An employee who meets the eligibility requirements described in Article 1 of this SPD.
Employer	***HALO BRANDED SOLUTIONS, INC.***
ERISA	The Employee Retirement Income Security Act of 1974, as amended from time to time.
HIPAA	The Health Insurance Portability and Accountability Act of 1996, as amended from time to time.
Participant	An individual who has satisfied the Prescription Drug Benefit's eligibility requirements and has elected to participate in the Prescription Drug Benefit.
Participating Employer	Any affiliated employer under Code section 414(b), (c), (m), or (o) that adopts the Plan with the consent of the Employer and as listed at Appendix A.
Plan	***HALO BRANDED SOLUTIONS, INC. WELFARE BENEFIT PLAN***
Plan Administrator	The Employer or person or entity that the Employer designates to perform specific administrative duties under the Plan.

Plan Year	The twelve-month period selected by the Employer to be the Plan Year.

Article 1

Eligibility and Enrollment

Eligibility

You are eligible for enrollment in the Prescription Drug Benefit if you are enrolled in one of the medical coverage options under the Plan ("Medical Coverage"). Your dependents are eligible for enrollment in the Prescription Drug Benefit if they are enrolled in Medical Coverage. See the Medical SPD.

Eligibly classes

- "Administration" means who work with the Employer on an active, full-time and full pay basis for at least 30.0 hours per week.
- "Sales Full-time" means active Commissioned Sales staff who meet an annual commission threshold set by the company each year.
- "Client Executive" means active Commissioned Sales staff who do not meet the annual commission requirement and therefore pay a higher premium.
- "Consultants" means Elite class of consultants earning at least the minimum salaried required by law. "Acquisitions" means who work with the Employer on an active, full-time and full pay basis for at least 30.0 hours per week - the waiting period for these employees is waived- eligible immediately.

Enrollment

You and your Eligible Dependents will be automatically enrolled in the Prescription Drug Benefit upon enrollment in Medical Coverage. Any changes you make to your Medical Coverage at open enrollment and during the year (in accordance with the Medical SPD) will also apply to your Prescription Drug Benefit coverage.

Your Prescription Drug Benefit coverage will become effective on the date your Medical Coverage becomes effective. Coverage for your Eligible Dependents will become effective on the date their Medical Coverage becomes effective. See the Medical SPD.

Cost of Coverage

You and the Employer share in the cost of the Plan. Information describing your share of the cost of the Plan, which includes your share of the cost of the Prescription Drug

Benefit, will be available at enrollment.

Article 2

How the Prescription Drug Benefit Works

The Prescription Drug Benefit is administered by CVS Caremark. CVS Caremark maintains the formulary, manages a network of Participating Pharmacies, and operates mail service and Specialty Drug pharmacies. CVS Caremark, in consultation with the Plan, may also provide services to promote the appropriate use of pharmacy benefits.

Understanding Your Benefits

Prescription Drug Formulary

Your coverage under CVS Caremark is based on a formulary – a list of covered medicines. Your formulary offers a wide selection of clinically sound, cost-effective Generic and Brand name prescription drugs. For more information or to check drug coverage, visit the CVS Caremark website (www.caremark.com).

Your Cost for Prescriptions

The amount you pay for your covered medications will generally depend on two factors:

- Whether your prescription is filled with a generic, a brand-name, or a specialty medication; and
- Where your prescription is filled (at a participating retail pharmacy, at an out-of-network retail pharmacy, through a mail service pharmacy, or through a specialty pharmacy).

The amount you pay for covered medications may include a deductible, copayment, and/or coinsurance.

- A deductible is the amount you pay for covered medications under the Plan before the Plan starts to pay.
- A copayment is a fixed amount that you pay for a covered medication under the Plan after you have paid your deductible.
- Coinsurance is the percentage of costs of a covered medication that you pay under the Plan after you have paid your deductible.
- Manufacturer copay assistance, patient assistance, or any other third party dollars used to cover the amount you owe may not apply to your deductible and maximum out of pocket.

You are required to pay the following amounts for the Prescription Drug Benefit:

	PPO Plan (HALO PPO)				
Type of Medication	Retail (up to 30-day supply)	Retail Pharmacy (Up to 90-day supply)	Mail Service Pharmacy (Up to 90-day supply)	Specialty – CVS Specialty Pharmacy	Out-of-Network Retail Pharmacy
Generic	***$10***	***$20***	***$20***	***$10***	***N/A***
Preferred Brand	***$30***	***$60***	***$60***	***30%***	***N/A***
Non-Preferred Brand	***$50***	***$100***	***$100***	***30%***	***N/A***
Out-of-Pocket maximum					
Employee-only coverage	***$3,400***				
Family coverage	***$6,800***				

	HSA Plan (HALO HSA)				
Type of Medication	Retail (up to 30-day supply)	Retail Pharmacy (Up to 90-day supply)	Mail Service Pharmacy (Up to 90-day supply)	Specialty – CVS Specialty Pharmacy	Out-of-Network Retail Pharmacy
Generic	***$10***	***$20***	***$20***	***$10***	***N/A***
Preferred Brand	***$30***	***$60***	***$60***	***20%***	***N/A***
Non-Preferred Brand	***$50***	***$100***	***$100***	***20%***	***N/A***
Deductible					
Employee-only coverage	***$1,600***				
Family coverage	***$3,200***				
Out-of-Pocket maximum					
Employee-only coverage	**$4,750**				
Family coverage	**$9,100**				

Coverage for Preventive Medicines

The Prescription Drug Benefit offers certain preventive services at no out-of-pocket cost to you. This means you do not have to pay a copay or coinsurance, even if you have not met your deductible. No out-of-pocket cost services include:

- Medicine and supplements to prevent certain health conditions for adults, women and children
- Medicine and products for quitting smoking or chewing tobacco (tobacco cessation)
- Medicine used prior to screenings for certain health conditions in adults
- Vaccines and immunizations to prevent certain illnesses in infants, children and adults
- Contraceptives for women

For the latest lists of covered preventive services benefits, visit the CVS Caremark website (www.caremark.com). These lists explain:

- Which medicines, supplements, health-related products or vaccines are covered
- Who they are covered for (such as children up to age six or adults age 65 or older)
- What health condition or illness they help prevent
- Other important information

Please note the following:

- Your doctor must write a prescription for these preventive services to be covered by the Prescription Drug Benefit, even if they are listed as over-the-counter.
- The dosage form is how the product is supplied. For example, tablet, capsule, liquid, syrup or chewable tablet.
- "Generic" or "brand name" is listed if only that product type is covered.
- Treatment recommendations may vary. Please call your doctor or pharmacist if you have questions about your health or medicine.
- Other rules, limits and exclusions may apply.
- An exceptions process is available for circumstances that fall outside the listed preventive services – such as, for example, a request for coverage of a Brand name product because the listed generic products are not medically appropriate. A process is also available for coverage of preventive services without Cost Share for plan members identifying with a gender that differs from the member's sex assigned at birth – such as, for example, a request for coverage of contraceptives or primary prevention of breast cancer for transgender members.

Out-of-Pocket Maximums

Once your out-of-pocket expenses for covered medications under the Plan reaches the levels specified ***in the table(s) above (under "Your Cost for Prescriptions"),*** the Plan will pay for covered medications at 100% for the remainder of the Plan year. The amount you spend on deductibles, copayments, and coinsurance counts toward the out-of-pocket maximum.

Your out-of-pocket maximum under the Prescription Drug Benefit is **combined with** the out-of-pocket maximum under the Medical Coverage.

How to Use Your Plan

Retail Participating Pharmacy

For medications you take for a short time, such as antibiotics for strep throat or pain relievers for an injury, you should fill your prescription at a retail Participating Pharmacy. To search for a retail Participating Pharmacy, log on to www.caremark.com (you must be a registered user) and click Find a Pharmacy.

To fill your prescription at a retail Participating Pharmacy, present your written prescription from your physician and your ID card to the pharmacist. Alternatively, some physicians send prescriptions to pharmacies electronically, in which case you will only need to present your ID card. You will be charged at the point of purchase for applicable deductible and/or copayment/coinsurance amounts. If you do not present your ID card, you may have to pay the full retail price of the prescription. If you do pay the full charge, ask your pharmacist for an itemized receipt and submit it to CVS Caremark along with the required claim form. See Article 4, "Filing Claims and Appeals," for information on how to file a claim for benefits.

For medications you take for a longer period, you can purchase up to a 30-day supply of your prescription drugs through a retail Participating Pharmacy. You may also fill your maintenance medications at a retail Participating Pharmacy, and receive a 90-day supply.

Mail Service Program

For prescription medications you take regularly to treat ongoing conditions (such as medications used to treat high-blood pressure or diabetes), you may fill a 90-day supply through the CVS Caremark Mail Service Program.

For new maintenance medications, complete a Mail Service Order Form and send it to CVS Caremark, along with your original prescription(s) and the applicable deductible

and/or copayment/coinsurance amounts for each prescription. Be sure to include your original prescription, not a photocopy. You may also ask your doctor to fax your prescription. You can expect to receive your prescription approximately 14 calendar days after CVS Caremark receives your order. The CVS Caremark mail order forms can be found on the CVS Caremark website (www.caremark.com).

The Mail Service Program may contact your doctor to obtain approval of a Drug Interchange. A Drug Interchange means that CVS Caremark may substitute a prescription drug that is not on the CVS Performance Drug List or the CVS Prescribing Guide for a clinically comparable drug on the CVS Performance Drug List or the CVS Prescribing Guide. The Drug Interchange does not include any substitution initiated by CVS Caremark that is due to:

- A drug utilization review;
- Participant safety reasons
- Market unavailability of the originally prescribed drug;
- A generic substitution of a brand drug; or
- The originally prescribed drug not being covered by the Plan.

Specialty Pharmacy

CVS Specialty is a full-service pharmacy that provides your choice of home delivery service or delivery to your local CVS pharmacy for Specialty Drugs. These medications are used to treat a number of complex conditions, such as a cancer and multiple sclerosis. CVS Specialty offers therapy-specific teams that provide an enhanced level of personalized service to patients with special therapy needs.

CVS Specialty must be used to fill Specialty Drug prescription orders, subject to a **30-day** supply, with the applicable deductible, coinsurance, or copayment specified in the table(s) above (under "Your Cost for Prescriptions"). For more information or to order your specialty medications, visit www.cvsspecialty.com.

To help offset your out-of-pocket costs for specialty medications, a Specialty Copay Assistance program is available to you. The clinical team at VPS will help you receive manufacturer copay assistance to cover most, if not all, of your out-of-pocket expenses for your specialty medications. For more information and to enroll in the program, contact VPS at 1-888-201-9175 prior to filling your specialty medication.

ImpaxRx Medication Under Management Service

ImpaxRx Medication Under Management™ Service provides access to medications over $5,000.00 (30 day supply) and will be required to be fulfilled through the ImpaxRx Medication Under Management™ Service unless the drug manufacturer or patient credentials result in a denial for that medication. When a new medication is identified during the plan year, the benefit has up to 6 months to bring the medication under management by the plan. A list or threshold of medications may be amended during the plan year, as determined by the plan sponsor, within the notice provisions defined in the plan.

Utilization Management Programs

To promote safety along with appropriate and cost-effective use of prescription medications, the Prescription Drug Benefit includes several utilization management programs.

Generics Preferred Program (Automatic Generic Substitution)

If you want to lower your out-of-pocket costs, ask your doctor whether a Generic medication is available and right for you. With a Generic medication, you get the same treatment that you get with its Brand-name counterpart, but with a lower copayment. FDA-approved Generic equivalent medications contain the same active ingredients and are subject to the same standards established by the FDA as their Brand-name counterparts. To help manage the cost of prescription benefits, the Prescription Drug Benefit includes an automatic Generic substitution feature.

How does the "generics preferred program" work? When your doctor prescribes a Brand-name medication and a Generic substitute is available, you will automatically receive the Generic unless:

- Your doctor writes Dispense As Written ("DAW") on the prescription; or
- You request the Brand-name medication at the time you fill your prescription

Your copayment for the Generic medication will be less than the copayment for the brand-name medication.

If a Generic is available, but you or your doctor request the Brand-name medication, you will pay the Brand copayment PLUS the full difference in cost between the Brand-name medication and the Generic equivalent. This difference in cost is referred to as the ancillary fee. The ancillary fee is in addition to the copayment, so the cost could exceed

the copayment maximum. This amount is not counted toward your out-of-pocket maximum.

[Only include this example if your plan design includes the "dispense as written" generic dispensing rules:] For example:

Brand-name medication cost	$120
Generic medication cost	$50
Difference (ancillary fee)	$70
Brand Copayment	$40
Total cost (Brand copayment + ancillary fee)	$110
If you chose the generic medication, you would pay the generic copayment only.	

Please note: If your doctor requests you take the Brand-name medication due to medical necessity, you may be approved to pay the Generic copayment only. Please refer to the Prior Authorization section below.

Step Therapy

The Prescription Drug Benefit includes a step therapy program for drugs used to treat ongoing medication conditions such as arthritis and high blood pressure. The step therapy program is designed to find the most appropriate medication therapy and reduce prescription costs. Medications are grouped into two categories:

- **First-line (or Step 1) medications:** These are the medications recommended for you to take first—usually Generics, which have been proven safe and effective. You pay the lowest copayment for these.

- **Second-line (or Step 2) medications:** These are Brand-name medications. They are recommended for you only if a first-line medication does not work. You may pay more for Brand-name medications.

For more information on step therapy, including a list of drugs that require step therapy, visit the CVS Caremark website (www.caremark.com).

Prior Authorization

Prescriptions for certain medications require a prior authorization—also known as a coverage review—to ensure the medication is cost-effective and clinically appropriate. The review uses both formulary and clinical guidelines and other criteria to determine if the plan will pay for certain medications.

The following situations may require prior authorization for your prescription:

- Your doctor prescribes a medication not covered by the formulary
- The medication prescribed is subject to age limits
- The medication is only covered for certain conditions

If you are not able to take the Generic medication, your doctor can request a prior authorization that would allow you to purchase the Brand without paying the ancillary charge.

In most cases, prior authorization can be started by phone. Your pharmacist or physician should call the toll free number on the back of your CVS Caremark ID card.

For more information on prior authorization, including a list of drugs that require prior authorization, visit the CVS Caremark website (www.caremark.com).

Quantity Level Limits

For some medications, the Prescription Drug Benefit covers a limited quantity within a specific period of time. A coverage review may be available to request additional quantities of these medications. Please note that the pharmacy does not automatically initiate a coverage review process for additional quantities. You or your doctor must initiate this process.

For more information on quantity level limits, including a list of drugs with quantity level limits, visit the CVS Caremark website (www.caremark.com).

Limitations and Exclusions

<u>Drug Exclusions:</u>
Rare Genetic Adipose Tissue Disorder

<u>Not Covered:</u>
Allergy Serums: Injectable
Allergy Serums: Non-Injectable
Arestin (Periodontal)

Cosmetic Drugs - including hair loss drugs, anti-wrinkle creams, hair removal creams and others (requiring a prescription) (includes Botox Cosmetic & Dysport)
Fluoride (Topical Fluoride Dental: Requires Rx)
Hypoactive Sexual Desire Disorder Agents
Impotency Drugs (Injectable, Oral, Supp, Kits)
Respiratory Therapy Supp: Nebulizers
Respiratory Therapy Supp: Peak Flow Meters
Respiratory Therapy Supp: Spacers
Vision Agents
Insulin Pumps
Insulin Pumps Accessories
Insulin Pump Supplies
OTC Coverage Plan - PPI (Proton Pump Inhibitor)
OTC Coverage Plan - NSA (non-sedating antihistamine)

Specialty Quantity Limits - Specialty Quantity Limits Program (30 days)

Prior Authorization:
Compound Rx PA Core Services
ANALGESICS OPIOID
ANDROGENS
ANDROGENS ANABOLIC STEROIDS
ANTIDIABETICS
ANTIFUNGAL
ANTIFUNGAL TOPICAL
ANTIINFECTIVES
ANTIOBESITY
CSID
DERMATOLOGICALS
DERMATOLOGICALS - ECZEMA AGENTS
DERMATOLOGICALS ACNE PRODUCTS
NARCOLEPSY

Quantity Limits:
ANALGESICS NONNARCOTIC
ANALGESICS OPIOID
ANTIASTHMATIC AND BRONCHODILATOR
ANTIDIABETICS
ANTIINFECTIVES
ANTIVIRALS
DERMATOLOGICALS - ANTIBIOTICS-TOPICAL
DERMATOLOGICALS - ROSACEA AGENTS
MEDICAL DEVICES AND SUPPLIES – CONTRACEPTIVES
MIGRAINE
MOUTH/THROAT/DENTAL AGENTS

NASAL AGENTS
OPHTHALMIC AGENTS
TETRACYCLINES
ADHD/ANTINARCOLEPSY
DERMATOLOGICALS
DERMATOLOGICALS ACNE PRODUCTS
DERMATOLOGICALS ANTIFUNGAL TOPICAL
GASTROINTESTINAL ANTIEMETICS
HYPNOTICS
LOCAL ANESTHETICS TOPICAL

Step Therapy:
CHELATING AGENTS
DERMATOLOGICALS
MIGRAINE
MIGRAINE PRODUCTS

Definitions and Other Important Terms

Please see the chart below for definitions. Some of the terms are specifically used in Article 2. Some are common prescription drug benefit terms may be helpful in order for you to better understand how the Prescription Drug Benefit works.

Adjudicated Dispensing Fee	The dispensing fee charged within a Claim's adjudication, as indicated on the claim's data record.
Adjudicated Ingredient Cost	The ingredient cost at which a Claim was adjudicated, as indicated on the Claim's data record.
Advanced Control Formulary	A CVS Caremark formulary that covers most Generics, and select Brands and Specialty Drugs. It is updated quarterly. It includes advanced controls for Specialty Drugs.
Advanced Control Specialty Formulary ("ACSF")	A CVS Caremark formulary that is a moderately aggressive approach and presents specialty trend management. This formulary utilizes formulary exclusions, new-to-market drug management, tiering strategy and specialty guideline management to help ensure clinically appropriate utilization and cost-effectiveness of specialty therapies.
AWP	The "average wholesale price" for a standard package size of a prescription drug from the most current pricing information provided to CVS Caremark by Medi-Span Prescription Pricing Guide (with supplements), or following notice to the Employer, any other nationally available reporting service of pharmaceutical prices as utilized by CVS Caremark as a pricing source for prescription drug pricing. The standard package size applicable to a mail service pharmacy shall mean the actual package size dispensed. The standard package size applicable to a Participating Pharmacy shall be the actual package size dispensed from a Participating Pharmacy as reported by such Participating Pharmacy to CVS Caremark.
Brand	A Claim that is adjudicated as a brand as indicated on the claim's record.
Claim	A prescription drug Claim processed through CVS Caremark's on-line claims adjudication system or otherwise transmitted or processed by the Claims Administrator.

Cost Share	The amount which a Participant is required to pay for a prescription in accordance under the Plan, which may be a deductible, a percentage of the prescription price, a fixed amount and/or other charge or penalty.
Covered Drug	A prescription drug, supply, Specialty product (if applicable), or other item that is covered under the Plan.
Dispense As Written ("DAW")	A prescription drug Claim that the prescribing provider or state law has mandated be dispensed as prescribed without substitutions.
Drug Interchange	Any substitution initiated by CVS of a prescription drug that is not on the PDL or the Prescribing Guide for a clinically comparable drug on the PDL or Prescribing Guide. Drug Interchange shall not include any substitution initiated by CVS that is (i) due to a drug utilization review; (ii) due to Participant safety reasons; (iii) due to market unavailability of the originally prescribed drug; (iv) a generic substitution of a brand drug; or (v) due to the originally prescribed drug not being covered by the Plan.
Generic	A claim that is adjudicated as a generic as indicated on the claim record.
Maximum Allowable Cost ("MAC")	The unit price that has been established by CVS Caremark for a multi-source drug (i.e., a drug with more than two sources) included on the MAC drug list applicable to the Plan, which list may be amended from time to time by CVS Caremark in maintaining its generic pricing program. The MAC list applicable to Plan is not the same as the MAC list published by the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration, or "HCFA MAC").
Participating Pharmacy	A retail pharmacy that participates in a retail network established by CVS Caremark.
Performance Drug List ("PDL")	A list of preferred pharmaceutical products, created and maintained by CVS Caremark, as amended from time to time, which: (a) has been approved by CVS Caremark's pharmacy and therapeutics committee; and (b) reflects CVS Caremark's

	recommendations as to which pharmaceutical products should be given favorable consideration by plans and their participants.
Prescriber	A health care practitioner licensed or authorized by law to issue an order for a prescription drug.
Prescribing Guide	The CVS Prescribing Guide, as modified and published from time to time, which has been approved by CVS Caremark's pharmacy and therapeutics committee.
Rebates	The formulary rebates, including base and market share rebates, collected by CVS Caremark in its capacity as a group purchasing organization for the Plan from various pharmaceutical companies that are attributable to the utilization of single source brand prescription drugs by Participants, but specifically excluding any rebates paid with respect to utilization of Specialty Drugs which shall be retained by CVS Caremark.
Specialty Drugs	Certain pharmaceuticals, biotech or biological drugs, as offered by CVS Caremark, that are used in the management of chronic or genetic disease, including but not limited to, injectable, infused, or oral medications, or products that otherwise require special handling.
Standard Formulary	CVS Caremark's standard formulary approach that covers generics, most brands and specialty.
Usual and Customary ("U&C")	The retail price a Participating Pharmacy would charge a customer without pharmacy benefits for the particular drug in a cash transaction on the date the drug is dispensed, as reported by the Participating Pharmacy.
Value Formulary	CVS Caremark's restrictive, closed formulary and that addresses all disease states and drug classes. It includes generics and select preferred, therapeutically necessary brands, which formulary is created, maintained and amended by CVS Caremark from time to time, and which has been approved by CVS Caremark's Pharmacy and Therapeutics Committee.

Article 3

When Coverage Ends; COBRA Continuation

When Coverage Ends

Your coverage under the Prescription Drug Benefit will end when your Medical Coverage ends. Your Eligible Dependent's coverage under the Prescription Drug Benefit will end when his or her Medical Coverage ends. See the Medical SPDs for more detail about when you and your dependent's coverage under the Plan may end.

Under some circumstances, you or your Eligible Dependents may continue coverage through COBRA continuation coverage.

Coverage During Leave of Absence

If you are on an approved leave of absence and are receiving pay directly from the Employer, your elections and salary reduction contributions will continue in accordance with the elections you made.

If you are on an approved leave where you are not receiving pay directly from the Employer, the Company will continue your coverage for the duration of time required under the Family and Medical Leave Act (FMLA) or for such longer period as provided for in leave of absence policies in effect at the time of your unpaid leave.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides for continuation of certain health benefits, including your Prescription Drug coverage, for "qualified beneficiaries" who lose their coverage due to a "qualifying event." You (or your Eligible Dependent) must be offered the same prescription drug coverage that you had the day before the qualifying event that caused you to lose coverage.

The cost of COBRA coverage will be the full cost of coverage (the employer plus employee portion), plus a 2% administrative fee. When you enroll, you will receive a separate notice that gives more information on your COBRA rights. You also will receive an election notice if you experience a qualifying event.

When You May Elect COBRA Coverage

You may continue coverage for yourself and your covered Eligible Dependents for up to 18 months, if your Prescription Drug Benefit ends for one of the following reasons:

- You separate from service with the Employer or a Participating Employer (for reasons other than gross misconduct on your part); or

- Your hours are reduced so that you are no longer eligible for the Prescription Drug Benefit.

If you—or any of your Eligible Dependents—are determined to be disabled (for Social Security benefit purposes) when your coverage ends, or within the first 60 days of COBRA coverage, coverage for your entire family may continue for a total of 29 months.

Your covered Eligible Dependents may elect to continue coverage for up to 36 months if coverage ends for one of the following reasons:

- Your death;
- Your divorce or legal separation;
- Your eligibility for Medicare during a COBRA continuation period; or
- If your covered dependent child no longer meets the eligibility requirements under the Prescription Drug Benefit.

Applying for COBRA Coverage

When your coverage ends, you or your Eligible Dependents have 60 days to elect continued coverage. The 60 days is counted from the day your active benefits end or the date your COBRA notice is mailed, whichever is later. If you lose coverage due to separation from service or a reduction in work hours, you will automatically receive a notice of your COBRA rights.

In the case of a divorce, legal separation, or when a child no longer qualifies for dependent coverage, you or your Eligible Dependent must notify the COBRA administrator within 60 days. Your dependents will not be eligible for COBRA coverage unless you notify the COBRA administrator that they have lost eligibility for coverage.

When COBRA Coverage Ends

COBRA coverage will end if:

- The Employer stops providing coverage for all employees;
- You or your Eligible Dependents do not pay your premiums on time;
- You or your Eligible Dependents become covered by another group health plan;
- You or your Eligible Dependents become covered by Medicare; or
- You or your Eligible Dependents extended COBRA coverage to 29 months due to

disability, but are no longer considered disabled.

Article 4

Filing Claims and Appeals

Complaints (Other than Claims for Benefits)
If you would like to formally file a complaint with CVS Caremark (other than a claim for benefits, described below), please call 1-866-475-0056. Your initial response will be addressed by a Customer Service Representative.

Your concerns will be logged into CVS Caremark' Customer Service Contact System. Unresolved complaints will be escalated to a customer service resolution expert or to a supervisor. You can also request that your issue be escalated.

If your issue is still not resolved to your satisfaction, you have the right to file a formal appeal either verbally by phone, or by mail. You may fax or mail your appeal to the following:

Fax	Mail
1-866-443-1172	Caremark, Inc.
ATTN: Appeals Department	Appeals Department MC 109
	P.O. Box 52084
	Phoenix, AZ 85072-2084

You will receive a follow-up phone call and/or letter regarding resolution of your issue.

Claims for Benefits: How to File an Initial Claim

You must file a claim for benefits with the Claims Administrator within 365 days of the prescription purchase date. You must complete and submit the Prescription Reimbursement Claim Form ("Claim Form"), along with any other information required by the Claim Form. The Claim Form is located online at CVS Caremark's website (www.caremark.com) and can also be requested by calling CVS Caremark Customer Care at ***844-256-4046***.

Mail the completed Claim Form (along with any other information required by the Claim Form) to the following address:

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

Claims for Benefits: How an Initial Claim for Benefits is Processed

Your claim for benefits will be processed under the procedures described below. The Claims Administrator will decide claims for benefits.

Urgent Claims Any claim for medical care or treatment where making a determination under the normal timeframes could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.	Notice of the Plan's determination will be sent as soon as possible taking into account the medical exigencies, and in no case later than 72 hours after receipt of the claim. You may receive notice orally, in which case a written notice will be provided within 3 days of the oral notice. If your urgent claim is determined to be incomplete, you will receive a notice to this effect within 24 hours of receipt of your claim, at which point you will have 48 hours to provide additional information. If you request an extension of urgent care benefits beyond an initially determined period and make the request at least 24 hours prior to the expiration of the original determination, you will be notified within 24 hours of receipt of the request.
Pre-Service Claims A claim for services that have not yet been rendered and for which the Plan requires prior authorization.	If your pre-service claim is improperly filed, you will be sent notification within five days of receipt of the claim. If your pre-service claim is filed properly, a claims determination will be sent within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days from receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond control of the Plan, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the Claims Administrator expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The Claims Administrator then will make its determination within 15 days from the date the Plan receives your

	information, or, if earlier, the deadline to submit your information.
Post-Service Claims A claim for services that already have been rendered, or where the Plan does not require prior authorization.	Notice of the Plan's determination will be sent within a reasonable time period but no later than 30 days from receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the Claims Administrator expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The Claims Administrator then will make its determination within 15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.
Concurrent Care Claims A claim that arises when there is a reduction or termination of ongoing care.	You will be notified if there is to be any reduction or termination in coverage for ongoing care in the timeframes specified above, depending on if the claim is urgent or non- urgent. If the claim is a request for an urgent extension of concurrent care and request is made within 24 hours of the end of period or number of treatments, you will be notified as soon as possible, but no later than 24 hours.

Claims for Benefits: How to File an Appeal

If your initial claim for benefits is denied in whole or in part, you may file an appeal with the Claims Administrator. You must submit your appeal within the timeframes set forth in "Claims for Benefits: How an Appeal is Processed," below. Your appeal should include the following information:

- A clear statement that the communication is intended to appeal an adverse coverage determination;

- Name of the person for whom the appeal is being filed. You, your Eligible Dependent, or your prescriber may file an appeal. You or your Eligible Dependent may also have a relative, friend, advocate, or anyone else (including an attorney) act on your behalf as your authorized representative;

- CVS Caremark identification number;

- Date of birth;

- A statement of the issue(s) being appealed;

- Drug name(s) being requested; and

- Comments, documents, records, relevant clinical information or other information relating to your claim.

You may fax or mail your appeal to the following:

Fax	Mail
1-866-443-1172 ATTN: Appeals Department	Caremark, Inc. Appeals Department MC 109 P.O. Box 52084 Phoenix, AZ 85072-2084

For appeals regarding specialty drugs, you may fax or mail your appeal to the following:

Fax	Mail
1-855-230-5548 ATTN: Appeals Department	CVS/Caremark, Inc. Specialty Guideline Management Appeals Department 800 Biermann Court Ste. B. Mt. Prospect, IL 60056

Claims for Benefits: How an Appeal is Processed

Your appeal will be conducted without regard to your initial determination by someone other than the party who decided your initial claim. No deference will be afforded to the initial determination. You will have the opportunity to submit written comments, documents or other information in support of your appeal. You have the right to request copies, free of charge, of all documents, records or other information relevant to your claim. The Claims Administrator, on behalf of the Plan, will provide you with any new or additional evidence or rationale considered in connection with your claim sufficiently

in advance of the appeals determination date to give you a reasonable opportunity to respond.

If your claim involves a medical judgment question, the Claims Administrator will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on appeal. Upon request, the Claims Administrator will provide you with the identification of any medical expert whose advice was obtained on behalf of the Plan in connection with your appeal.

In the case of an urgent care claim, you may request an expedited appeal of an adverse benefit determination either orally or in writing, and all necessary information, including the Plan's benefit determination on appeal, will be transmitted by telephone, fax, or other available expeditious method.

The Claims Administrator will make a final decision on appeal within the time periods specified below.

Urgent Claims	You must submit your appeal within 180 days of the date of your initial denial notice (or first level appeal notice, for second level appeals) You will be notified of the determination as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim.
Pre-Service Claims	You must submit your appeal within 180 days of the date of your initial denial notice (or first level appeal notice, for second level appeals). For both the first and second levels of appeal, you will be notified of the determination within a reasonable period of time taking into account the medical circumstances, but no later than 15 days from the date your request is received (30 days if there is only one level of appeal).
Post-Service Claims	You must submit your appeal within 180 days of the date of your initial denial notice (or first level appeal notice, for second level appeals) For both the first and second levels of appeal, you will

	be notified of the determination within a reasonable period of time, but no later than 30 days from the date your request is received (60 days from the date if there is only one level of appeal).
Concurrent Care Claim	You must submit your appeal within 180 days of the date of your initial denial notice (or first level appeal notice, for second level appeals). You will be notified of the determination before treatment ends or is reduced, where the determination is a decision to reduce or terminate concurrent care early.

Claims for Benefits: Notice of Determination

If your claim or appeal is in part or wholly denied, you will receive notice of an adverse benefit determination that will, where applicable:

- state specific reason(s) for the adverse determination;
- reference specific Plan provision(s) on which the benefit determination is based;
- describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary (initial claim only);
- describe the Plan's claims review procedures and the time limits applicable to such procedures (initial claim only);
- include a statement of your right to bring a civil action under section 502(a) of ERISA following appeal;
- state 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 (appeal only);
- describe any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures (appeal only);
- disclose any internal rule, guidelines, or protocol relied on in making the adverse determination (or state that such information will be provided free of charge upon request);

- if the denial is based on a medical necessity or experimental treatment or similar limit, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);

- include information sufficient to identify the claim involved, including date of service, health care provider, and claim amount;

- include the denial code and corresponding meaning;

- include a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and treatment code and its corresponding meaning;

- describe the Claims Administrator's standard, if any, used in denying the claim;

- describe the external review process, if applicable;

- include a statement about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under health care reform laws to assist individuals with internal claims and appeals and external review processes.

Claims for Benefits: External Review

You may have the right to request an independent review with respect to any claim that involves medical judgment or a rescission of coverage. Your external review will be conducted by an independent review organization not affiliated with the Plan. This independent review organization may overturn the Plan's decision, and the independent review organization's decision is binding on the Plan. Your appeal denial notice will include more information about your right to file a request for an external review and contact information.

You or your authorized representative may request external review by submitting supporting documentation, such as clinical records or medical history information. You must file your request for external review within four months of receiving your final internal appeal determination. Filing a request for external review will not affect your ability to bring a legal claim in court. When filing a request for external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

You may fax or mail your request for external review to the following:

Fax	Mail
1-866-443-1172	Caremark, Inc.
ATTN: Appeals Department	Appeals Department MC 109
	P.O. Box 52084
	Phoenix, AZ 85072-2084

The independent review organization will provide you and the Claims Administrator (on behalf of the Plan) with written notice of its final external review decision within 45 days after it receives the request. You may also request an expedited external review and it will be conducted as quickly as possible.

Deadline to Bring Legal Action

You may not bring a lawsuit to recover benefits under this Plan until you have exhausted the administrative process described in this section. No action may be brought at all unless brought no later than 1 year following a final decision on your claim for benefits. This statute of limitations on suits for all benefits shall apply in any forum where you may initiate such suit.

Article 5

Coordination of Benefits

Please refer to medical SPD for Coordination of Benefits details.

Article 6

Right to Reduction, Reimbursement, and Subrogation

Please refer to Medical SPD for any rules surrounding Right to Reduction, Reimbursement, and Subrogation.

Article 7

Plan Administration

Discretion to Interpret Plan

The Plan Administrator, and Claims Administrator if so delegated, shall have absolute discretion to construe and interpret any and all provisions of the Plan, including, but not limited to, the discretion to resolve ambiguities, inconsistencies, or omissions conclusively; provided, however, that all such discretionary interpretations and decisions shall be applied in a uniform and nondiscriminatory manner to all Participants and Eligible Dependents similarly situated. The decisions of the Plan Administrator, and Claims Administrator to the extent delegated final decision-making authority, upon all matters within the scope of its authority shall be binding and conclusive upon all persons.

Powers and Duties

In addition to the powers described in this Article and all other powers specifically granted under the Plan, the Plan Administrator, and Claims Administrator if so delegated, shall have all powers necessary or proper to administer the Plan and to discharge its duties under the Plan, including, but not limited to, the following powers:

(1) To make and enforce such rules, regulations, and procedures as it may deem necessary or proper for the orderly and efficient administration of the Plan;

(2) To enter into an administrative services agreement or insurance policy with an individual or entity to perform services with respect to one or more benefits under the Plan;

(3) In its discretion, to interpret and decide all matters of fact in granting or denying benefits under the Plan, its interpretation and decision thereof to be final and conclusive on all persons claiming benefits under the Plan;

(4) In its discretion, to determine eligibility under the terms of the Plan, its decision thereof to be final and conclusive on all persons;

(5) In its discretion, to authorize the payment of benefits under the Plan, its decision thereof to be final and conclusive on all persons;

(6) To prepare and distribute information explaining the Plan;

(7) To obtain from the Employer, Participating Employers, Eligible Employees, and Eligible Dependents such information as is necessary for the proper administration of the Plan;

(8) To appoint a Claims Administrator to review, determine, and authorize payment of requests for distribution under the Plan, to direct and supervise the payment of benefits, to review appeals of the denial of requests for distribution under the Plan, and to perform any other actions or duties the Plan Administrator may delegate to it;

(9) To sue or cause suit to be brought in the name of the Plan and to compromise and settle claims brought against, by, or on behalf of the Plan;

(10) To administer or pay benefits, or provide or receive any communications under the Plan, in electronic form, in accordance with applicable law; and

(11) To take any other action necessary or advisable to carry out its duties with respect to the Plan.

Right to Delegate

The Plan Administrator may from time to time allocate to one or more of the Employer's officers, employees, or agents, and may delegate to any other person or organization, any of its powers, duties, and responsibilities with respect to the operation and administration of the Plan, including, without limitation, the administration of claims, the authority to authorize payment of benefits, the review of denied or modified claims, and the discretion to decide matters of fact and interpret Plan provisions, and may employ and authorize any person to whom any of its fiduciary responsibilities have been delegated to employ persons to render advice with regard to any fiduciary responsibility held hereunder. Upon such designation and acceptance, the Plan Administrator shall have no liability for the acts or omissions of any such designee. All allocations and delegations of fiduciary responsibility shall be terminable upon such notice as the Plan Administrator in its discretion deems reasonable and prudent, under the circumstances.

Named Fiduciary

For purposes of ERISA, the Plan Administrator shall be the Plan's "named fiduciary" and may designate other named fiduciaries.

Indemnification

To the fullest extent authorized by law, and to the extent not otherwise covered by insurance, the officers and employees of the Employer or Participating Employers who provide services to the Plan shall be indemnified by the Employer against any and all liabilities arising by reason of any act, or failure to act, in relation to the Plan or the funds of the Plan, including without limitation, expenses reasonably incurred in the defense of any claim relating to the Plan or funds of the Plan, and amounts paid in compromise or settlement relating to the Plan or the funds of the Plan, unless (1) it is established by a final judgment or a court of competent jurisdiction that such act or failure to act

constituted gross negligence or willful misconduct, or (2) in the event of a settlement or other disposition of the claim, it is determined in a written opinion of legal counsel to the Plan that the act constituted gross negligence or willful misconduct.

Plan Expenses

All fees and expenses incurred in connection with the operation and administration of the Plan, including, but not limited to, legal, accounting, actuarial, investment, management, and administrative fees and expenses may be paid out of Plan assets to the extent that it is legally permissible for these fees and expenses to be so paid. The Employer may, but is not required, to pay such fees and expenses directly. The Employer may also advance amounts properly payable by the Plan and then obtain reimbursement from the Plan for these advances.

Article 8

HIPAA Compliance

Disclosures to Employer

The Plan may disclose participant information to the Employer (the "plan sponsor" for purposes of ERISA), as permitted under the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 ("HIPAA Privacy Regulations"). In addition, the Plan may disclose protected health information to the Employer as necessary to allow the Employer to perform plan administration functions, within the meaning of the HIPAA Privacy Regulations.

Use of PHI

The Plan will not use or disclose protected health information ("PHI") that is genetic information for underwriting purposes.

Access to Medical Information

The following employees or individuals under the control of the Employer shall have access to the Plan's protected health information to be used solely for plan administration functions, as defined in the HIPAA Privacy Regulations:

(1) Benefits personnel at the Plan's claims processing locations;

(2) Members of the legal, finance, information technology, audit, accounting, and human resources departments to the extent they perform functions with respect to the Plan; and

(3) Such other individuals or classes of individuals identified by the Plan's Privacy Officer as necessary for the Plan's administration.

Employer Agreement to Restrictions

The Plan will not disclose protected health information to the Employer until the Employer has certified to the Plan that it agrees to:

(1) Not use or disclose protected health information other than as permitted or required by law or as specified above;

(2) Not use or disclose the protected health information in any employment-related decisions or in connection with any other benefit or employee benefit plan of the Employer;

(3) Report to the Plan any use or disclosure of protected health information that is inconsistent with the uses and disclosures permitted by law or specified above of which the Employer becomes aware;

(4) Make protected health information accessible to the subject individual in accordance with the HIPAA Privacy Regulations;

(5) Allow the subject individuals to amend or correct their protected health information and incorporate any amendments to protected health information in accordance with the HIPAA Privacy Regulations;

(6) Make available the information to provide an accounting of its disclosures of protected health information in accordance with the HIPAA Privacy Regulations;

(7) Make its internal practices, books and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for determining compliance;

(8) Return or destroy the protected health information received, if feasible, after it is no longer needed for the original purpose and retain no copies of such information or, if not feasible, restrict access and uses to those that make the return or destruction of the information infeasible as required by the HIPAA Privacy Regulations;

(9) Ensure that any agents, including a subcontractor, of the Employer to whom the Employer provides protected health information shall also agree to these same restrictions;

(10) Ensure that adequate separation between the Employer and Plan is established as required under the HIPAA Privacy Regulations and restrict access to protected health information to those classes of employees or individuals identified above under "Access to Medical Information"; and

(11) Restrict the use of protected health information by those employees or individuals identified above under "Access to Medical Information" for plan administration functions within the meaning of the HIPAA Privacy Regulations.

Permitted Disclosure to Employer

Notwithstanding the foregoing, the Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose to the Employer the following types of information:

(1) Summary health information may be disclosed to the Employer if the Employer requests the summary health information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan, or

(2) modifying, amending, or terminating the Plan.

(2) Information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(3) Information provided pursuant to an authorization within the meaning of Section 164.508 of the HIPAA Privacy Regulations.

(4) De-identified information, as defined under the HIPAA Privacy Regulations.

Noncompliance

In the event of noncompliance with the restrictions herein by a designated employee or other entity or person receiving protected health information on behalf of the Employer, the employee or other individual shall be subject to discipline in accordance with the Employer's disciplinary procedures. Complaints or issues of noncompliance by such persons shall be filed with the Plan's Privacy Officer.

HIPAA Security Standards

(1) Safeguards. The Employer shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan, as required under 45 CFR Part 160 and Subparts A and C of Part 164 (the "HIPAA Security Standards").

(2) Agents. The Employer shall ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate safeguards to protect such information.

(3) Security Incidents. The Employer shall report to the Plan any security incident under the HIPAA Security Standards of which it becomes aware.

(4) Adequate Separation. The Employer shall establish reasonable and appropriate security measures to ensure adequate separation between the Plan and Employer in support of the requirements described herein.

Article 9

Other Legal Information

Applicable Law

The Plan and all rights hereunder are governed by and construed, administered, and regulated in accordance with the provisions of ERISA, HIPAA, and the Code to the extent applicable, and to the extent not preempted by ERISA, the laws of Illinois, without giving effect to its conflicts of laws provision. The Plan may not be interpreted to require any person to take any action, or fail to take any action, if to do so would violate any applicable law.

Plan Amendment & Termination

The Employer has the right to amend or terminate the Plan at any time. This reservation of the right to amend or terminate benefits applies to benefits for current employees and their dependents and also to retired or terminated employees and their survivors or dependents.

Nothing in this document or other communication from the Employer or its delegee with respect to the Plan shall be deemed to create or imply a continuing obligation by the Employer provide or fund benefits to current employees or their dependents or survivors, or retired or terminated employees or their dependents or survivors.

All amendments 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 Plan shall be invalid and unenforceable and may not be relied upon by any individual or entity.

Assignment of Benefits

You may not transfer or assign any benefit or right under the Plan. Any such assignment shall be void. Notwithstanding the foregoing, the Plan may choose to remit payments directly to health care providers with respect to covered services, if authorized by the Participant, but only as a convenience to Participants. Health care providers are not, and shall not be construed as, either "participants" or "beneficiaries" under this Plan and have no rights to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) Participants under any circumstances.

Right to Recover Overpayment

Payments are made in accordance with the provisions of the Plan. If it is determined that payment was made for an ineligible charge or that other insurance was considered primary, the Plan has the right to recover the overpayment. The Plan will attempt to collect the overpayment from the party to whom the payment was made. However, the Plan reserves the right to seek overpayment from any Participant. Failure to comply with this request will entitle the Plan to withhold benefits due a Participant. In addition, the Plan has the right to engage an outside collection agency to recover overpayments on the Plan's behalf if the Plan's collection effort is not successful.

Missing Persons

If the Plan Administrator or Claims Administrator cannot locate an individual covered under the Plan, after making a reasonably diligent effort, including by giving written notice addressed to the individual's last known address as shown by the records of the Plan, the amount payable to the individual is forfeited.

Article 10

Legal Notices

Newborns' & Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Statement of ERISA Rights

If you are a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

Receive Information About the Plan

- Examine, without charge, at the Plan Administrator's office and at other specified locations all documents governing the Plan, including, if applicable, insurance contracts, collective bargaining agreements, and a copy of the latest annual report 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, if applicable, insurance contracts and copies of the latest annual report (Form 5500 Series) and an updated SPD. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan’s annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your employer 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 welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have appealed all adverse determinations you may file suit in a state or Federal court. Any such suit must be brought no later than 180 days following a final decision on the claim for benefits. If it should happen that the 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 the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain

publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Appendix A

Participating Employers

HALO BRANDED SOLUTIONS INC.