



Flexible Spending Account Program Guide

Amended and Restated
Effective June 1, 2010

California

Table of Contents

Introduction to Flexible Spending Accounts	3
How Flexible Spending Accounts Work	3
Health Care Spending Account Program	3
Dependent Care Spending Account Program	3
Administration	3
Eligibility	4
Health Care Spending Account	5
What is the Health Care Spending Account Program and Who Should Enroll?	5
How Does the Health Care Spending Account Program Work?	6
Who Are Eligible Family Members?	7
Health Care Spending Account Planning Worksheet	8
Table of Eligible Expenses	9
Dual Purpose Expenses	10
Ineligible Expenses	10
How Do I Use My Debit Card to Pay for Eligible Expenses?	11
How Do I Get Reimbursed If I Do Not Use the Debit Card?	12
Sick, Family Medical, and Military Leaves	13
Other Approved Leaves	13
Termination, Death or Retirement	14
Dependent Care Spending Account	15
What is the Dependent Care Spending Account Program and Who Should Enroll?	15
How Does the Dependent Care Spending Account Program Work?	15
Who Are Eligible Family Members?	16
Deciding How Much to Contribute to Your Dependent Care Spending Account	17
Planning Worksheets	18
Table of Eligible Expenses	19
Ineligible Expenses	19
How Do I Use My Debit Card to Pay for Eligible Expenses?	20
How Do I Get Reimbursed If I Do Not Use the Debit Card?	21
Leaves and Termination of Participation	21
Health Care & Dependent Care Spending Account Information & Forms	22
How Do I Enroll?	22
Changing Your Election	23
Separate Accounting	23
Forfeiture Rules Under the Plan	24
When Participation Ends	24
Erroneous Claims and Administrative Errors	24
COBRA Continuation Coverage	25
Medical Child Support Orders	26
Questions	26
How to File an Appeal	26
Your Rights Under ERISA	28
General Information	29
Plan Sponsor	29
Plan Administrator	29
Agent for Service of Legal Process	29
Claims Administrator	30

Plan Funding	30
Plan Year	30
Future of the Plans	30
Employer Identification Number	30
Plan Number	30
Health Care Spending Account Claim Form Instructions	31
Health Care Spending Account Claim Form	33
Dependent Care Spending Account Claim Form Instructions	34
Dependent Care Spending Account Claim Form	35

Introduction to Flexible Spending Accounts

CVS Caremark Corporation ("CVS") is pleased to sponsor an employee benefit plan, known as the CVS Caremark Corporation Flexible Benefits Plan (the "Plan"). It is so-called because it lets you choose among component programs under the Plan -- known as the Health Care Flexible Spending Account Program (the "Health Care Spending Account Program") and the Dependent Care Flexible Spending Account Program (the "Dependent Care Spending Account Program") -- according to your individual needs. These programs help you because they allow you to pay certain health care and dependent care expenses with pre-tax money. You will not pay any federal, Social Security and in most cases, state or local taxes on funds placed in the Plan. You can save an estimated \$15 to over \$35 on every \$100 you elect to contribute to the Plan. The amount of your savings will depend on your federal, state and local income tax brackets.

This Guide describes the basic features of the Plan's Health Care and Dependent Care Spending Account Programs as in effect on June 1, 2010, how they operate, and how you can get the maximum advantage from these programs. **This Guide is not a part of the official plan documents. In case of any conflict between this Guide and the Plan documents -- or if the Plan is required to operate in a different manner to comply with federal tax law -- the Plan documents or federal laws will control.**

How Flexible Spending Accounts Work

Health Care Spending Account Program. There are some medical, dental, and vision expenses that are not covered by insurance. You may also have deductibles and copays. Therefore, the Health Care Spending Account Program offers an arrangement under which you can pay for those non-covered items on a pre-tax basis. You can do that by contributing a portion of your pay on a pre-tax basis to your Health Care Spending Account. You can then receive tax-free reimbursements out of this account for non-covered health expenses. You can use your Health Care Spending Account not only for the out-of-pocket medical, dental, and vision expenses that you incur, but also for the expenses incurred by your spouse and eligible family members even if they are covered by insurance elsewhere.

Dependent Care Spending Account Program. If you have work-related dependent care expenses (such as a nursery, day care center, or private sitter), the Dependent Care Spending Account Program allows you to pay for these expenses on a pre-tax basis. You can do this by contributing a portion of your pay on a pre-tax basis to your Dependent Care Spending Account. You can then receive tax-free reimbursements out of this account for your work-related dependent care expenses. For your dependent care expenses to be work-related, the expenses must be incurred while you are at work (if you are single parent) or, if you are married, while you and your spouse are both at work. If your dependent care expenses are for a child, your child must be under the age of 13 to qualify unless he or she is disabled and meets the criteria discussed below.

Administration. The Senior Vice President and Chief Human Resources Officer of CVS is the Plan Administrator. The Plan Administrator has the sole discretionary authority to decide all questions relating to eligibility to participate and the benefits offered under the Plan. Accordingly, benefits will be paid under the Plan only if the Plan Administrator determines that you are eligible to receive benefits.

An independent third party administrator, known as the "Claims Administrator," has been retained to assist the Plan Administrator in administering the Plan on a daily basis. The Claims Administrator, Benefit Strategies, LLC, reviews and processes all claims for reimbursement according to the terms of the Plan, and answers all questions regarding the Plan.

Claims Administrator

Benefit Strategies, LLC
P.O. Box 3910
Manchester, NH 03105-3910
Phone: 1-800-371-7542
Fax: 1-401-457-7266 or 1-800-796-4971
Email: customerserviceri@BenStrat.com

Generally, the Plan works as follows:

- Each year you decide how much to contribute to the Health Care and Dependent Care Spending Accounts.
- Money is deducted from your paycheck (before taxes are calculated) and put into the account(s).
- When you have eligible expenses, use your Benefits MasterCard debit card to pay those expenses or pay for expenses yourself (and request reimbursement). If you pay with the debit card, you may be required to submit a receipt (as explained in more detail in this Guide). If you pay for the expenses yourself, you will need to submit the Health Care or Dependent Care Claim Form (as applicable) with receipts for the expenses and get a tax-free reimbursement from your account.
- If you choose to pay for eligible expenses, reimbursements are made weekly by either check or direct deposit. If you use the debit card, the expenses are paid from your account as explained in more detail in this Guide.

Benefit Strategies' website provides some tools to help you decide if enrolling in the Spending Account Programs can benefit you:

- Calculate your tax savings – an online version of planning worksheets (described below) that helps you determine how much you can save by participating in the Health Care and Dependent Care Spending Account Programs.
- View a list of expenses that qualify.
- View answers to the most frequently asked questions regarding the Health Care and Dependent Care Spending Account Programs.

Eligibility

Participation in the Health Care Spending Account Program and the Dependent Care Spending Account Program commences upon satisfying the eligibility requirements and completing the required enrollment procedures discussed in this Guide. Those employees who actually participate in the Health Care and Dependent Care Spending Account Programs under the Plan are called "participants."

You are eligible to participate if you are an active full-time employee working in the United States, are employed by CVS Caremark Corporation or a related company that has adopted the Plan, and meet the service requirement (discussed in the paragraphs below). However, you will not be eligible to participate if you are (a) covered under a collective bargaining agreement where benefits were the subject of good faith bargaining (unless that agreement provides for participation in the Health Care Spending Account Program), (b) classified, by CVS in its sole discretion under its customary worker classification procedures as a part-time employee, temporary employee, seasonal employee, leased employee, independent contractor, consultant, part-time employee or other designation that would exclude eligibility (whether or not you actually are an employee) unless your specific contract or employment agreement with CVS provides for coverage under the Program.

If you are scheduled to work an average of 30 hours or more per week upon hire, you may begin participation in the Program on the first day of the month following 90 days of continuous full-time active employment with CVS. If you are scheduled to work an average of at least 23 (but less than 30) hours per week upon hire, you may begin participation in the Health Care Spending Account Program on the first day of the second month following 26 weeks of continuous employment. If you do not enroll when first eligible, you must wait until the next Annual Enrollment to enroll. You will be notified of the Annual Enrollment period.

If you do not meet the eligibility requirements during your initial qualification period, you may meet the eligibility requirements during a subsequent semi-annual qualification period by working an average of at least 23 hours per week. To remain eligible for the Program, you must work an average of at least 23

hours per week. Continued eligibility for benefits is reviewed for all eligible employees twice annually based on whether this minimum average has been maintained during the prior 26-week period.

Note that employees who work for Retail and PBM are classified according to the respective jobs they hold for each business unit. Hours worked are not aggregated for purposes of benefit eligibility.

Special Rule for Transfers, Reclassified Employees. Certain affiliated entities of CVS – such as MinuteClinic – have not adopted the Plan, and therefore employees of these companies do not participate in the Plan. If you transfer to CVS from an affiliated entity that has not adopted the Plan, you are given credit for service performed as a full-time employee at the affiliated entity in determining whether you have satisfied the Plan’s 90-day service requirement. Likewise, if you do not participate in the Plan because of your status as a union employee (*i.e.*, you are covered under a collective bargaining agreement, as described above), and your employment status subsequently changes to non-union, you are given credit for service performed as a full-time union employee in determining whether you have satisfied the Plan’s 90-day service requirement.

If you are transferred to CVS from an affiliated entity, or are reclassified as a non-union employee, and have satisfied the 90-day service requirement after service is attributed to you, you may begin Plan participation immediately – *i.e.*, you do not have to satisfy a new waiting period.

Health Care Spending Account

What Is the Health Care Spending Account Program and Who Should Enroll?

The Health Care Spending Account Program offers significant income tax savings opportunities for eligible expenses. Essentially, you accumulate money in an account by contributing through convenient pre-tax payroll deductions. Then you draw from the account by using the debit card or by submitting a Health Care Claim form to reimburse yourself for out-of-pocket expenses. Both your payroll deductions and reimbursements are tax-free.

The Health Care Spending Account Program is beneficial to anyone who has out-of-pocket medical/prescription, dental, vision, or hearing expenses beyond what insurance plans cover.

This program can be a cost-effective way to pay for such items as medical/prescription and dental plan deductibles/copayments, eyeglasses, contact lenses, orthodontics, over-the-counter medications, and other health-related expenses. (See page 9 for a more complete listing of eligible expenses.)

Because the Health Care Spending Account Program allows you to pay for health-related expenses with pre-tax dollars, you save money by lowering your taxable income and your taxes. Even taxpayers who do not itemize can take advantage of this tax break using the Health Care Spending Account Program. Under the Health Care Spending Account Program, your contributions are not subject to federal, state (in most cases), Social Security, and Medicare taxes.

Here’s an example of what a family situation might look like:

Eligible Expenses	Without the Health Care Spending Account	With the Health Care Spending Account
Health & Dental Plan Copayments or Deductibles	\$300	\$300
+ Prescription Copayments	200	200
+ Eyeglasses/Lenses Expenses	200	200
+ Orthodontia	300	300
= Total Out-of-Pocket Expenses	\$1,000	\$1,000
Taxes on Income Earned to Pay Expenses (28%)	\$280	\$0
Actual Cost	\$1,280	\$1,000
Actual Savings	\$0	\$280

By paying for medical/prescription-related expenses through the Health Care Spending Account Program, this family could save \$280 a year in taxes.

If you currently itemize your deductions on your federal income tax return and you deduct health-related expenses, you should consult your tax advisor to determine if you should participate in the Health Care Spending Account Program. Generally it will be more cost-effective for you to pay expenses through the Health Care Spending Account Program as most individuals are not able to deduct medical expenses.

When you reduce your FICA taxes, you reduce your Social Security contribution, and thus, your eventual Social Security payout. Studies show, however, that your tax savings significantly outweigh your Social Security reduction.

How Does the Health Care Spending Account Program Work?

The Plan Year is June 1st through May 31st. Your coverage begins on the date stated in your benefits letter or on June 1st of the current year if enrolling as part of the Annual Enrollment. Before your coverage begins, determine your anticipated expenses. You may include qualified out-of-pocket expenses for yourself and any eligible family members (which generally is anyone you can claim as a dependent for tax purposes). You can contribute up to a maximum of \$5,000 per Plan Year, which amount is credited to a recordkeeping account. In estimating your expenses, keep in mind that if you are enrolling at Annual Enrollment, you will participate in the Plan for a 12-month Plan Year beginning June 1st and ending May 31st (unless you cease to be eligible during the Plan Year, for example due to a termination of employment, and do not elect COBRA continuation coverage [discussed below]). If you enter the Plan after the beginning of the Plan Year, you will participate in the Plan for a period that spans from your participation date to May 31st following your entry into the Plan. For example, if you were hired on July 15th, your participation would begin on November 1st. Since the Plan Year ends on May 31st, you will need to estimate expenses for the period of November 1 through May 31. A planning worksheet is provided on page 8.

After you have determined your estimated expenses (and decided on your total contribution to the Health Care Spending Account Program), equal amounts will be deducted before taxes from each regular paycheck and contributed to your Health Care Spending Account. As you submit eligible expenses you have incurred, you will be reimbursed on a non-taxable basis from your account. If the eligible expenses incurred by you and your eligible family members during the Plan Year (or portion of the Plan Year in which you participate) are less than the amount you elected to contribute to your account for that Plan Year, Internal Revenue Service ("IRS") rules require that the leftover money be forfeited (as discussed in the "Forfeiture Rules Under the Plan" Section of this Guide).

What Is a Recordkeeping Account?

After you enroll, recordkeeping account(s) are established in your name. The account is credited each pay period with the contribution you elected beginning with your first paycheck of your participation. Note: the "account" is for recordkeeping only.

Benefit Strategies, the record keeper for the health care and dependent care spending accounts, is there to meet your needs. Contact **Benefit Strategies** whenever you have a question about eligible expenses, reimbursement, claim forms, account balances and more at customerserviceri@BenStrat.com or 1-800-371-7542.

The elections you make under the Health Care Flexible Spending Account Program for a Plan Year do not carry over to subsequent years. As a result, you must re-enroll in the Health Care Flexible Spending Account Program each Plan Year. You will be notified of the Annual Enrollment.

Who Are Eligible Family Members?

The contributions you make to your Health Care Spending Account are used to reimburse you for eligible expenses incurred by you and your eligible family members. Your eligible family members for the Health Care Spending Account are:

- Your legal spouse of the opposite sex;
- Your child (or a descendant of such child) or your brother, sister, step-brother, or step-sister (or a descendant thereof) who:
 - lives in your home for more than one-half of the year;
 - does not provide over one-half of his or her own support; and
 - has not attained, as of the end of the year, the age of 19 or the age of 24 if he or she is a full-time student (unless the child is disabled, in which case no age limit applies); or
- Your parent, step-parent, grandparent, brother, sister, step-brother, step-sister, niece, nephew, child (or his or her descendant), aunt, uncle, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, or other person who lives in your home and is a member of your household (where your relationship with this individual does not violate local law), who:
 - depends on you for at least 50% of his or her support; and
 - is not your child as described above.

In the case of an individual whose parents (i) are divorced or legally separated, (ii) are separated under a written separation agreement, or (iii) live apart at all times during the last six months of the year, the individual will be considered an eligible "child" of either parent if the child receives one-half of the child's support from the child's parents and such child is in custody of one or both of the child's parents for more than one-half of the calendar year.

You do not need to claim the individual as a dependent on your federal income tax return.

In addition, the eligible family members under the Health Care Spending Account Program do not need to be covered under any of your health plan options. For example, if you are married, it may be the case that your spouse is not being covered under CVS's health plan. If your spouse incurs a copayment expense under a plan sponsored by his or her employer, you may be reimbursed through the Health Care Spending Account Program for that copayment expense.

Is My Same-Sex Spouse or Domestic Partner an Eligible Family Member?

Under IRS rules, neither same-sex spouses nor non-domestic partners are treated as "eligible spouses" for purposes of the Health Care Spending Account. However, your same-sex spouse or domestic partner (or their children) may be treated as an eligible family member *if* they meet the requirements discussed above -- *i.e.*, they live in your home and are a member of your household (where your relationship does not violate local law) and dependent on you for at least 50% of their support.

Health Care Spending Account Planning Worksheet

You should estimate the amount of medical, dental, and vision expenses you (and your eligible family members) are likely to incur during the Plan Year which will not be paid by any insurance or benefit plans in which you or your family are enrolled. If possible, you should look at the amount of out-of-pocket medical, dental, and vision expenses that you and your family incurred over the past couple of years, and then think about the expenses you may incur for the coming Plan Year. This will require a careful budgeting decision by you (and your family), because if you do not "spend" the money in your Health Care Spending Account during the Plan Year (or portion of the Plan Year in which you participate in the Plan), you will lose it (as discussed under the "Forfeiture Rules of the Plan" Section of this Guide). The maximum amount you can contribute to your Health Care Spending Account each Plan Year is \$5,000.

Health expenses that will be paid by you with no reimbursement from other plans*

Health plan deductibles/coinsurance/copays	\$ _____
Immunizations	\$ _____
Routine physical exams/well baby care	\$ _____
Prescription drug deductibles/coinsurance	\$ _____
Other medical/prescription expenses not covered by benefit plans	\$ _____

Over the Counter (OTC) eligible items*

Pain relievers	\$ _____
Allergy medicine	\$ _____
Eye drops	\$ _____

Dental expenses that will be paid by you with no reimbursement from other plans*

Dental plan deductibles/coinsurance/copays	\$ _____
Dental expenses not covered in full	\$ _____
Orthodontia expenses not covered in full	\$ _____
Other dental expenses not covered by benefit plans	\$ _____

Vision expenses that will be paid by you with no reimbursement from other plans*

Exams	\$ _____
Eyeglasses and contact lenses	\$ _____
Other expenses	\$ _____

Hearing expenses that will be paid by you with no reimbursement from other plans*

Exams	\$ _____
Hearing aids	\$ _____
Other expenses	\$ _____

Other Eligible Expenses*

\$ _____

TOTAL

\$ _____ **

*All eligible expenses must have been incurred during the Plan Year to be reimbursed. **Effective January 1, 2011, the Federal government will prohibit the reimbursement of OTC's without a prescription.**

**This is the total amount you may wish to contribute to your Health Care Spending Account.

Table of Eligible Expenses*

Below are many of the expenses eligible for payment under the Health Care Spending Account Program, to the extent such expenses are not covered by medical/prescription insurance, dental insurance, or other insurance. In general, all office visit copayments, medical plan deductibles, prescription copayments, dental plan deductibles, eye glasses, contact lenses, orthodontics, and other health-related expenses (including over-the-counter medications approved by the IRS) that are not covered by your insurance can be submitted for reimbursement under the Health Care Spending Account Program, provided the service or item is used to diagnose, prevent, alleviate or treat illness or injury. The list is not meant to be all-inclusive. Other expenses not specifically mentioned may also qualify.

<p>Dental Services Crowns/Bridges Dental X-rays Dentures Exams/Teeth Cleaning Extractions Fillings Gum Treatment Oral Surgery Orthodontia</p>	<p>Practitioners Allergist Chiropractor Christian Science Dermatologist Homeopath Naturopath Ophthalmologist Optometrist Osteopath Physician Psychiatrist Psychologist</p>	<p>Counseling Crutches Hearing Aids & Batteries Hospital Bed Oxygen Equipment Prosthesis Splints/Casts Syringes Transportation Expenses (essential to medical care) Tuition Fee at Special School for Disabled Child Wheelchair</p>
<p>Insurance Related Items Copay and Coinsurance Amounts Deductibles Pre-existing Condition Expenses (medical/prescription) Private Hospital Room Differential</p>	<p>Other Medical/Prescription Treatments/Procedures Acupuncture Alcoholism (inpatient treatment) Drug Addiction Hearing Exams Hospital Services Infertility In-vitro Fertilization Norplant Insertion or Removal Physical Examination (not employment-related) Physical Therapy Speech Therapy Sterilization Transplants (including organ donor) Vaccinations/Immunizations Vasectomy Well Baby Care</p>	<p>Over-the-Counter (OTC)* Medication Acne treatment Aspirin Antacids Allergy medicines Cold and Cough medicines Prenatal Vitamins Fiber Supplements Laxatives Motion sickness pills Muscle/joint pain medicines Nicotine Replacement Products Pregnancy Test Sleep aids Smoking Cessation Program Fees Eye drops</p>
<p>Lab Exam/Tests Blood Tests Cardiograms Diagnostic Lab Fees Metabolism Tests Spinal Fluid Tests Urine/Stool Analysis X-rays</p>	<p>Other Medical/Prescription Equipment, Supplies and Services Abdominal/Back Supports Ambulance Services Arches/Orthopedic Shoes (cost difference of common product) Bandages/Gauze Pads Telephone for the Deaf/Hearing Impaired Medica Alert Bracelets/Necklace Braille Books and Magazines Car Controls (for the disabled)</p>	<p>Vision Services Artificial Eyes Contact Lenses Contact Lens Solution Eye Examinations Eyeglasses Laser Eye Surgeries Prescription Sunglasses Radial Keratotomy Guide Dog (for a visually/hearing impaired person)</p>
<p>Medication Insulin Prescribed Birth Control Prescribed Vitamins Prescription Drugs Retin A</p>		
<p>Obstetric Services Lamaze Classes Midwife Expenses OB/GYN Exams Postnatal Treatment Prenatal Treatment</p>		

All expenses eligible for reimbursement must be legally purchased. **Effective January 1, 2011, the Federal government will prohibit the reimbursement of OTC's without a prescription.*

For more information about additional eligible expenses, see IRS publication #502, "Medical/prescription and Dental Expenses." It is available on the Internet at <http://www.irs.gov/pub/irs-pdf/p502.pdf>, from your local public library, or by calling (800) TAX-FORM.

Important. IRS regulations require that the reimbursement of Over-the-Counter (OTC) medications be reasonable in the quantity of a particular item. The intention is to have a reasonable quantity of an item on hand for use during the Plan Year. Reimbursement claim forms will be audited accordingly.

Dual Purpose Expenses

Dual purpose expenses are expenses that may have both a medical purpose and a personal/cosmetic or general health purpose. Items in this category require a statement from a licensed medical practitioner that describes the specific medical condition that the item or service is recommended to treat.

These expenses are eligible with a doctor's certification identifying the physical nature of the medical/prescription condition and length of treatment program. For example, massage therapy for the sole purpose of tension/stress relief does not qualify as an eligible expense. (This is not an all-inclusive listing.)

Calcium Supplements	Herbs and Herbal Medicines	Sunscreen
Cosmetic Surgery/Procedures	Homeopathic Drugs	Support Hose
Electrolysis	Massage Therapy	Vitamins
Exercise Equipment	Rogaine	Weight Loss Programs/Drugs
Fitness Programs	St. John's Wort	Wigs (hair loss due to disease)
Hair Loss Medications	Special Foods	
Health Club Dues	(cost difference of common product)	

Ineligible Expenses

Ineligible expenses include expenses that are used to promote general health. The IRS does not allow the following expenses to be reimbursed under the Health Care Spending Account Program. (This is not an all-inclusive listing.)

Baby-sitting and Child Care	Face Creams/Moisturizers	Prescription Drug Discount
Cancelled Appointment	Illegal Operation or Treatment	Program Premiums
Charges	Insurance Premium Interest Charge	Student Health Fee
Contact Lens Insurance	Insurance Premiums	Swimming Lessons
Dancing Lessons	Lip Balm	Teeth Whitening/Bleaching
Diaper Service	Marriage Counseling	Toiletries, Toothpaste etc.
Discounts/Write-offs	Maternity Clothes	Vision Discount Program Premiums
Eyeglass Insurance	Medicated Shampoo	
	Personal Trainer	

If you receive a reimbursement from your Health Care Spending Account for an ineligible expense, you are responsible for repaying the money to your Health Care Spending Account. Refer to the "Administrative Claims and Administrative Errors" Section of this Guide for a discussion of how erroneous claims are recovered and the impact of failing to repay the Plan.

How Do I Use My Debit Card to Pay for Eligible Expenses?

When you have eligible medical, dental, or vision expenses, use your "Benefits MasterCard" debit card for instant access to your Health Care Spending Account when making a purchase at a pharmacy (such as CVS), physician and dentists' offices, as well as other health care providers. The Benefits MasterCard looks and works like a typical debit card. You will not have to pay for services out-of-pocket and wait to be reimbursed. If the MasterCard logo is not accepted at the location where you have incurred an eligible expense or you choose not to use it at the time of service, you will still need to fill out a Health Care Spending Account Claim Form for reimbursement.

Save Your Receipts

While you have the convenience of the debit card, you will still be required to submit receipts for many expenses. Because the IRS rules require substantiation of claims paid from your account, be prepared to submit receipts for eligible expenses paid using your debit card. For example, you will be required to substantiate (*i.e.*, submit receipts) debit card transactions for deductibles and co-insurance at a healthcare provider. As discussed below, certain transactions will be automatically substantiated and thus no receipt will be required.

Transactions using IIAS technology. Certain merchants (such as CVS) use an "inventory information approval system" ("IIAS"), which is a point-of-sale technology allowing for instant approval of debit card transactions for eligible Health Care Flexible Spending Account expenses. IIAS automatically processes over-the-counter items, including aspirin and band aids, and prescriptions purchased with your debit card. In stores where IIAS is used, in most cases you will not be required to submit additional documentation. (Certain transactions, such as a purchase of items for which a doctor's letter is required, will not be recognized by IIAS technology.) Non-pharmacy merchants (such as grocery stores, wholesale discounters and online pharmacies) have implemented the IIAS (and if you go to a non-pharmacy merchant that has not implemented the IIAS, your card will be denied in which case you must pay and submit a claim for reimbursement). For a complete list of merchants that have adopted the IIAS, visit **Benefit Strategies'** website at www.benstrat.com.

Other transactions. If you are enrolled in the CVS medical plan, your copayment information will already be on file with **Benefit Strategies**; therefore, you generally will not be required to submit receipts for copayments made under the CVS medical plan.

If you are not enrolled in a CVS medical plan, you will be required to submit a receipt to **Benefit Strategies** the first time you incur a copayment. After this first submission, **Benefit Strategies** will have your copayment for that particular merchant or health care provider on file and future copayment transactions in that amount at the same merchant or health care provider will be automatically substantiated by **Benefit Strategies**. However, if your debit card transaction does not match the copayment amount (for example, if you purchase a prescription *and* an over-the-counter medication in a single debit card transaction and the IIAS is not in place), a receipt will be requested.

In the event **Benefit Strategies** determines that you have received payment for an ineligible amount, you will be asked to pay back that amount. If you do not repay the Plan, your debit card will be suspended. Also, refer to the "Erroneous Claims and Administrative Errors" section of this Guide for an explanation of other consequences for not repaying the ineligible expenses.

Terms and Conditions of Using Debit Card

In order to use the debit card, you must agree to abide by the following terms and conditions when you first become eligible to participate in the Plan and during each Annual Enrollment:

- You must certify (under **Benefit Strategies** procedures) that you will use the debit card only for eligible expenses.

- You must certify that you have not been reimbursed for the eligible expense from any other source and that you will not seek reimbursement from any other source. (This certification is reaffirmed each time you use your debit card.)
- Unless **Benefit Strategies** does not request substantiation (for example, due to the IIAS technology or for copayments as discussed above), you must certify that you will substantiate claims for reimbursement made through the debit card. This means that, upon request, you will provide **Benefit Strategies** a statement that includes the nature of the expense, the date the expense was incurred, and the amount of the expense.
- You must agree to pay back to the Plan any improperly paid claim.

Each time you use the debit card, you are certifying that you agree to abide by the above terms and conditions.

How Do I Get Reimbursed If I Do Not Use the Debit Card?

If you choose not to use the debit card and instead pay for eligible expenses with cash, check, or another form of credit, complete a Health Care Spending Account Claim Form for reimbursement of those expenses from your account. Health Care Spending Account Claim Forms are available online at www.BenStrat.com. A Health Care Spending Account Claim Form is also attached to this Guide. Note that eligible expenses must be incurred during the Plan Year. This means the services must actually be provided during the Plan Year, regardless of when you are billed for the services or pay for the services.

Complete and sign the Health Care Spending Account Claim Form and include the following: name of employee or eligible family members receiving care, dates of service, name of service provider, charges incurred or a receipt from the provider. Services must be received while you were actively at work (unless you are covered under the Plan during a leave or through COBRA continuation coverage, as discussed below) and enrolled in the Plan. Additionally, services must be received prior to a request for reimbursement. Mail the information to **Benefit Strategies**. Additional instructions are supplied on the form.

Reimbursement claim forms and reimbursement checks are processed daily. Your reimbursement check stub includes a summary of the claim processed on that check and the balance in the account. If you elect direct deposit you will not receive a check advising of your direct deposit. This information is available to you online.

Direct Deposit Available. Rather than have reimbursement checks mailed to your home, you can have your reimbursements deposited to the account of your choice. Simply go to www.BenStrat.com or call **Benefit Strategies** at **1-800-371-7542** to request a direct deposit form and elect to have your reimbursements direct deposited. The direct deposit feature saves you trips to the bank, eliminates postal service delays, and reduces worry about lost, stolen, or forged checks. If you elect direct deposit, the first disbursement will be in the form of a check and then starting with the 2nd disbursement, the funds will be deposited to your selected account.

The cut-off date for submitting claims incurred during the Plan Year is **3 months after the end of Plan Year**; this means that all documentation necessary to substantiate your claim must be post-marked by this date. (Likewise, if your claim is faxed, the fax transmittal information must reflect a date on or before the cut-off.) For example, eligible expenses incurred during the Plan Year beginning June 1 and ending May 31 (and the documentation to substantiate those expenses), must be submitted for reimbursement to **Benefit Strategies** with a post-mark date (or fax date) that is no later than August 31.

You may obtain up-to-date account information, such as remaining account balance and last check issued, 24 hours per day, seven days per week at www.BenStrat.com

You may submit claims for reimbursement that exceed your current Health Care Spending Account balance but not in excess of your Plan Year elections. The funds that are reimbursed will be recovered as deductions continue to be deposited into your Health Care Spending Account throughout the Plan Year.

Be sure to plan your contributions carefully. IRS regulations require that money left unused in your account at the end of the Plan Year be forfeited.

Sick, Family Medical, and Military Leaves

During the Plan Year, if you take an **approved sick leave, family medical leave, or military leave**, you may continue to participate in the Health Care Spending Account Program during the first 90 days of the leave. (If you are on unpaid leave, you may also revoke your coverage during your leave.) If you continue coverage and return to work prior to the end of the 90-day period, missed contributions to the Plan will be deducted (pre-tax) from your first paycheck upon return from leave.

If you are on leave longer than **90 days** or end your leave before that time but do not return to work, you are no longer eligible to participate in the Health Care Spending Account Program unless you elect to continue coverage under COBRA (discussed under the "COBRA Continuation Coverage" Section of this Guide). COBRA offers you the opportunity to continue making after-tax contributions to your Health Care Spending Account. If you properly elect and pay for COBRA, you may submit claims for reimbursement for eligible expenses (according to the rules discussed above) incurred during your period of COBRA continuation coverage. Should you decline COBRA, you are eligible to continue to submit claims for reimbursement for expenses incurred prior to your participation termination date.

If you elect COBRA, upon returning to work following a leave, you may re-enroll within 30 days of your return by calling the CVS Contact Support Center at 1-866-528-7272. You will then be instructed to complete a change form, or enroll using the telephonic or online enrollment tools, depending on your situation. If you return to work following a sick leave, military leave, or family medical leave during which you had discontinued coverage, you may either resume coverage at the level in effect before your leave (and make up unpaid premiums), or resume coverage at a reduced level (and reduce your initial election by amounts not contributed during your leave). If you have experienced a Change in Status (defined in the "Changing Your Election" Section of this Guide) and re-enroll within the same Plan Year, you may make an election change that is consistent with the Change in Status. If you re-enroll during a subsequent Plan Year, you may make a new election for that Plan Year without regard to your prior election.

Other Approved Leaves

In the event of an **approved leave (other than sick, family, or military)**, your participation will end **30 days** following the start of the leave. If you return to work prior to the end of the 30-day period, missed contributions to the Health Care Spending Account Program will be deducted (pre-tax) from your first paycheck upon return from leave. If the leave is longer than 30 days, you are no longer eligible to participate in the Health Care Spending Account Program unless you elect to continue coverage by electing COBRA continuation coverage (discussed in the "COBRA Continuation Coverage" Section of this Guide). If you elect COBRA, any missed contributions while on leave will need to be made up and then you may continue to submit claims for reimbursement. Should you decline COBRA, you are eligible to continue to submit claims for reimbursement for expenses incurred prior to your participation termination date.

If you elect COBRA, upon returning to work following a leave, you may re-enroll within 30 days of your return by calling the CVS Contact Support Center at 1-866-528-7272. You will then be instructed to complete a change form, or enroll using the telephonic or online enrollment tools, depending on your

situation. If you have not experienced a Change in Status (defined in the "Changing Your Election" Section below) and re-enroll within the same Plan Year, your initial enrollment election, reduced by any amounts not contributed during your leave due to cessation of participation, will remain in place. If you have experienced a Change in Status and re-enroll within the same Plan Year, your election must be consistent with the Change in Status. If you re-enroll during a subsequent Plan Year, you may make a new election for that Plan Year without regard to your prior election.

Termination, Death or Retirement

If your participation ends because you cease to be an eligible employee (for example due to a change from full-time to part-time status, transfer of employment to an affiliated entity that does not participate in the Plan [such as MinuteClinic], termination, death, or retirement), your Health Care Spending Account deductions will stop with the processing of your last check and you are no longer eligible to participate in the Health Care Spending Account Program unless you elect to continue coverage by electing COBRA continuation coverage (discussed in the "COBRA Continuation Coverage" Section of this Guide). You are, however, eligible to continue to submit claims for reimbursement for expenses incurred prior to your participation termination date even if you do not elect COBRA. The reimbursement claim forms and supporting documentation can be submitted **up to 3 months after the end of the Plan year**.

If you elect COBRA, if you again become an eligible employee (for example, you return to full-time status or are re-hired), you may become a participant in the Health Care Spending Account Program after satisfying the service requirements described in the "Eligibility" Section of this Guide. If you re-enroll during the same Plan Year, your initial enrollment election, reduced by amounts not contributed during the period in which you did not participate, will remain in place unless you have a Change in Status. If you re-enroll in a subsequent Plan Year, you may make a new election for that Plan Year without regard to your prior election.

Dependent Care Spending Account

What Is the Dependent Care Spending Account Program and Who Should Enroll?

For many people, dependent care is necessary for them to be able to work. Normally, you would pay for these expenses with after-tax income. And, because taxes reduce the value of your dollar, you would have to earn considerably more than \$100 to pay \$100 for dependent care expenses.

To help this situation, CVS offers the Dependent Care Spending Account Program, which allows you to pay for work-related dependent care expenses with pre-tax dollars. As a result, you save money by lowering your taxable income and your taxes. Under this program, your contributions are not subject to federal, state (in most cases), and Social Security taxes. Generally, this tax savings can be between 15% and 35%, depending on your tax bracket. As a direct result of these personal tax savings, you can actually increase your disposable income.

The example below shows how the tax savings works:

Eligible Expenses	Without the Dependent Care Account	With the Dependent Care Account
Payment to Baby-sitter, Child Care Center, After-School Program, Day Camp, Nursery School, or Adult Day Care Center	\$5,000	\$5,000
Taxes on income earned to pay expenses (28%)	\$1,400	0
Actual Cost	\$6,400	\$5,000
Actual Savings	\$0	\$1,400

In this example, the participant elected the maximum contribution to the Plan. The tax savings in a 28% tax bracket would be \$1,400.

How Does the Dependent Care Spending Account Program Work?

The Plan Year is June 1st through May 31st. Your coverage begins on the date stated in your benefits letter or on June 1st of the current year if enrolling as part of Annual Enrollment.

Before your coverage begins, determine how much money you wish to place in your account based on your estimate of your work-related dependent care expenses for the upcoming Plan Year. Keep in mind the time in which your dependent is not receiving care, such as vacation or sick time. The maximum dollar amount that you can contribute is discussed in the "Deciding How Much to Contribute to Your Dependent Care Spending Account" Section of this Guide.

After you have estimated work-related dependent care expenses and determined your contribution to the Dependent Care Spending Account Program, equal amounts will be deducted before taxes from each regular paycheck and contributed to your Dependent Care Spending Account. As you submit eligible expenses you have incurred, you will be reimbursed up to the amount in your Dependent Care Spending Account. If work-related dependent care expenses are less than you elected to contribute for that Plan Year (or portion of the Plan Year in which you participate in the Plan), IRS rules require that the leftover money be forfeited (as discussed under the "Forfeiture Rules of the Plan" Section of this Guide).

Please note that your dependent care expenses may not be reimbursed from your Dependent Care Spending Account before the expenses are incurred. For this purpose, dependent care expenses are

treated as having been incurred when the dependent care expenses are provided, not when the expenses are formally billed, charged, or paid by you. Thus, if a dependent care provider requires payment before the dependent care services are provided (for example, if advance payment or deposit is required) those expenses cannot be reimbursed at the time of payment, even through the use of the debit card (discussed below).

The elections you make under the Dependent Care Spending Account Program for a Plan Year do not carry over to a subsequent year. As a result, you must re-enroll in the Dependent Care Spending Account Program each Plan Year. You will be notified of the Annual Enrollment period.

Who Are Eligible Family Members?

The contributions you make to your Dependent Care Spending Account are used to reimburse you for child and/or dependent day care services provided for eligible family members. To qualify as an eligible family member for the Dependent Care Spending Account Program, the person must meet the IRS definition of a "dependent" for federal income tax purposes (you do not need to claim the individual as a dependent on your federal income tax return but the dependent must be eligible for you to do so) and must be:

- Your child under age 13. For these purposes, "child" includes your child (or a descendant of such child), or your brother, sister, step-brother, or step-sister (or a descendant thereof) who:
 - lives in your home for more than one-half of the year; and
 - does not provide over one-half of his or her own support.

- Your legal spouse of the opposite sex or dependent of any age who (1) is physically or mentally incapable of self-care, (2) lives with you for more than one-half of the year, and (3) regularly spends at least 8 hours each day in your home. For these purposes, the term "dependent" includes (A) any child described above who is age 13 or older and (B) your parent, step-parent, grandparent, brother, sister, step-brother, step-sister, niece, nephew, child (or his or her descendant), aunt, uncle, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, or other person who lives in your home and is a member of your household (where your relationship with this individual does not violate local law), who:
 - depends on you for at least 50% of his or her support; and
 - is not your child as described above.

Who is Incapable of Self-Care?

Individuals who are considered incapable of self-care are those who are not able to dress, clean, or feed themselves because of physical or mental problems, and who require constant attention to prevent them from injuring themselves or others.

Is My Same-Sex Spouse or Domestic Partner an Eligible Family Member?

Under IRS rules, neither same-sex spouses nor non-domestic partners are treated as "eligible spouses" for purposes of the Health Care Spending Account. However, your same-sex spouse or domestic partner (or their children) may be treated as an eligible family member *if* they meet the requirements discussed above -- *i.e.*, they live in your home and are a member of your household (where your relationship does not violate local law) and dependent on you for at least 50% of their support.

Planning Worksheets

The following worksheets provide an opportunity to compare the potential tax savings available through the Dependent Care Spending Account versus the federal income tax credit. For most taxpayers, the Dependent Care Spending Account is expected to result in greater tax savings. However, you should consult a tax advisor to determine the best approach for you.

Because you reduce your FICA taxes by participating in the Dependent Care Spending Account, you will also be reducing your Social Security contribution. Studies show, however, that your tax savings significantly outweigh your Social Security reduction.

Federal Income Tax Credit Worksheet

1. The amount of expenses for day care during the calendar year
(cannot exceed your income or that of your spouse, whichever is less) \$ _____
2. Maximum expenses eligible for tax credit
(\$3,000 for one dependent, \$6,000 for more than one dependent) \$ _____
3. Estimated federal adjusted gross income for you and your spouse \$ _____
4. Percentage from table below based on adjusted gross income _____%
5. Estimated tax credit
(multiply line 4 by the smaller of line 1, line 2, or line 3) \$ _____

Adjusted Gross Income	%	Adjusted Gross Income	%	Adjusted Gross Income	%	Adjusted Gross Income	%
Up to \$15,000	35%	\$21,001-\$23,000	31%	\$29,001-\$31,000	27%	\$37,001-\$39,000	23%
\$15,001-\$17,000	34%	\$23,001-\$25,000	30%	\$31,001-\$33,000	26%	\$39,001-\$41,000	22%
\$17,001-\$19,000	33%	\$25,001-\$27,000	29%	\$33,001-\$35,000	25%	\$41,001-\$43,000	21%
\$19,001-\$21,000	32%	\$27,001-\$29,000	28%	\$35,001-\$37,000	24%	\$43,001-Unlimited	20%

Dependent Care Spending Account Worksheet

1. The amount of deposit to your dependent care reimbursement account
(must not exceed the lesser of your income, your spouse's income, \$5,000 or \$2,500 if you are married and file a separate return, or the lower dollar threshold set forth highly compensated individuals, if applicable) \$ _____
2. Your federal tax rate from the table below _____%
3. FICA tax rate. Enter 7.65% for earnings up to \$102,000*
Enter 1.45% for earnings over \$102,000* _____%
4. State and local tax rate** _____%
5. Total tax rate (line 2 + line 3 + line 4) _____%
6. Estimated tax savings (multiply line 5 by line 1) \$ _____

Estimated Federal Tax Rate***

	Head of Household	Married Filing Jointly
10%	Up to \$11,950	Up to \$16,700
15%	\$11,950 to \$45,500	\$16,700 to \$67,900
25%	\$45,500 to \$117,450	\$67,900 to \$137,050
28%	\$117,450 to \$190,200	\$137,050 to \$208,850
33%	\$190,200 to \$372,950	\$208,850 to \$372,950
35%	\$372,750 +	\$372,950 +

Note: Higher tax rates apply for higher incomes, and these rates are applied to other income levels for individuals filing as "single" or "married filing single".

* \$106,800 is the FICA wage base for 2010. The federal government annually adjusts this amount.

** Deposits to your account are generally exempt from state and local taxes. This exemption is dependent, however, on the state and locality in which you reside.

***Based on 2009 tax rates, which are subject to change.

If line 6 on the Dependent Care Spending Account Worksheet is larger than line 5 on the Federal Income Tax Credit Worksheet, then the Dependent Care Spending Account can be expected to provide you a greater tax savings than the tax credit.

If your contributions to your Dependent Care Spending Account are less than the amount of your actual dependent care expenses, you may use the federal income tax credit for the balance, however, the total amount of your expenses reimbursed under the Plan and those claimed on the tax credit cannot exceed the limits set forth for the tax credit. Consult your tax advisor for assistance.

Table of Eligible Expenses

Only eligible work-related dependent care expenses actually incurred during the Plan Year may be reimbursed from your Dependent Care Spending Account. This means that only expenses incurred which allow you (and your spouse, if married) to work or attend school as a full-time student are eligible. The following expenses are eligible:

<ul style="list-style-type: none"> ➤ A day care center or other provider outside your home that complies with State and local licensing laws. ➤ A day camp during school vacation (if not primarily for educational purposes). ➤ A licensed nursery school, even though the school provides lunch and educational services. ➤ Before-school and after-school day care programs. ➤ A sitter or nurse in or out of your home (during your working hours), provided the sitter is over age 18 and not one of your eligible dependents. 	<ul style="list-style-type: none"> ➤ A housekeeper, maid, or cook, but only if at least part of their services are to provide day care for a person who qualifies as an eligible family member (discussed below). ➤ A relative who cares for your eligible dependent(s), as long as that relative is not one of your eligible dependents or one of your children under age 19. ➤ Someone who cares for an elderly or incapacitated dependent who lives with you. ➤ An adult day care facility for an elderly or incapacitated dependent who lives with you (but not expenses of overnight or nursing home facilities).
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For more information about additional eligible expenses, see IRS publication #503, "Child and Dependent Care Expenses." It is available on the Internet at <http://www.irs.gov/pub/irs-pdf/p503.pdf>, from your local public library, or by calling (800) TAX-FORM.

You may use any care provider you choose. The services may be as informal as care provided by your neighbor, as long as the provider claims the money received for services as income when determining his or her taxes at the end of the year. You will also need to obtain the provider's federal identification/Social Security number for inclusion on your own tax filing form.

If your work-related dependent care expenses during the Plan Year are less than the amount you elect to contribute to your account for that Plan Year, the left over money will be forfeited (as discussed in the "Forfeiture Rules Under the Plan" Section of this Guide).

Ineligible Expenses

While not a complete list, the following are examples of ineligible Dependent Care Spending Account expenses:

Child support payments	Late payment fees	Expenses applied toward a federal income tax credit
Food, clothing, and entertainment	Medical/prescription expenses	Day care expenses for children age 13 and over
Cleaning and cooking services not provided by the caregiver	Expenses incurred when you (or your spouse) are not working or your spouse is not a full-time student or mentally or physically incapable of self-care	Amounts you claim as a federal dependent care income tax credit on your federal income tax return for the calendar year
Educational supplies		
Kindergarten	Expenses for 24-hour custodial care, such as nursing home care	
Overnight camp		
Activity fees		

If you use your debit card to pay for ineligible expenses or you receive a reimbursement from your Dependent Care Spending Account for an ineligible expense, you are responsible for repaying the money to your account. Refer to the "Erroneous Claims and Administrative Errors" Section of this Guide for a discussion of how these amounts are recovered and the impact of failing to repay the Plan.

How Do I Use My Debit Card to Pay for Eligible Expenses?

When you have eligible dependent care expenses, use your "Benefits MasterCard" debit card for instant access to your dependent care spending account when paying for childcare or eldercare. The Benefits MasterCard looks and works like a typical debit card. You will not have to pay for services out-of-pocket and wait to be reimbursed. If the MasterCard logo is not accepted at the location where you have incurred an eligible expense or you choose not to use it at the time of service, you will still need to fill out a Dependent Care Spending Account Claim Form for reimbursement.

Save Your Receipts

While you have the convenience of the debit card, you are still required to submit receipts for dependent care expenses, as explained below.

At the beginning of the Plan Year and upon enrollment in the Dependent Care Spending Account Program, you will need to pay your initial expenses to your dependent care provider and substantiate the initial expenses by submitting to **Benefit Strategies** a statement from your dependent care provider that sets forth the dates and amounts for the services. Later card transactions that have been previously approved as to your dependent care provider will be treated as substantiated by you if **Benefit Strategies** determines that the expense is recurring. For example, if you notify **Benefit Strategies** that the expense is recurring or if a debit transaction is for an amount equal to or less than the previously substantiated amount, you generally will not need to submit receipts for the recurring expenses.

Accessing Your Dependent Care Spending Account

After you substantiate a claim to **Benefit Strategies** (but not before the expenses are incurred), the Plan will make available through the debit card an amount equal to the lesser of (1) your previously incurred and substantiated expense and (2) your total salary reduction amount to date. For example, assume salary reduction amounts are made based on a weekly payroll and your election results in a \$100 salary reduction per week beginning on June 1. If after 9 weeks of salary reduction you have not made a claim, you will have \$900 in your Dependent Care Spending Account and can use your debit card to make payment in that amount, provided your dependent care expenses have been incurred and are considered substantiated at that time.

In the event **Benefit Strategies** determines that you have received payment for an ineligible amount, you will be asked to pay back that amount. If you do not repay the Plan, your debit card will be suspended. Also, refer to the "Erroneous Claims and Administrative Errors" section of this Guide for an explanation of other consequences for not repaying the ineligible expenses.

Terms and Conditions of Using Debit Card

In order to use the debit card, you must agree to abide by the following terms and conditions when you first come eligible to participate in the Plan and during each Annual Enrollment:

- You must certify (under **Benefit Strategies'** procedures) that you will use the debit card only for eligible expenses.
- You must certify that you have not been reimbursed for the eligible expense from any other source and that you will not seek reimbursement from any other source. (This certification is reaffirmed each time you use your debit card.)

- Unless **Benefit Strategies** does not request substantiation (for certain recurring expenses, discussed above), you certify that you will substantiate claims for reimbursement made through the debit card. This means that, upon request from **Benefit Strategies**, you will provide a statement that includes the nature of the expense, the date the expense was incurred, and the amount of the expense.
- You must agree to pay back to the Plan any improperly paid claim.

Each time you use the debit card, you are certifying that you agree to abide by the above terms and conditions.

How Do I Get Reimbursed if I Do Not Use the Debit Card?

If you choose not to use the debit card, and instead pay for eligible Dependent Care expenses with cash, check, or another form of credit, complete a Dependent Care Spending Account Claim Form and attach itemized receipts that include: name of dependent receiving care, dates of service, name of service provider, provider's social security or Tax ID Number. Canceled checks, bankcard receipts, credit card receipts and credit card statements are NOT acceptable forms of documentation. Mail the information to **Benefit Strategies**. Additional instructions are supplied on the form.

Dependent Care Spending Account Claim Forms are available online at www.BenStrat.com. A Dependent Care Claim Form is also attached to this Guide.

You will be reimbursed up to your Dependent Care Spending Account balance at the time you submit your claim. If your claim is for more than your Dependent Care Spending Account balance, the unreimbursed portion of your claim will be tracked by **Benefit Strategies**. You will be automatically reimbursed as additional deductions are taken from your paycheck and deposited into your Dependent Care Spending Account.

Claim forms and checks are processed daily. Your reimbursement check stub includes a summary of the claim processed on that check and the balance in the account.

Direct Deposit Available. Rather than have reimbursement checks mailed to your home, you can have your reimbursements deposited to the account of your choice. Simply go to www.BenStrat.com or call **Benefit Strategies** at **1-800-371-7542** to request a direct deposit form and elect to have your reimbursements direct deposited. The direct deposit feature saves you trips to the bank, eliminates postal service delays, and reduces worry about lost, stolen, or forged checks. If you elect direct deposit, the first disbursement will be in the form of a check and then starting with the 2nd disbursement, the funds will be deposited to your selected account.

You may obtain up-to-date account information such as account balance and last check issued, 24 hours per day, seven days per week, by going to www.BenStrat.com.

The cutoff date for submitting claims incurred during the Plan Year is **3 months after the end of the Plan Year**; this means that all documentation necessary to substantiate your claim must be post-marked by this date. (Likewise, if your claim is faxed, the fax transmittal information must reflect a date on or before the cutoff.) For example, eligible expenses incurred during the Plan year beginning June 1, and ending May 31 (and the documentation to support those expenses), must be submitted to **Benefit Strategies** for reimbursement with a post-mark date (or fax date) that is no later than August 31.

Leaves and Termination of Participation

During the Plan Year, if you take an approved sick leave, family medical leave, or military leave, your participation will end as of the effective date of the leave. Your Dependent Care Spending Account deduction will stop with the processing of your last regular paycheck. You are eligible to continue to submit claims incurred prior to your participation termination date up to the amount you have contributed

to your Dependent Care Spending Account. If you return to work during the Plan Year, your deductions will automatically resume. If you experience a Change in Status (defined in the "Changing Your Election" Section of this Guide), you may make an election change consistent with that Change in Status. If you return to work the following Plan Year and you would like to participate, you must make a new enrollment election within 30 days of your return to work. Call the CVS Contact Support Center at 1-866-528-7272 within 30 days of your return to work.

If you transfer from CVS to work at an affiliated entity that does not participate in the Plan (*e.g.*, MinuteClinic), your active participation in the Plan will end. However, you will remain eligible to be reimbursed from the remaining balance in your Dependent Care Spending Account for dependent care expenses incurred after you cease participation (due to the transfer to the affiliated entity) and through the last day of the Plan Year.

All other leaves, termination, death, or retirement will result in termination of your participation in the Dependent Care Spending Account Program as of the effective date of the event. Your Dependent Care Spending Account deductions stop with the processing of your last paycheck, and you are no longer eligible to contribute to your Dependent Care Spending Account. You are eligible to continue to submit claims for dates of service incurred prior to your participation termination date up to the amount you have contributed to your Dependent Care Spending Account.

If you again become an eligible employee (for example, you are re-hired), you may become a participant in the Dependent Care Spending Account Program after satisfying the service requirements described in the "Eligibility" Section of this Guide. If you re-enroll during the same Plan Year, your initial election, reduced by amounts not contributed during the period in which you did not participate, will remain in place. If you re-enroll during a subsequent Plan Year, you may make a new election for that Plan Year without regard to your prior election.

Health Care and Dependent Care Spending Account Information

How Do I Enroll?

Follow these steps to enroll:

1. Estimate the expenses that you will incur during the Plan Year (or portion of the Plan Year in which you participate in the Plan). The maximum Plan Year election for the Health Care Spending Account is \$5,000. The maximum Plan Year election for the Dependent Care Spending Account is \$5,000 (\$2,500 if you are married and file separate federal income tax forms). If you are considered highly compensated (earned more than \$110,000 in 2009), your election for the Dependent Care Spending Account may be reduced.
2. Communicate your elections to CVS through the EmployeeZone at <http://my.cvs.com>, additional instructions are provided in your enrollment materials.
3. **Benefit Strategies** will send a welcome kit with more information on how the debit card works. The debit card will be sent to your home a few days later. Your paycheck deductions will begin following enrollment.
3. If you have specific questions regarding the Health Care Spending Account or the Dependent Care Spending Account, you may contact **Benefit Strategies** at customerserviceri@BenStrat.com or call 1-800-371-7542 and ask to speak to a customer service representative between the hours of 8 a.m. and 6 p.m. EST Monday – Thursday or 8 a.m. and 5 p.m. EST on Friday.

Changing Your Election

The IRS strictly limits the circumstances under which you may make election changes outside the Annual Enrollment period. Generally, you cannot change your election during the Plan Year and must wait until Annual Enrollment (and then, election changes are only for the coming Plan Year), although your election will terminate if you are no longer working for CVS. However, you may make certain election changes during the Plan Year if you experience a "Change in Status" event and notify CVS by calling the CVS Contact Support Center at 1-866-528-7272 **within 30 days** of the Change in Status. You will then be provided with additional instructions to complete this transaction. You will be required to take action and complete the transaction by the later of (a) 14 days of your calling the CVS Contact Support Center or (b) 30 days following your Change in Status. The occurrences which qualify as Change in Status include:

- a change in your legal marital status (such as marriage, divorce, legal separation, annulment, or death of a spouse);
- events that change the number of your dependents (such as birth, adoption, or placement for adoption, or death);
- a change in employment status or work hours that affects benefit eligibility;
- a change in the place of residence or work for you, your spouse or dependent which impacts availability or cost of current health plan coverage;
- your dependent satisfies or ceases to satisfy the requirements for unmarried dependents; or
- a judgment, decree, or court order that requires dependent care support payments or that requires you to add or allows you to drop health care coverage for your child.

An election change must be on account of and consistent with the Change in Status. The Plan Administrator, in its sole discretion, will determine whether a requested change is on account of and consistent with a Change in Status. Retroactive deduction changes are not permitted.

If you have a Change in Status, you may be able to increase or decrease your spending account contributions. For example, you may enroll or increase (not decrease) your contributions to the Dependent Care Spending Account.

Your election change will become effective as of the date of the event.

Remember to report your Change in Status within 30 days of the event. Otherwise, you will have to wait until Annual Enrollment to make a change. You may also be asked to provide proof of your Change in Status. However, even if you do not yet have proof of your Change in Status, you must call the CVS Contact Support Center at 1-866-528-7272 **within 30 days** of the event.

Separate Accounting

According to federal law, contributions to the Health Care Spending Account and Dependent Care Spending Account cannot be used interchangeably. Any contributions you make to the Health Care Spending Account must be used for eligible health care expenses; any contributions made to the Dependent Care Spending Account must be used for eligible dependent day care expenses. Federal law mandates that CVS review spending accounts to ensure they meet specific guidelines. The amounts you contribute to spending account(s) may be returned to you to comply with federal guidelines. You will be advised if this becomes necessary.

Forfeiture Rules Under the Plan

Contributions to your Health Care Spending Account or Dependent Care Spending Account are not subject to federal income tax, state income tax (in most cases), or Social Security tax. This can mean several hundred -- or even thousands -- of dollars in savings to you over the course of the Plan Year. However, it is important to understand that the Plan is governed by the Internal Revenue Code and, as such, there are rules and regulations that govern its operation. One of these rules states that you must actually "spend" the money that you elect to contribute to your Health Care Spending Account and/or Dependent Care Spending Account during the Plan Year. By law, any money that you do not spend by the end of the Plan Year cannot be carried forward into a new Plan Year nor may it be returned to you. This is called the "use it or lose it" rule. As an example, let's assume you elect to contribute \$1,200 to a Dependent Care Spending Account. Now, suppose you incur only \$1,000 of reimbursable expenses during the Plan Year. Under the rules of the Internal Revenue Code, you would forfeit the remaining \$200 at the end of the Plan Year. Likewise, if you transfer from employment with CVS to another affiliated entity that does not participate in the Plan (such as MinuteClinic), your Health Care Spending Account contributions under the Plan will be forfeited under the above "use it or lose it" rule. (Note that a special rule allows you to use your unused Dependent Care Spending Account contributions for the remainder of the Plan Year after you cease participation in the Plan due to a transfer to an affiliated entity that does not participate in the Plan.)

When Participation Ends

Your participation in the Health Care or Dependent Care Spending Account Program ends on May 31st of each Plan Year. To continue your participation in the spending account programs, you must re-enroll each year during the Annual Enrollment period.

Your participation will also end on the earlier of:

- the termination of the Plan;
- the date you cease to be an eligible employee (or, in the case of the Health Care Spending Account Program, when your COBRA coverage ends if elected); or
- the date you cease to contribute or revoke your election to the extent permitted under the Plan.

Erroneous Claims and Administrative Errors

If the Plan Administrator determines that you have received a reimbursement under either the Health Care Spending Account Program or the Dependent Care Spending Account Program that either (i) exceeds the amount of substantiated eligible expenses, or (ii) was paid to you in error, you will be required to repay the excess reimbursements to the Plan. The Plan provides that the Plan Administrator in its discretion may recoup the excess reimbursements under any methods of collection available, including any of the following:

- notification to you of the excess reimbursement, and an accompanying request that you immediately pay the excess reimbursement as directed by the Plan Administrator;
- offsetting the excess reimbursement against any other eligible expense submitted for reimbursement under the Health Care or Dependent Care Spending Account Program (regardless of the Plan Year in which it is submitted); and
- if permissible under applicable law, withholding the amount of the excess reimbursements from your pay on a post-tax basis.

If the Plan Administrator is unable to recoup the excess reimbursements from you, the excess reimbursements will be reported as such for tax purposes.

If the Plan Administrator determines that you were erroneously included in the Plan as a participant, you will be disenrolled from the Plan, paid amounts credited to your account(s) at disenrollment, and liable to CVS as set forth above.

If the Plan Administrator is unable to recover all or a portion of your debt to the Plan, you may not be eligible to participate in the Health Care Spending Account Program and/or the Dependent Care Spending Account Program during the next Annual Enrollment period.

COBRA Continuation Coverage

A federal law called "COBRA" requires most employers sponsoring group health plans and medical reimbursement plans to offer employees and their families the opportunity for a temporary extension of coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan otherwise would end due to the occurrence of a "qualifying event." Thus, if you are no longer eligible to participate in the Health Care Spending Account due to a qualifying event, you may continue contributing to your Health Care Spending Account under COBRA.

In general, a qualifying event under COBRA includes the following events which result in your loss of coverage:

- termination of your employment (other than by reason of gross misconduct), or reduction of your work hours;
- your death;
- divorce or legal separation from your spouse;
- your becoming eligible to receive Medicare benefits; or
- when a dependent of yours ceases to be a dependent.

For a qualifying event that is a divorce or legal separation from your spouse, or your dependent ceasing to be eligible to participate in the Plan, it will be your obligation to inform the Plan Administrator of the event in writing within 60 days of its occurrence. The Plan Administrator, in turn, has a legal obligation to furnish you, your spouse, or your dependent as the case may be, with a notice of your rights under COBRA and with the option to elect to continue the applicable coverage provided at stated premium costs. Qualified beneficiaries have 60 days following receipt of the notice regarding their COBRA rights to elect to continue coverage under COBRA. The notification you will receive regarding your rights under COBRA will explain all the terms and conditions of the continued coverage in detail.

Under COBRA, you may contribute to your Health Care Spending Account for the remainder of the Plan Year in which your coverage ceases, but only on an after-tax basis with an administrative charge of 2% of your contribution. In addition, you may elect to continue coverage under your Health Care Spending Account only if, at the time of your qualifying event, your Health Care Spending Account has a positive account balance, taking into account all claims submitted for reimbursement prior to the qualifying event. Your Health Care Spending Account will have a positive account balance at the time of the qualifying event if the amount of your medical reimbursement claims for that Plan Year has not exceeded the amount you contributed to the account for that Plan Year at the time of the qualifying event.

Medical Child Support Orders

The Health Care Spending Account Program will comply with the requirements of any “qualified medical child support order” as defined in ERISA. The Plan Administrator has developed procedures to determine whether a medical child support order is qualified and for complying therewith. A participant may obtain, without charge, a copy of these procedures upon request to the Plan Administrator.

Questions

If you have questions, you may contact **Benefit Strategies** at customerserviceri@BenStrat.com or **1-800-371-7542** between the hours of 8 a.m. and 6 p.m. EST Monday – Thursday or 8 a.m. and 5 p.m. EST on Friday. At www.BenStrat.com, you may obtain up-to-date account information such as remaining account balance and last check issued, 24 hours per day, seven days per week.

How to File an Appeal

This program has established the following claims review procedure in the event you are denied a benefit under this Plan.

Step 1: Claim Denial Notice is received from Benefit Strategies. If your claim is denied, you will receive written notice that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond its control, **Benefit Strategies** may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The deadline by which **Benefit Strategies** must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: Review your notice carefully. Once you have received your notice from **Benefit Strategies**, review it carefully. For claims under the Health Care Spending Account Program, the notice will contain:

- The reason(s) for the denial and the Plan provisions on which the denial is based;
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- A description of the Plan’s procedures if you wish to appeal **Benefit Strategies’** claim denial, including your right to submit written comments and have them considered, your right to review (upon request at no charge) relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim;
- If an internal rule, guideline, protocol, or other similar criterion is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
- A statement regarding your right to request all documentation relevant to your claim.

Step 3: If you disagree with the decision, file an Appeal. If you do not agree with the decision and you wish to appeal the denial of your claim, you must file your appeal with **Benefit Strategies** within the following time period following receipt of the denial notice described in Step 1. You have 30 days from the date of your original denial for a claim under the Dependent Care Spending Account

Program and 180 days from the date of your original denial for a claim under the Health Care Spending Account Program. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request at no charge) documents and other information relevant to your appeal.

Step 4: Notice of Appeal Denial is received from Benefit Strategies. If the claim is again denied, you will be notified in writing as soon as possible but no later than 60 days after receipt of the appeal by **Benefit Strategies**. The Plan Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided. If the decision on review affirms the initial denial of your claim and your claim relates to your Health Care Spending Account, you will be furnished with a notice of adverse benefit determination on review setting forth:

- The specific reason(s) for the decision on review;
- The specific Plan provision(s) on which the decision is based;
- A statement of your right to receive (upon request and at no charge) relevant documents and other information;
- If an internal rule, guideline, protocol, or other similar criterion is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
- A statement of your right to bring suit under ERISA 502(a) (where applicable).

Time Bar to Legal Action. No legal action may be commenced or maintained against the Plan until the claims procedures set forth above are exhausted. If you do not follow the above claims procedures, you will lose your right to sue. In addition, no legal action may be commenced against the Plan more than 90 days after the Plan Administrator's decision on review under the claims procedures set forth above.

Important Information

Other important information regarding your appeals:

- For the Health Care Spending Account Program only, each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal); and
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information.

Your Rights Under ERISA

As a participant in the Health Care Spending Account Program under the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants in the Health Care Spending Account Program under the Plan 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 work sites or union halls, all documents governing the Plan, including collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in 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 which is denied or ignored, in whole or in part, you may file suit in state or Federal court subsequent to exhausting the Plan's claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court subsequent to exhausting 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 a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the party you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

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

General Information

This section provides administrative information for the Plan (which includes the Health Care and Dependent Care Spending Account Programs). This description of administrative information is not an employment contract or any type of employment guarantee.

The Plan Administrator will help resolve any problem you might have about your rights to benefits. The official Plan documents, and related information are available if you want to review these materials. If, for some reason, it becomes necessary to contact the U.S. Employee Benefits Security Administration, Department of Labor, you will need to provide the information contained in this section to identify the Plan properly.

Plan Sponsor

CVS Caremark Corporation
One CVS Drive
Woonsocket, RI 02895
(401) 765-1500

Plan Administrator

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

Agent for Service of Legal Process

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

Process may also be served on the Plan Administrator.

Claims Administrator

Benefit Strategies, LLC
P.O. Box 3910
Manchester, NH 03105-3910
Phone: (800) 371-7542
Fax: (401) 457-7266 or 1-800-796-4971
Email: customerserviceri@benstrat.com
www.BenStrat.com

Plan Funding

How administrative costs and claims for benefits are paid is referred to as funding. Your Health Care and Dependent Care Spending Accounts are funded through the general assets of CVS. All administrative services and all claims are paid from CVS's general assets.

Plan Year

Each year beginning June 1 and ending May 31

Future of the Plans

While CVS expects to continue the Health Care and Dependent Care Spending Account Programs, CVS reserves the right to terminate, modify, or amend them at any time without notice, by CVS or by approval of the Senior Vice President and Chief Human Resources Officer of CVS. Any claims requested after the effective date of termination, modification, or amendment are payable in accordance with the respective Program documents. However, no amendment or termination can reduce or otherwise affect any claim for a benefit you became entitled to before the date of amendment or termination. In the event the Health Care and/or Dependent Care Spending Account Program terminates, you will be informed of any termination rights you may have.

Employer Identification Number

The employer identification number assigned to CVS by the Internal Revenue Service (IRS) is 05-0494040.

Plan Number

The Plan, which is a component plan of the CVS Caremark Corporation Welfare Benefits Plan, has a Plan Number of 510.

Health Care Spending Account Claim Form Instructions

Health Care Spending Account

To qualify for reimbursement from your Health Care Spending Account, the following is required:

1. The receipts submitted must be for health, dental, vision, over-the-counter items, or hearing expenses which are allowed by IRS regulations. The expense must have been incurred prior to the time that the reimbursement claim form is being submitted.
2. The expense must be incurred by you or a dependent for who you will be entitled to a personal exemption on your federal income tax return.
3. If there is a question as to the eligibility of a particular expense or the dependency status of a particular individual, you will be contacted for more information.

How to file a claim •

- Complete the top portion of the form by filling your name and social security number.
- In the claims section, complete all information for each amount claimed for reimbursement. •
- You must sign and date the claim form. •
- Attach your itemized bills and any explanation of benefits (EOB) forms from the insurance carriers (photocopies accepted).

Mail or fax the claim form and receipts to:

**Benefit Strategies LLC
P. O. Box 3910
Manchester, NH 03105-3910
or
Fax to: (401) 457-7266
(800) 796-4971**



Health Care Spending Account Claim Form

Employer: CVS/pharmacy

Employee Name: _____ **Social Security Number:** _____

Phone: _____ **E-mail (Optional):** _____

Please complete this claim form. Incomplete forms will be returned to you. To expedite your claim, please provide all appropriate information and review the Total Health Care Expense amounts.

Unreimbursed Health Expense Claims				
Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
<i>*Attach appropriate receipt(s) and submit with this claim form.</i>			Total Health Care Expense Claim	\$

Read Carefully: The undersigned participant in the Health Care Spending account Program (the "Plan") certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Employee's Signature

Date

Mail the claim form and receipts to: Benefit Strategies LLC, P. O. Box 3910, Manchester, NH 03105-3910

**Or fax to: (401) 457-7266
 (800) 796-4971**

Dependent Care Spending Account Claim Form Instructions

Dependent Care Spending Accounts

To qualify for reimbursement from your Dependent Care Spending Account, the following is required:

1. Dependent care expenses must be incurred to enable you (and your spouse, if married) to work.
2. The person providing the dependent care service must not be a child of yours under age 19 or a dependent for whom you will be entitled to a personal exemption on your federal income tax return.
3. The dependent(s) being cared for must be less than 13 years old (unless physically or mentally unable to care for themselves).
4. You will be required to provide the taxpayer I.D. (TIN) or Social Security Number, name, and address of the dependent care provider on your federal income tax return.
5. Your expense limit for the federal tax credit is reduced by the amount of reimbursed expenses through your Dependent Care Spending Account.
6. You cannot receive more than actual deposits reported as of the date your claim is processed.

How to file a claim

- Complete the top portion of the form by filling in the employee's name and social security number.
- In the claims section, complete all information for each amount claimed for reimbursement.
- The employee must sign and date the claim form.
- Attach a copy of a bill, invoice or other written statement from a third party, which supports each reimbursement request and shows the date the service was incurred **or** have the dependent care provider sign the claim form in the Provider's Signature box.
- Statements showing only a balance forward and copies of **cancelled checks** or **credit card receipts** are **not** valid receipts.

Mail or fax the claim form and receipts to:

Benefit Strategies LLC
P. O. Box 3910
Manchester, NH 03105-3910
or
Fax to: (401) 457-7266
(800) 796-4971

Dependent Care Spending Account Claim Form

Employer: CVS/pharmacy

Employee Name: _____ **Social Security Number:** _____

Phone: _____ **E-mail (Optional):** _____

Please complete this claim form. Incomplete forms will be returned to you. To expedite your claim, please provide all appropriate information and review the Total Dependent Care Expense amounts.

Dependent Care Expense Claims				
Name of Dependents	Period Covered		Name, Address, and Taxpayer Identification Number of Service Provider	Amount Incurred
	From	To		
Attach a receipt from your daycare provider, or include the daycare provider's signature.			Provider's Signature:	
			Total Dependent Care Expense Claim*	\$

***NOTE:** The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of \$200 if there is one (1) child or dependent, or \$400 if there are two (2) or more.) No payment may be made under the Plan, if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19.

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Employee's Signature _____
Date

Mail the claim form and receipts to: Benefit Strategies LLC, P. O. Box 3910, Manchester, NH 03105-3910

Or fax to: (401) 457-7266 or (800) 796-4971