YP Holdings, LLC Prescription Drug Program

Summary Plan Description

This summary plan description ("SPD") describes the prescription drug benefits available to participants who are currently enrolled in a YP Holdings, LLC medical plan option. Enrollment in the Express Scripts (ESI) Prescription Drug Program (the "Program") is automatic based upon an employee's election of medical coverage. This SPD is a supplement to the SPD for your medical plan option and should be read together with the SPD for your medical plan option.

The Program provides coverage for a variety of generic and brand-name prescription medications that members may purchase from any retail network pharmacy or through ESI's mail order program.

Eligibility

The Program's eligibility requirements and terms of coverage are governed by YP Holdings, LLC's medical plan provisions, which are detailed in the medical summary plan description, which has been distributed to you electronically. You may also obtain a copy of your medical summary plan description by contacting your local HR representative. You are not eligible for coverage under the Program unless you are also covered under a YP Holdings, LLC medical plan option.

Enrollment

Enrollment in the Program is automatic when you enroll in a YP Holdings, LLC medical plan option. The coverage effective date and termination date of each member's prescription drug coverage is in accordance to the coverage terms established by YP Holdings, LLC's medical plan(s) provisions.

How the Program Works

The Prescription Drug Program uses a three-tier cost share design. The three-tier design maintains a broad choice of covered drugs for patients and their doctors, while providing an incentive to use medications that are safe, effective and less costly. Frequently there is more than one prescription drug that your physician could prescribe for a particular illness or condition. Talk with your doctor about your options to determine the best choice for you.

You will receive the following benefits based upon your medical plan. Note that certain medical plan options will not provide coverage until you have satisfied the annual deductible. Refer to your medical plan option SPD for more details. The coverage for each prescription varies by type of drug and whether you fill your prescription at a retail pharmacy or through mail order.

	CDHP	
Type of drug	Retail cost share *(30-day supply)*	Mail Order cost share *(90-day supply)*
	All copays apply after the medical deductible has been satisfied, with the exception of preventive drugs which bypass the deductible. Copays are waived after medical out of pocket maximum is met.	
Generic	$10	$25
Preferred Brand	$30	$75
Non-Preferred Brand	$50	$125
Specialty	*Standard non-specialty drug copays apply	*Standard non-specialty drug copays apply

Brand-Name and Generic Drugs

A brand-name drug features a trade name under which it is advertised and sold, and is protected by a patent. Generic drugs are drugs for which the brand-name patent has expired, allowing other manufacturers to produce and distribute the product. A generic drug has the same active ingredients as its brand-name counterpart, and manufacturers of generic drugs must follow stringent Food and Drug Administration (FDA) regulations for safety.

When you fill a prescription, the pharmacy will check if a generic is available.

- If a generic is available and you do not choose it, you pay the standard cost for a generic drug, plus the difference in price between the brand and its equivalent generic. This penalty will apply even if your doctor writes "dispense as written" on the prescription.

Preferred Drug List (PDL)

The preferred drug list, or formulary, is a list of recommended prescription medications that is created, reviewed and regularly updated by a team of physicians and pharmacists. The list contains a wide range of brand-name preferred products that have been approved by the FDA.

Use of a preferred drug is voluntary; however, your prescription cost may be higher if your doctor does not prescribe a drug on the preferred list. Sometimes your doctor may prescribe a medication for which either a preferred brand-name or generic alternative drug is available.

The pharmacist may ask your doctor whether an alternative preferred drug might be appropriate for you. If your doctor agrees, your prescription will be filled with the alternative drug. Ask your doctor if you have questions about the change in prescription. Your doctor always makes the final decision on your medication, and you can always choose to keep the original prescription. Pharmacies will dispense only the medication authorized by the doctor. Note that the mail-order pharmacy will automatically dispense a generic if available, unless you request the brand-name medication and are willing to pay the cost difference between the generic and brand-name medication.

Newly Approved Drugs

ESI's PDL is traditionally updated on a quarterly basis. If new drugs are added, they will be reflected on the PDL which is available online at www.ESI.com.

Retail Pharmacy Purchases

Express Scripts offers a nationwide network of participating pharmacies. To locate a participating pharmacy in your home ZIP code area, call ESI at 1-866-536-1406 or visit ESI's website at www.express-scripts.com/yp to access the pharmacy directory.

When you have your prescription filled at a participating retail pharmacy, remember to present your prescription drug ID card. This card is separate from your medical ID card and provides your pharmacist the required information to accurately process your claim and collect the appropriate copay amount. Presenting your prescription drug ID card at the time of purchase should also alleviate the need for you to complete and submit a claim form directly to ESI.

You can initially purchase up to two 30-day supplies of prescription medication from any participating retail pharmacy. It is recommended that you obtain maintenance medications through ESI's Mail Order program, which typically offers a better value for a 90-day supply of the same maintenance medications you would obtain at a retail pharmacy. Please refer to the following section labeled "Mail Order Purchases" for additional details.

Mail-Order Purchases

Through ESI's Mail Order program, you can order up to a 90-day supply of a maintenance medication as prescribed by your doctor. Maintenance medications are those drugs taken regularly for treating long-term chronic conditions (e.g., asthma, diabetes, high cholesterol or high blood pressure)

Typically, a pharmacist at ESI Mail Order will fill your prescription with a generic drug (if available) unless you specify otherwise. In addition, the pharmacist may contact your doctor if your prescription is unclear or incomplete, or to ask whether a substitution or change may be made to the prescription he/she has written.

To order a prescription from the mail-order program, you may obtain a ESI order form from your plan administrator or directly from ESI at www.express-scripts.com/yp, complete, and mail your order form directly to ESI. You must include your 90-day written prescription (with up to one year of refills, if appropriate) and applicable copayment amount.

For new prescription orders, you'll receive your medication within 10-14 days from the date ESI receives your order. If you need your medication sooner, ask your doctor to write two prescriptions:

- one for up to a 30-day supply to be filled immediately at a retail pharmacy and paid at the retail coinsurance/copay; and
- another that you can send to the mail-order program for an additional 90-day supply at the mail-order coinsurance/copay.

Once your medication is down to a 30-day supply, you may order a refill. You'll normally receive your refill within 10-14 business days.

What's Covered

Generally, the Program covers drugs that require a prescription for dispensing, are medically necessary and are not experimental in nature. Certain medications may require prior authorization before they are covered. Covered categories include, but are not limited to:

- Diabetic supplies (e.g. insulin syringes, lancets, test strips, etc)
- Prescription vitamins
- Fertility agents ($20,000 lifetime maximum)

Please call the ESI Customer Service Center at 866-536-1406 to confirm how your drug(s) is covered under the Program

What's Not Covered

The following categories are examples of what is not covered under the Program:

- Over the counter (OTC) medications
- Nutritional supplements
- Allergy sera
- Certain medical devices (e.g. continuous glucose monitors, insulin pumps, contraceptive devices, etc)
- Weight loss medications*
- Cosmetic agents*
- Erectile dysfunction agents*

Note that this is not an all-inclusive list and is subject to change. Please call the ESI Customer Service Center at 866-536-1406 to confirm how your drug(s) is covered under the Program.

*These are Personal Choice Drugs. They are available for purchase by a Covered Person at 100% of YP Holdings' negotiated discount plus the fee for dispensing the medication when the drug is purchased at an Express Script's Network Retail Pharmacy and participant presents Prescription Drug ID card.

Claims Review and Appeals Procedures

The Prescription Drug Program has a specific amount of time, by law, to evaluate and respond to benefit claims. These time limits apply to plans subject to ERISA. The period of time permitted to evaluate and respond to a claim begins on the date the claim is first filed. In addition, there are specific timelines and information requirements that you must comply with when filing a claim, or the claim may be denied and the rights you might otherwise have may be forfeited.

How to File Claims

Network participating pharmacies typically file claims for you. In rare cases, you'll need to pay for the care you receive up-front, then file a claim for reimbursement.

To file a claim, you need to complete the ESI claim form and submit it, together with any other information the form requires, to ESI at the following address:

Express Scripts

P.O. Box 14711

Lexington, KY 40512

You can request claim forms from ESI or download them from the ESI website at www.express-scripts.com/yp.

If you're not satisfied with the outcome of your claim, you can ask to have the claim reviewed.

Claims Appeal Process

ESI will provide at least a first level or initial benefit reconsideration which ensures the benefit or prior authorization criteria were applied correctly.

Under ERISA, you may appeal any aspect of a claim including a co-payment/co-insurance, quantity limitation, drug exclusion, prior authorization denial, etc. Appeals relating to non-clinical benefits (e.g., eligibility, co-pay issues, plan exclusions, quantity limits, etc.) are reviewed by the appeals analyst. These benefit appeals are reviewed strictly against the plan design.

Appeal determinations for clinical based denials (e.g., diagnosis, prior authorization) are reviewed by the appeals pharmacist. These appeals are reviewed against YP Holdings, LLC's approved criteria for the drug based on its approved FDA indication(s). These appeals are not reviewed for medical necessity. They are reviewed to be sure the criteria were applied correctly and if the information submitted with the appeal would now meet the criteria.

The second level appeal is a medical necessity review for denials that are based on diagnosis (e.g., prior authorization).

Medical necessity appeals are only for prior authorization (diagnosis based) denials that were upheld in the first appeal. If the appeals pharmacist has denied a clinical appeal, the participant may submit a second appeal for medical necessity.

All second level claim appeals are handled by YP Holdings, LLC. Claims at this level should be directed to YP Holdings, LLC at the address below.

Appeal Review Time Frame

Appeal processing time frames are established by ERISA:

- First level benefit appeals are reviewed within 30 days
- First level clinical appeals are reviewed within 15 days
- Second level medical necessity appeals are reviewed within 15 days

ERISA also allows for urgent care appeals. Urgent appeals may only be requested for clinical based appeals and can only be requested by your physician. Urgent appeals are reviewed within 72 hours.

You will be notified in writing of the appeal decision. If the appeal decision is a denial, you will also be advised of your rights for your next option in the appeals process.

Submitting an Appeal

You or your representative (e.g., physician) should submit your appeal in writing either by fax or mail to:

First Level
Express Scripts
PO Box 631850
Irving, TX
75063-0030
ATTN: Clinical Appeals

Urgent appeal requests by physicians may also be submitted by calling the physician only toll-free number: 800-864-1135

Second Level
YP Holdings, LLC
2247 Northlake Pwky
Tucker, GA
30084

About Continuation Coverage

In some circumstances, federal law requires that persons who lose group health plan coverage, which includes prescription drug benefits, be given the chance to continue that coverage for a period of time. You will be eligible to continue Program coverage on the same terms and conditions contained in your medical plan option. Refer to your medical plan option SPD for more details.

Additional Rights

Family and Medical Leave Act (FMLA)

If you are absent from work due to an approved family or medical leave under the Family and Medical Leave Act of 1993 (FMLA), coverage may be continued for the duration of the approved leave of absence as if there was no interruption in employment. Such coverage will continue until the earlier of the expiration of such leave or the date you notify the Employer that you do not intend to return to work. You are responsible for all required Contributions.

If you do not return after an approved leave of absence, coverage may be continued under federal law, provided you elect to continue coverage.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA restricts how a group health plan may apply pre-existing condition exclusions, requires plans to provide documentation of coverage under this plan for employees and Dependents to use in applying for another group coverage, permits special enrollment periods and prohibits discrimination based on health status.

HIPAA also requires the plan to maintain the privacy of your health information and to provide you with a notice of the plan's legal duties and privacy practices with respect to your health information. The notice will describe how the plan may use or disclose your health information and under what circumstances they may share your health information without your authorization (generally, to carry out treatment, payment or health care operations). In addition, the notice will describe your rights with respect to your health information. Please refer to the plan's privacy notice for more information. You can obtain a copy of the notice by contacting YP Holdings, LLC directly.

Military Leave of Absence

If you are absent from work due to military service leave qualifying under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you may elect to continue the type of coverage in effect on the day immediately prior to the start of such leave. Such coverage will continue until the earlier of the following occurs: the date you fail to return to active employment as required under USERRA or 24 months. To continue coverage, you must continue to pay the required contribution under the Program during the first 30 days of leave. Thereafter, you may pay a premium in the same amount as is required for COBRA continuation coverage under the Program.

If you decide to waive coverage under the Program during a military leave qualifying under USERRA and return to employment following the leave (within the time period specified by USERRA), you will be reinstated in the Program. Once you resume coverage, the Program does not cover any expenses you incur relating to any illness or injury incurred in, or aggravated during, the performance of military service.

Qualified Medical Child Support Order

A qualified medical child support order (QMCSO) is a court or administrative order requiring child support for medical coverage of a Program member's child, or requiring Program coverage for the child. A typical reason courts or certain administrative agencies issue a qualified medical child support order is to protect the benefit coverage of children in cases of divorce.

You will be notified if the Company receives a QMCSO that affects you. If you receive a qualified medical child support order, please contact your human resources representative. Your human resources representative will then follow the necessary administrative procedures. This will ensure compliance in determining the status of the QMCSO.

Program participants (and beneficiaries) may obtain, without charge, copies of the Program's procedures governing QMCSOs and a sample QMCSO by contacting YP Holdings, LLC.

Summary Plan Description

Name of Plan

The YP Holdings LLC Welfare Benefit Plan

Name, Address, and Telephone Number of Plan Sponsor and Named Fiduciary

YP Holdings, LLC

Employer Identification Number (EIN)

80-0803728

IRS Plan Number

501

Effective Date of Plan

January 1, 2013

Type of Plan

Group prescription drug coverage

Name, Business Address, and Business Telephone Number of Plan Administrator

YP Holdings, LLC
2247 Northlake Pkwy.
Tucker, GA 30084

Claims Administrator

The claims administrator is:

Express Scripts
P.O. Box 14711
Lexington, KY 40512

Legal Agent

The agent for service of legal process for the ESI Prescription Drug Program is:

YP Holdings, LLC

Legal process may also be served upon the trustee or the plan administrator.

Other Rules and Regulations

Plan Documents

Every effort has been made to ensure that the information in this summary is complete and accurate. However, if there's an inconsistency between any of the terms of the official plan documents or this SPD with respect to the legal compliance requirements under ERISA or any other federal law, the plan will be enforced consistent with the terms of applicable current law.

Copies of all plan documents are available for review upon written request to the plan administrator. A copy of any of these documents will be furnished to a plan participant or beneficiary (or an authorized representative) upon request.

Your Rights Under ERISA

As a participant in the Caremark Prescription Drug Program, you're entitled to certain rights and protections under ERISA. ERISA provides that all plan participants are entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified YP Holdings, LLC locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

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. See your medical plan summary plan description and the documents governing the plan on the rules governing your COBRA coverage rights.

If you have creditable coverage from another plan, a reduction or elimination of exclusionary periods of coverage for pre-existing conditions may apply under your group health plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA coverage, when your COBRA coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and don't receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the administrator's control. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you're discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you're successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

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

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