# PLAN DOCUMENT

# AND

# SUMMARY PLAN DESCRIPTION

Prescription Drug Benefit

***Shields Health Care Group***

January 1, 2023

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# Introduction

## Overview

The prescription drug benefit ("Prescription Drug Benefit") is a benefit offered under the Shields Health Care Group (the "Plan"), which is an employer-sponsored health and welfare employee benefit plan. The Prescription Drug Benefit is governed under ERISA.

This booklet, together with the documents incorporated by reference, serve as the "summary plan description" ("SPD") and formal plan document for the Prescription Drug Benefit for purposes of ERISA. The summary plan description for the medical benefits ("Medical SPD") provided to you by Employer is incorporated by reference into this document unless otherwise noted. An amendment to one of these documents constitutes an amendment to the Plan.

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

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

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

## Plan Contact Information

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

## Administrative Information

| | |
|---|---|
| Plan Name & Number | Name: Shields Health Care Group Prescription Drug Benefit Plan<br>Number: 502 |
| Plan Sponsor | Shields Health Care Group |
| Employer Identification Number | 04-3164965 |
| Plan Administrator<br>& Agent for Service of Legal Process | Shields Health Care Group<br>700 Congress Street, Suite 204<br>Quincy, MA 02169 |
| Claims Administrator | OptumRx<br><br>For contact information, see Article 3, "Filing Claims and Appeals" |
| Plan Year | 2023 |
| Plan Type | This Summary Plan Description and Plan Document describes the prescription drug benefits under the Plan. |
| Administration & Funding | The Prescription Drug Benefit is self-funded and is administered by the Claims Administrator. |
| Source of Contributions | Contributions will be paid out of the Employer's and any Participating Employer's general assets and through contributions paid by Eligible Employees, in the amounts determined by the Employer in its discretion. |

## Glossary

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| Claims Administrator | A third party that makes claims determinations under the Plan pursuant to a contractual arrangement with the Employer. The Claims Administrator does not insure any benefits under the Plan. The Claims Administrator is listed in the "Administrative Information" section. |
| COBRA | The Consolidated Omnibus Budget Reconciliation Act, which provides continuation coverage for certain benefits when an Eligible Employee or Eligible Dependent has experienced a loss of coverage due to a qualifying event. |
| Eligible Dependent | A dependent of an Eligible Employee who meets the eligibility requirements described in Article 1 of this SPD. |
| Eligible Employee | An employee who meets the eligibility requirements described in Article 1 of this SPD. |
| Employer | Shields Health Care Group |
| ERISA | The Employee Retirement Income Security Act of 1974, as amended from time to time. |
| HIPAA | The Health Insurance Portability and Accountability Act of 1996, as amended from time to time. |
| Participant | An individual who has satisfied the Prescription Drug Benefit's eligibility requirements and has elected to participate in the Prescription Drug Benefit. |
| Participating Employer | Any affiliated employer under Code section 414(b), (c), (m), or (o) that adopts the Plan with the consent of the Employer and as listed at Appendix A. |
| Plan | PPO, HDHP, HSA, EPO |
| Plan Administrator | The Employer or person or entity that the Employer designates to perform specific administrative duties under the Plan. |
| Plan Year | 1/1/2023 – 12/31/2023 |

# Article 1

## Eligibility and Enrollment

### Eligibility

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

### Enrollment

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

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

### Cost of Coverage

You and the Employer share in the cost of the Plan. Information describing your share of the cost of the Plan, which includes your share of the cost of the Prescription Drug Benefit, will be available at enrollment.

# Article 2

## How the Prescription Drug Benefit Works

OptumRx administers the Prescription Drug Benefit. OptumRx maintains the formulary, manages a network of Network Pharmacies, and operates home delivery and Specialty Drug pharmacies. OptumRx, in consultation with the Plan, may also provide services to promote the appropriate use of pharmacy benefits.

### Understanding Your Benefits

*Prescription Drug Formulary List*

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

*Your Cost for Prescriptions*

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

- Whether your prescription is filled with a Generic, a Brand-Name, or a specialty medication; and
- Where your prescription is filled (at a participating retail pharmacy, at an out-of-network retail pharmacy, through home delivery, or through a specialty pharmacy).

The amount you pay for covered medications may include a Deductible, Copay, and/or Coinsurance.

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

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

| | ***EPO 1500 - 00102AF; 00102AS; 00102CS*** | | |
|---|---|---|---|
| **Type of Medication** | Retail<br>(up to 30-day supply) | Retail Pharmacy<br>(up to 90-day supply) | Home Delivery<br>(up to 90-day supply) |
| Generic | $10 | $20 | $20 |
| Preferred Brand | $25 | $50 | $50 |
| Non-Preferred Brand | $45 | $90 | $90 |
| Specialty | 30% Copay<br>**$10 max for Generics*<br>**30%*<br>**30 Day Supply* | | |
| **Deductible** | Embedded<br>***Deductible does not apply to Rx*** | | |
| Employee-only coverage | $1,500 | | |
| Family coverage | $3,000 | | |
| **Out-of-Pocket maximum** | Embedded | | |
| Employee-only coverage | $6,000 | | |
| Family coverage | $12,000 | | |

| | ***PPO 2000 - 00103AF; 00103AS; 00103CS*** | | |
|---|---|---|---|
| **Type of Medication** | Retail<br>(up to 30-day supply) | Retail Pharmacy<br>(up to 90-day supply) | Home Delivery<br>(up to 90-day supply) |
| Generic | $10 | $20 | $20 |
| Preferred Brand | $25 | $50 | $50 |
| Non-Preferred Brand | $45 | $90 | $90 |
| Specialty | 30% Copay<br>**$10 max for Generics*<br>**30% After Deductible is met*<br>**30 Day Supply* | | |
| **Deductible** | Non-Embedded<br>***Deductible applies to Rx*** | | |
| Employee-only coverage | $2,000 | | |
| Family coverage | $4,000 | | |
| **Out-of-Pocket maximum** | Embedded | | |
| Employee-only coverage | $6,000 | | |
| Family coverage | $12,000 | | |

| | ***PPO 2500 - 00101AF; 00101AS; 00101CS*** | | |
|---|---|---|---|
| **Type of Medication** | Retail<br>(up to 30-day supply) | Retail Pharmacy<br>(up to 90-day supply) | Home Delivery<br>(up to 90-day supply) |
| Generic | $10 | $20 | $20 |
| Preferred Brand | $25 | $50 | $50 |
| Non-Preferred Brand | $45 | $90 | $90 |
| Specialty | 30% Copay<br>**$10 max for Generics*<br>**30% After Deductible is met*<br>**30 Day Supply* | | |
| **Deductible** | Non-Embedded<br>***Deductible does not apply to Rx*** | | |
| Employee-only coverage | $2,500 | | |
| Family coverage | $5,000 | | |
| **Out-of-Pocket maximum** | Embedded | | |
| Employee-only coverage | $7,500 | | |
| Family coverage | $15,000 | | |

**Coverage for Preventive Medicines**

The Prescription Drug Benefit offers certain preventive services at no out-of-pocket cost to you. This means you don't have to pay a Copay or Coinsurance, even if you haven't met your deductible, if a deductible applies. No out-of-pocket cost services include:

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

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

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

Please note the following:

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

**Out-of-Pocket Maximums**

Once your out-of-pocket expenses for covered medications under the Plan reaches the levels specified the Plan will pay for covered medications at 100% for the remainder of the Plan year. The amount you spend on Deductibles, Copays, and Coinsurance counts toward the out-of-pocket maximum.

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

**How to Use Your Plan**

*Retail Network Pharmacy*

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

To fill your prescription at a retail Network Pharmacy, present your written prescription from your physician and your ID card to the pharmacist. Alternatively, some physicians send prescriptions to pharmacies electronically, in which case you will only need to present your ID card. You will be charged at the point of purchase for applicable deductible and/or copayment/coinsurance amounts. If you do not present your ID card, you may have to pay the

full retail price of the prescription. If you do pay the full charge, ask your pharmacist for an itemized receipt, and submit it to OptumRx along with the required claim form. See Article 4, "Filing Claims and Appeals," for information on how to file a claim for benefits.

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

*Home Delivery Program*

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

You can start home delivery in the following ways:

- **ePrescribe:** Ask your doctor to send an electronic prescription to OptumRx.
- **Online:** Set up your account at optumrx.com and choose which medication you want to move to home delivery. Or use the OptumRx App on your smart phone or tablet.
- **Phone**: Call OptumRx toll-free at 1-888-658-0539 (TTY 711) any day, anytime.
- **Mail**: Complete an order form and mail it with your written prescription(s) to OptumRx. You can find an order form at www.optumrx.com.

*Out-of-Network Pharmacy*

If you use a pharmacy that is not covered in the network, you must pay the entire cost of the medication and then submit a claim for reimbursement. See Article 4, "Filing Claims and Appeals," for information on how to file a claim for benefits.

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

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

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

**Utilization Management Programs**

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

*Generics Preferred Program (Automatic Generic Substitution)*

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

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

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

Your Copay for the Generic medication will be less than the Copay for the Brand-Name medication.

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

*Step Therapy*

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

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

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

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

*Prior Authorization*

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

The following situations may require prior authorization for your prescription:

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

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

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

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

*Quantity Level Limits*

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

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

**Definitions and Other Important Terms**

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

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| Average Wholesale Price ("AWP") | This is the suggested wholesale price of a drug that is published. This is usually the lowest price possible. It is seldom the actual price paid, but may serve as a cost basis for pricing prescriptions. |
| AWP Discount % (AWP Minus X%) | The negotiated amount a drug plan pays to pharmacies for the ingredient cost of a prescription and commonly expressed as a percentage off of Average Wholesale Price. |
| Brand-Name Drug | A drug protected by a patent issued to the original innovator or marketer and designated as single source or multi-source brand according to First DataBank or Medi-Span; includes patent protected cross-licensed products. Prior to the expiration date, the patent prohibits the manufacture of the drug by other companies without consent of the innovator. The trademarked name of the drug that appears on the package label. |
| Closed Formulary | A formulary that contains a limited number of drugs. New drugs are added selectively. A closed formulary commonly requires prior authorization from the pharmacy benefit manager for coverage of non-formulary products. |
| Coinsurance | Similar to Copay, this is the amount the member must pay each time he or she receives a covered prescription. Coinsurance is calculated as a percentage of the cost of the drug rather than as a fixed-dollar amount. |
| Compound | Products made up of two or more ingredients that the pharmacy dispenses as a single product. |
| Copay | The portion of the claim that the member pays when filling a prescription. |
| Cost Sharing | A provision of a health care or pharmacy benefit plan that requires members to pay some portion of their expenses. Cost-sharing mechanisms include Deductibles, Coinsurance and Copays. |

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| Drug Assistance Programs (“DAPs”) | Drug Assistance Programs are public and private resources that can help people with the cost of their medicines. Some of these programs have options for buying drugs at discounted prices. Others help people who cannot afford any part of their medicine costs. |
| Dispense as Written (“DAW”) | A prescribing directive issued by physicians to indicate that the pharmacy should dispense the product prescribed by the physician. |
| Deductible | The dollar amount a member must pay out-of-pocket each year before the Plan will begin making payments for eligible benefits. |
| Dispensing Fee | The amount paid to a pharmacist for each prescription dispensed, in addition to the negotiated formula for reimbursing ingredient cost. |
| Formulary List | Formulary lists regulate what drugs are covered. If a member uses a drug not on their health insurance plan’s formulary list, they will pay higher out-of-pocket costs. Also called a preferred formulary. |
| Generic Drug | A chemically and pharmaceutically equivalent version of a Brand- Name Drug whose patent has expired. A generic drug meets the same FDA standard for bio-equivalency that brand name drugs are required to meet, but is typically substantially less expensive. |
| Maintenance Drugs | Drugs that are commonly used to treat a chronic disease. These are usually administered continuously rather than intermittently. |
| Network Pharmacy | A pharmacy where members can get their prescription drug benefits at a discount that has been negotiated with the pharmacy or chain of pharmacies. |
| Open Formulary | A list of drugs that typically includes a large number of products, and to which new drugs are easily added. |
| Rebate | For any period, all rebates, reimbursements, or other discounts received under a pharmaceutical manufacturer’s discount program with respect to pharmaceutical products dispensed to a plan participant under the benefit plan design for such period. A monetary amount returned to a payer from a prescription drug manufacturer based upon utilization by a covered person or purchases by a provider. |

# Article 3

## When Coverage Ends; COBRA Continuation

### When Coverage Ends

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

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

### Coverage During Leave of Absence

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

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

### COBRA Continuation Coverage

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

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

*When You May Elect COBRA Coverage*

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

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

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

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

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

- Your death;

- Your divorce or legal separation;

- Your eligibility for Medicare during a COBRA continuation period; or

- If your covered dependent child no longer meets the eligibility requirements under the Prescription Drug Benefit.

*Applying for COBRA Coverage*

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

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

*When COBRA Coverage Ends*

COBRA coverage will end if:

- The Employer stops providing coverage for all employees;

- You or your Eligible Dependents do not pay your premiums on time;

- You or your Eligible Dependents become covered by another group health plan;

- You or your Eligible Dependents become covered by Medicare; or

- You or your Eligible Dependents extended COBRA coverage to 29 months due to disability, but are no longer considered disabled.

# Article 4

# Filing Claims and Appeals

## Claims for Benefits: How to File an Initial Claim

You must file a claim for benefits with the Claims Administrator. You must complete and submit the Prescription Reimbursement Request Form ("Claim Form"), along with any other information required by the Claim Form. The Claim Form is located online at OptumRx's website (www.optumrx.com) and can also be requested by calling customer service at 1-800-356-3477.

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

OptumRx
PO Box 509075
San Diego, CA 92150-9075

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

Your claim for benefits will be processed under the procedures described below. Claims for benefits will be decided by the Claims Administrator.

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|---|---|
| ***Urgent Claims***<br><br>Any claim for medical care or treatment where making a determination under the normal timeframes could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim. | Notice of the Plan's determination will be sent as soon as possible taking into account the medical exigencies and in no case later than 72 hours after receipt of the claim.<br><br>You may receive notice orally, in which case a written notice will be provided within 3 days of the oral notice. If your urgent claim is determined to be incomplete, you will receive a notice to this effect within 24 hours of receipt of your claim, at which point you will have 48 hours to provide additional information.<br><br>If you request an extension of urgent care benefits beyond an initially determined period and make the request at least 24 hours prior to the expiration of the original determination, you will be notified within 24 hours of receipt of the request. |
| ***Pre-Service Claims***<br><br>A claim for services that have not yet been rendered and for which | If your pre-service claim is improperly filed, you will be sent notification within five days of receipt of the claim. |

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

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| | end of period or number of treatments, you will be notified as soon as possible, but no later than 24 hours. |

**Claims for Benefits: How to File an Appeal**

If your initial claim for benefits is denied in whole or in part, you may file an appeal with the Claims Administrator. You, your prescriber or your authorized representative (someone you name to act for you, such as a family member, an attorney or a friend) may file an appeal. OptumRx reserves the right to establish and implement reasonable procedures to determine whether an individual has been authorized to act as your representative.

To file an appeal, please send any written comments, documents or other relevant documentation with your appeal to the address listed below:

OptumRx
c/o Appeals Coordinator
P.O. Box 25 U 4
Santa Ana, CA 92799
Phone: 1-888-403-3398
Fax: 1-877-239-4565

**Claims for Benefits: How an Appeal is Processed**

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

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

In the case of an urgent care claim, you may request an expedited appeal of an adverse benefit determination either orally or in writing, and all necessary information, including the Plan's

benefit determination on appeal, will be transmitted by telephone, fax, or other available expeditious method.

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

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|---|---|
| ***Urgent Claims*** | You must submit your appeal within 180 days of the date of your initial denial notice (or first level appeal notice, for second level appeals)<br><br>You will be notified of the determination as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim. |
| ***Pre-Service Claims*** | You must submit your appeal within 180 days of the date of your initial denial notice (or first level appeal notice, for second level appeals).<br><br>For both the first and second levels of appeal, you will be notified of the determination within a reasonable period of time taking into account the medical circumstances, but no later than 15 days from the date your request is received (30 days if there is only one level of appeal). |
| ***Post-Service Claims*** | You must submit your appeal within 180 days of the date of your initial denial notice (or first level appeal notice, for second level appeals)<br><br>For both the first and second levels of appeal, you will be notified of the determination within a reasonable period of time, but no later than 30 days from the date your request is received (60 days from the date if there is only one level of appeal). |
| ***Concurrent Care Claim*** | You must submit your appeal within 180 days of the date of your initial denial notice (or first level appeal notice, for second level appeals).<br><br>You will be notified of the determination before treatment ends or is reduced, where the determination is a decision to reduce or terminate concurrent care early. |

**Claims for Benefits: Notice of Determination**

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

- state specific reason(s) for the adverse determination;
- reference specific Plan provision(s) on which the benefit determination is based;
- describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary (initial claim only);
- describe the Plan's claims review procedures and the time limits applicable to such procedures (initial claim only);
- include a statement of your right to bring a civil action under section 502(a) of ERISA following appeal;
- state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits (appeal only);
- describe any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures (appeal only);
- disclose any internal rule, guidelines, or protocol relied on in making the adverse determination (or state that such information will be provided free of charge upon request);
- if the denial is based on a medical necessity or experimental treatment or similar limit, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);
- include information sufficient to identify the claim involved, including date of service, health care provider, and claim amount;
- include the denial code and corresponding meaning;
- include a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and treatment code and its corresponding meaning;
- describe the Claims Administrator's standard, if any, used in denying the claim;
- describe the external review process, if applicable;

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

**Claims for Benefits: External Review**

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

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

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

OptumRx
c/o Appeals Coordinator
P.O. Box 25184
Santa Ana, CA 92799
Phone: 1-888-403-3398
Fax: 1 -877-239-4565

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

**Deadline to Bring Legal Action**

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

# Article 5

# Plan Administration

## Discretion to Interpret Plan

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

## Powers and Duties

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

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

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

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

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

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

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

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

(8) To appoint a Claims Administrator to review, determine, and authorize payment of requests for distribution under the Plan, to direct and supervise the payment of benefits, to

review appeals of the denial of requests for distribution under the Plan, and to perform any other actions or duties the Plan Administrator may delegate to it;

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

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

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

**Right to Delegate**

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

**Named Fiduciary**

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

**Plan Expenses**

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

# Article 6

# HIPAA Compliance

## Disclosures to Employer

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

## Use of PHI

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

## Access to Medical Information

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

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

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

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

## Employer Agreement to Restrictions

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

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

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

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

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

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

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

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

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

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

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

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

**Permitted Disclosure to Employer**

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

(1) Summary health information may be disclosed to the Employer if the Employer requests the summary health information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan, or (2) modifying, amending, or terminating the Plan.

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

(3) Information provided pursuant to an authorization within the meaning of Section 164.508

of the HIPAA Privacy Regulations.

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

**Noncompliance**

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

**HIPAA Security Standards**

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

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

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

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

# Article 7

# Other Legal Information

## Plan Amendment & Termination

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

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

All amendments to the Plan shall be in writing, and any oral statements or representations made by any individual or entity that purport to alter, modify, amend, or are inconsistent with the written terms of the Plan shall be invalid and unenforceable and may not be relied upon by any individual or entity.

# Article 8

# Legal Notices

## Newborns' & Mothers' Health Protection Act

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

## Statement of ERISA Rights

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

### Receive Information about the Plan

- Examine, without charge, at the Plan Administrator's office and at other specified locations all documents governing the Plan, including, if applicable, insurance contracts, collective bargaining agreements, and a copy of the latest annual report filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including, if applicable, insurance contracts and copies of the latest annual report (Form 5500 Series) and an updated SPD. The Plan Administrator may make a reasonable charge for the copies.

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

### Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your employer or any other person, may

fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

**Enforce Your Rights**

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have appealed all adverse determinations you may file suit in a state or Federal court. Any such suit must be brought no later than 180 days following a final decision on the claim for benefits. If it should happen that the fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance with Your Questions**

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

## Amendment A

## Scripta Insights, Inc.

Shields Health Care Group has contracted with Scripta Insights to find prescription medicines that are the same or clinically equivalent to the ones you are already taking but may be less money based on our benefit plan. If there is an opportunity to save, a Personalized Savings Report, which is HIPPA compliant, will list your current medications and lower priced options to discuss with your doctor. This is a free member benefit and there is no cost to participate.

Savings reports will be able to be downloaded through email or text and accessed in the Scripta app or online through the Scripta portal. Once you receive your report, discuss with your doctor, then ask to switch to the lower cost alternative, and lastly fill at your pharmacy and begin saving.

Any questions, once enrolled, may be directed to Scripta Member Support at 866-572-7478.

## Amendment B

### ImpaxRx Medication Under Management ™

ImpaxRx Medication Under Management™ Service. As of the effective date of the plan amendment, 01/01/2022, all access to medications over $20,000.00 (30-day supply) will be required to be fulfilled through the ImpaxRx Medication Under Management™ Service unless the drug manufacturer or patient credentials result in a denial for that medication. When a new medication is identified during the plan year, the benefit has up to 6 months to bring the medication under management by the plan. A list or threshold of medications may be amended during the plan year, as determined by the plan sponsor, within the notice provisions defined in the plan.

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The above language, which serves as a Summary of Material Modifications, contains highlights of certain features of the Shields Health Care Group, Inc. prescription drug plan. The Plan reserve the right to amend, modify or terminate the Plan at any time.

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