

SUMMARY PLAN DESCRIPTION
FOR THE
SPECIALTY DRUG MEDICAL EXPENSE REIMBURSEMENT PLAN¹
as effective September 1, 2024²

¹ The sample summary plan description should be carefully reviewed by the plan sponsor and its advisors.

² The plan sponsor must complete the information noted here and in Article III of the summary plan description.

Table of Contents

	Page
ARTICLE I Introduction	1
ARTICLE II General Information About the Plan	1
2.1 What is the purpose of the Plan?	1
2.2 Who can become a participant in the Plan?	1
2.3 What Benefits are offered through the Plan?	1
2.4 How will the Plan work?	1
2.5 How do I become a Participant?	2
2.6 What if I cease to be an eligible Employee?	2
2.7 What is COBRA continuation coverage? If I or my Spouse or Dependent has a COBRA Qualifying Event, can I continue to participate in the Plan?.....	2
2.8 Will I have any administrative costs under the Plan?	3
2.9 How long will the Plan remain in effect?.....	3
2.10 Are my Benefits taxable?	3
2.11 What happens if my claim for Benefits is denied?.....	3
ARTICLE III Administrative Information.....	6
ARTICLE IV ERISA Rights	7
ARTICLE V HIPAA Privacy Rights.....	8
ARTICLE VI Miscellaneous	8
6.1 Effect of the Plan on Your Employment Rights	8
6.2 Prohibition Against Assignment of Benefits.....	8
6.3 Overpayments or Errors	9

ARTICLE I **INTRODUCTION**

Your employer (the Employer) is pleased to provide the Specialty Drug Medical Expense Reimbursement Plan (the Plan) for eligible Employees. The Plan is integrated with the Health Plan identified in Article ARTICLE III. Only Employees who have coverage under the Health Plan can become Participants in the Plan.

This summary plan description (“SPD”) describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. It is only a summary of the key parts of the Plan and a brief description of your rights as a Participant. If there is a conflict between the official, complete Plan document and this SPD, the official Plan document will control. Capitalized terms used in this SPD that are not defined in the SPD have the meaning set forth in the Plan.

ARTICLE II **GENERAL INFORMATION ABOUT THE PLAN**

2.1 What is the purpose of the Plan?

The purpose of the Plan is to protect Participants from the high-cost they may be required to pay to a specialty pharmacy for a specialty drug as coinsurance under the Health Plan. These amounts are referred to as “Coinsurance Expenses.”

2.2 Who can become a Participant in the Plan?

If you are an Employee who is covered under the Health Plan and you have not opted out of the Plan, you may become a Participant in the Plan.

2.3 What Benefits are offered through the Plan?

The Coinsurance Expenses may be incurred by you or your Spouse or Dependent who is covered under the Health Plan. You will be required to pay the full amount until your plan deductible is met. Once your plan deductible is met for the year, you will be required to pay 10% of the cost of the generic specialty medication, 30% of the preferred specialty medication and 50% of the non-preferred specialty medication up to a co-insurance limit per prescription. The Plan will pay for any remaining expenses that exceed the coinsurance listed above or the coinsurance limit. The Plan includes coinsurance limits of: \$50 for generic specialty medications; \$150 for preferred branded specialty medications; \$250 for non-preferred branded specialty medications.

2.4 How will the Plan work?

Benefits under the Plan will typically be paid directly to a specialty pharmacy. You will be required to pay the first 10%, 30% and 50% of expenses, up to the limits specified above, as applicable, directly to the specialty pharmacy, and the Plan will pay the remaining expenses. If you initially pay for the full cost of the claim, you may submit a written claim to the Administrator for reimbursement of Coinsurance Expenses. Your written claim must include all the information required by the administrator, must relate to Coinsurance Expenses incurred while you were a

Participant in the Plan, and must be submitted by November 30th following the close of the Plan Year in which the Coinsurance Expense was incurred. Contact the Administrator if you wish to submit a claim for reimbursement.

2.5 How do I become a Participant?

You will become a Participant in the Plan on the same day you become covered under the Health Plan.

2.6 What if I cease to be covered under the Health Plan?

If you cease to be covered by the Health Plan for any reason, including as a result of your termination, your participation in the Plan will end when your Health Plan coverage ends, unless you are eligible for and elect COBRA continuation coverage as described below. You will be reimbursed for any Coinsurance Expenses prior to the date your participation ends, if you comply with the reimbursement request procedures required under the Plan.

2.7 What is COBRA continuation coverage? If I or my Spouse or Dependent has a COBRA Qualifying Event, can I continue to participate in the Plan?

COBRA is a federal law that gives certain employees, spouses, and dependent children of employees the right to temporary continuation of their health care coverage under the Employer's medical plans. If you, your Spouse, or your Dependent children incur an event known as a "Qualifying Event," and if such individual is covered under the Health Plan and the Plan when the Qualifying Event occurs, then the individual incurring the Qualifying Event will generally be entitled under COBRA to elect to continue his or her coverage under the Health Plan and the Plan if he or she pays the applicable premium for such coverage. "Qualifying Events" are certain types of events that would cause, except for the application of COBRA's rules, an individual to lose his or her health coverage. A Qualifying Event includes the following:

- Your termination from employment or reduction of hours;
- Your divorce or legal separation from your Spouse;
- Your becoming eligible to receive Medicare benefits;
- Your Dependent child ceasing to qualify as a Dependent.

If the Qualifying Event is termination from employment, then the COBRA continuation coverage runs for a period of 18 months following the date that regular coverage ended. COBRA continuation coverage may be extended to 36 months if another Qualifying Event occurs during the initial 18-month period. You are responsible for informing the Administrator of the second Qualifying Event within 60 days after the second Qualifying Event occurs. COBRA continuation coverage may also be extended to 29 months in the case of an individual who becomes disabled within 60 days after the date the entitlement to COBRA continuation coverage initially arose and who continues to be disabled at the end of the 18 months. (In the event that family coverage is continued under COBRA, the Employee, Spouse, and Dependents may all extend coverage to 29 months regardless of which individual has become disabled.) In all other cases to which COBRA

applies, COBRA continuation coverage shall be for a period of 36 months.

2.8 Will I have any administrative costs under the Plan?

Generally, no. The Employer is currently bearing the entire cost of administering the Plan while you are an Employee.

2.9 How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to terminate the Plan at any time. The Employer also reserves the right to amend the Plan at any time and in any manner that it deems reasonable, in its sole discretion.

2.10 Are my Benefits taxable?

The Plan is intended to meet certain requirements of existing federal tax laws, under which the Benefits that you receive under the Plan generally are not taxable to you. However, the Employer cannot guarantee the tax treatment to any given Participant, since individual circumstances may produce differing results. If there is any doubt, you should consult your own tax advisor.

2.11 What happens if my claim for Benefits is denied?

If your claim for Benefits is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims for Benefits under the Plan are discussed below.

(a) When must I receive a decision on my claim?

You are entitled to notification of the decision on your claim within 30 days after the Administrator's receipt of the claim. This 30-day period may be extended by an additional period of up to 15 days if the extension is necessary due to conditions beyond the control of the Administrator. The Administrator is required to notify you of the need for the extension and the time by which you will receive a determination on your claim. If the extension is necessary because of your failure to submit the information necessary to decide the claim, then the Administrator will notify you regarding what additional information you are required to submit, and you will be given at least 45 days after such notice to submit the additional information. If you do not submit the additional information, the Administrator will make the decision based on the information that it has.

(b) What information will a notice of denial of a claim contain?

If your claim is denied, the notice that you receive from the Administrator will include the following information:

- Information about your claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available;

- The specific reason for the denial;
- A reference to the specific Plan provision(s) on which the denial is based;
- Any denial code (and its corresponding meaning) that was used in denying the claim;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA Section 502(a) following a denial on review; and
- If the Administrator relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request.

(c) Do I have the right to appeal a denied claim?

Yes, you have the right to an appeal.

(d) Do I have to appeal a denied claim before I can go to court?

You will not be allowed to take legal action against the Plan, the Employer, the Administrator, or any other entity to whom administrative or claims processing functions have been delegated unless you exhaust your appeal rights.

(e) What are the requirements of my appeal?

Your appeal must be in writing, must be provided to the Administrator, and must include the following information:

- Your name and address;
- The fact that you are disputing a denial of a claim or the Administrator's act or omission;
- The date of the notice that the Administrator informed you of the denied claim; and
- The reason(s), in clear and concise terms, for disputing the denial of the claim or the Administrator's act or omission.

You should also include any documentation that you have not already provided to the Administrator.

(f) Is there a deadline for filing my appeal?

Yes. Your appeal must be delivered to the Administrator within 180 days after receiving the denial

notice or the Administrator's act or omission. *If you do not file your appeal within this 180-day period, you lose your right to appeal.* Your appeal will be heard and decided by the Administrator.

(g) How will my appeal be reviewed?

Any time before the appeal deadline, you may submit copies of all relevant documents, records, written comments, testimony, and other information to the Administrator. The Plan is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your appeal, the Administrator will take into account all relevant documents, records, comments, and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination.

If the Administrator receives new or additional evidence that it considered, relied upon, or generated in connection with the claim, other than evidence that you have provided to it, you will be provided with this information and given a reasonable opportunity to respond to the evidence before the due date for the Administrator's notice of final adverse benefit determination. Similarly, if the Administrator identifies a new or additional reason for denying your claim, that new or additional reason will be disclosed to you and you will be given a reasonable opportunity to respond to that new rationale before the due date for the Administrator's notice of final adverse benefit determination.

The appeal determination will not afford deference to the initial determination and will be conducted by a fiduciary of the Plan who is not: (1) the individual who made the original determination; (2) an individual who is a subordinate of the individual who made the initial determination; or (3) an individual whose terms and conditions of employment are affected by the results of his or her decision.

If the appeal determination will be based on the medical judgment of a health care professional retained by the Administrator, the health care professional retained for purposes of the appeal will not be an individual who was consulted in connection with the determination that is being appealed or any subordinate of that individual.

(h) When will I be notified of the decision on my appeal?

The Administrator must notify you of the decision on your appeal within 60 days after receipt of your request for review.

(i) What information is included in the notice of the denial of my appeal?

If your appeal is denied, the notice that you receive from the Administrator will include the following information:

- Information about your claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available;
- The specific reason for the denial upon review;

- A reference to the specific Plan provision(s) on which the denial is based;
- Any denial code (and its corresponding meaning) that was used in denying the claim;
- A statement providing that you are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;
- If an internal rule, guideline, protocol, or similar criterion was relied upon in making the review determination, either the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request; and
- A statement of your right to bring a civil action under ERISA Section 502(a).

(j) Who is the Administrator?

The Employer is the Administrator and the named fiduciary for the Plan.

(k) May I elect to permanently opt out of the Plan?

Yes. You may elect to permanently opt out of and waive any right to reimbursements from the Plan for expenses incurred after the election takes effect. This opportunity will be offered at least annually by the Plan.

ARTICLE III
ADMINISTRATIVE INFORMATION

The Administrator administers the Plan and has the discretionary authority to interpret all Plan provisions and to determine all issues arising under the Plan, including issues of eligibility, coverage, and Benefits. The Administrator’s failure to enforce any provision of the Plan shall not affect its right to later enforce that provision or any other provision of the Plan. The Administrator may delegate some of its administrative duties to agents.

The name of the Plan is the “Specialty Drug Medical Expense Reimbursement Plan.”

The name, address, telephone number, and employer identification number (EIN) for the sponsoring Employer and Administrator are as follows:

Name of Employer
Physical Address
Contact Phone #
EIN:

The Plan number for the Plan is [insert 3-digit plan number].

The Plan Year is the calendar year.

The Plan became effective on 9/1/2024.

Service may be made on the Administrator at the address listed above.

The financial records of the Plan are kept on a Plan Year basis.

The Plan is intended to qualify as an employer-provided medical reimbursement plan under Code Sections 105 and 106 and the regulations issued thereunder.

The Administrator pays applicable Benefits from the general assets of the Employer.

The Plan is paid for by the Employer out of the Employer's general assets. There is no trust or other fund from which Benefits are paid.

ARTICLE IV **ERISA RIGHTS**

As a Participant in the Plan, you may be entitled to certain rights and protection under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all plan participants are entitled to:

- Examine, without charge, at the Administrator's office and at other specified locations (such as worksites and union halls) all plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, such as detailed annual reports;
- Obtain copies of all plan documents and other plan information upon written request to the Administrator (the Administrator may charge a reasonable amount for the copies); and
- Receive a summary of the Plan's annual information report (the Administrator is required by law to furnish each Participant with a copy of this summary annual report).

You are entitled to continue health care coverage under COBRA for yourself, your Spouse, or your Dependents if there is a loss of coverage under the Health Plan and the Plan as a result of a qualifying event. You, your Spouse, or your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan for the rules governing your COBRA continuation rights.

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 the Participants. No one, including your Employer, your union, or any other person, may discriminate against you in any way to prevent you from obtaining a Benefit from the Plan or from exercising your rights under ERISA.

If your claim for a Benefit is ignored or denied 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 materials 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 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 that is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, then you may file suit in state or federal court. In addition, if you disagree with the Plan's decision or lack thereof regarding the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

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 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 that your claim is frivolous).

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this part of the SPD or about your rights under ERISA, or if you need assistance in obtaining documents from the 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.

ARTICLE V **HIPAA PRIVACY RIGHTS**

Group health plans, including the Plan, are required to take steps to ensure that certain "protected health information" (PHI) is kept confidential. You may receive a separate notice from the Employer that outlines its health privacy policies, including with regard to electronic PHI.

ARTICLE VI **MISCELLANEOUS**

6.1 Effect of the Plan on Your Employment Rights

The Plan is not to be construed as giving you any rights against the Plan except those expressly described in this document. The Plan is not a contract of employment between you and the Employer.

6.2 Prohibition Against Assignment of Benefits

No Benefit payable at any time under the Plan shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind.

6.3 Overpayments or Errors

If it is later determined that you and/or your Spouse or Dependent(s) received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the Plan.

If you do not refund the overpayment or erroneous payment, the Plan and the Employer reserve the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your pay.