TO: Lakota Local School District

AMENDMENT TO THE HEALTH AND WELFARE BENEFITS PLAN

IT IS UNDERSTOOD AND AGREED THAT THE FOLLOWING MODIFICATIONS SHALL BE MADE:

1. In the benefits section of the Plan document, the **SCHEDULE OF PRESCRIPTION DRUG BENEFITS** will be deleted in its entirety. In its place, the following new schedule will be added:

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

Important Notes for Eligible Prescription Drugs
1. As used in this Schedule of Benefits, the term "Rx Formulary Tier 1" generally means a category of prescription drugs that includes most generic drugs and may include some low-cost brand-name drugs. The term "Rx Formulary Tier 2" means a category of prescription drugs that includes preferred brand-name drugs and may include some high-cost generic drugs. The term "Rx Formulary Tier 3" means a category of prescription drugs that generally includes all non-preferred drugs. For additional information about the coverage status and Rx Formulary Tier category of a drug, as well as any quantity/age limits or prior authorization requirements that may apply, the Covered Person can contact ARORx at 833-306-4092. 2. All specialty drugs and drugs identified on the ARORx high-cost drug formulary list are excluded. If member is determined by ARORx to be ineligible for an alternative sourcing program through the drug's manufacturer, ARORx will source medication for member through direct sourcing with ARORx's contracted direct source pharmacies. Contact ARORx at 833-306-4092 for high-cost drug formulary list. 3. "Dispense as Written" (DAW): No penalty will apply when a physician requests the brand as medically necessary.
4. In accordance with applicable law, the Plan provides coverage for certain preventive care medications without any cost-sharing provisions such as medical Deductibles or prescription drug co-payments. Preventive care medications include, but are not limited to, certain FDA-approved contraceptive agents, certain smoking cessation intervention products when prescribed by a Physician, and breast cancer medications that lower the risk of cancer or slow its development. For more information about eligible preventive care medications, Covered Persons can contact ARORx at 833-306-4092 at the telephone number on the health plan identification card. 5. Certain immunizations administered at a pharmacy within the designated network, including any injection/administration fees charged by the pharmacy, will be covered by the Plan through the Prescription Drug Card Program at 100% (no prescription drug

Important Notes for Eligible Prescription Drugs
co-payment or medical Deductible will be applied). Covered Persons can contact ARORx for more information on how to find a pharmacy within the designated network that administers these immunizations.

Schedule of Prescription Drug Benefits: Lakota Blue Access PPO 600 & Lakota Blue HPN 600	
Prescription Drug Co-Payments Retail Prescription Drug Card Program Co-Payments (30-Day Supply) A Covered Person may fill a prescription for up to and including a 30-day supply for the co-payment amounts shown. If a prescribing Physician requests more than a 30-day supply of a drug, an 84- to 90-day supply of a covered prescribed maintenance medication can be purchased at a participating pharmacy for the applicable Mail Service Program co-payment specified below.	$15 /Rx Formulary Tier 1 drug, $35 /Rx Formulary Tier 2 drug, $55 /Rx Formulary Tier 3 drug, All specialty drugs and drugs identified on the ARORx high-cost drug formulary list are excluded. If member is determined by ARORx to be ineligible for an alternative sourcing program through the drug's manufacturer, ARORx will source medication for member through direct sourcing with ARORx's contracted direct source pharmacies. Contact ARORx at 833-306-4092 for high-cost drug formulary list
Mail Service Program Co-Payments (90-Day Supply)	$35 /Rx Formulary Tier 1 drug, $85 /Rx Formulary Tier 2 drug, $135 /Rx Formulary Tier 3 drug, All specialty drugs and drugs identified on the ARORx high-cost drug formulary list are excluded. If member is determined by ARORx to be ineligible for an alternative sourcing program through the drug's manufacturer, ARORx will source medication for member through direct sourcing with ARORx's contracted direct source pharmacies. Contact ARORx at 833-306-4092 for high-cost drug formulary list

Schedule of Prescription Drug Benefits: Lakota Blue Access PPO 600 (2) & Lakota Blue HPN 600	
Prescription Drug Co-Payments Retail Prescription Drug Card Program Co-Payments (30-Day Supply) A Covered Person may fill a prescription for up to and including a 30-day supply for the co-payment amounts shown. If a prescribing Physician requests more than a 30-day supply of a drug, an 84- to 90-day supply of a covered prescribed maintenance medication can be purchased at a participating pharmacy for the applicable Mail Service Program co-payment specified below.	$15 /Rx Formulary Tier 1 drug, $35 /Rx Formulary Tier 2 drug, $55 /Rx Formulary Tier 3 drug, All specialty drugs and drugs identified on the ARORx high-cost drug formulary list are excluded. If member is determined by ARORx to be ineligible for an alternative sourcing program through the drug's manufacturer, ARORx will source medication for member through direct sourcing with ARORx's contracted direct source pharmacies. Contact ARORx at 833-306-4092 for high-cost drug formulary list
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Schedule of Prescription Drug Benefits: Lakota Blue HPN 3300 & Blue Access PPO HSA 3300	
Prescription Drug Co-Payments Retail Prescription Drug Card Program Co-Payments (30-Day Supply) A Covered Person may fill a prescription for up to and including a 30-day supply for the co-payment amounts shown. If a prescribing Physician requests more than a 30-day supply of a drug, an 84- to 90-day supply of a covered prescribed maintenance medication can be purchased at a participating pharmacy for the applicable Mail Service Program co-payment specified below.	$15 after deductible /Rx Formulary Tier 1 drug, $35 after deductible /Rx Formulary Tier 2 drug, $55 after deductible /Rx Formulary Tier 3 drug, All specialty drugs and drugs identified on the ARORx high-cost drug formulary list are excluded. If member is determined by ARORx to be ineligible for an alternative sourcing program through the drug's manufacturer, ARORx will source medication for member through direct sourcing with ARORx's contracted direct source pharmacies. Contact ARORx at 833-306-4092 for high-cost drug formulary list
Mail Service Program Co-Payments (90-Day Supply)	$35 after deductible /Rx Formulary Tier 1 drug, $85 after deductible /Rx Formulary Tier 2 drug, $135 after deductible /Rx Formulary Tier 3 drug, All specialty drugs and drugs identified on the ARORx high-cost drug formulary list are excluded. If member is determined by ARORx to be ineligible for an alternative sourcing program through the drug's manufacturer, ARORx will source medication for member through direct sourcing with ARORx's contracted direct source pharmacies. Contact ARORx at 833-306-4092 for high-cost drug formulary list

Schedule of Prescription Drug Benefits: Lakota Blue HPN 3300 (2) & Blue Access PPO HSA 3300 (2)	
Prescription Drug Co-Payments Retail Prescription Drug Card Program Co-Payments (30-Day Supply) A Covered Person may fill a prescription for up to and including a 30-day supply for the co-payment amounts shown. If a prescribing Physician requests more than a 30-day supply of a drug, an 84- to 90-day supply of a covered prescribed maintenance medication can be purchased at a participating pharmacy for the applicable Mail Service Program co-payment specified below.	$15 after deductible /Rx Formulary Tier 1 drug, $35 after deductible /Rx Formulary Tier 2 drug, $55 after deductible /Rx Formulary Tier 3 drug, All specialty drugs and drugs identified on the ARORx high-cost drug formulary list are excluded. If member is determined by ARORx to be ineligible for an alternative sourcing program through the drug's manufacturer, ARORx will source medication for member through direct sourcing with ARORx's contracted direct source pharmacies. Contact ARORx at 833-306-4092 for high-cost drug formulary list
Mail Service Program Co-Payments (90-Day Supply)	$35 after deductible /Rx Formulary Tier 1 drug, $85 after deductible /Rx Formulary Tier 2 drug, $135 after deductible /Rx Formulary Tier 3 drug, All specialty drugs and drugs identified on the ARORx high-cost drug formulary list are excluded. If member is determined by ARORx to be ineligible for an alternative sourcing program through the drug's manufacturer, ARORx will source medication for member through direct sourcing with ARORx's contracted direct source pharmacies. Contact ARORx at 833-306-4092 for high-cost drug formulary list

2. The **PRESCRIPTION DRUG BENEFIT** section of the Plan document will be deleted in its entirety. In its place, the following new section will be added:

PRESCRIPTION DRUG BENEFIT

HIGH-COST PRESCRIPTION DRUG COVERAGE PROVISION

All specialty drugs and drugs identified on the ARORx high-cost drug formulary list are excluded. If member is determined by ARORx to be ineligible for an alternative sourcing program through the drug's manufacturer, ARORx will source medication for member through direct sourcing with ARORx's contracted direct source pharmacies. Contact ARORx at 833-306-4092 for high-cost drug formulary list.

PRESCRIPTION DRUG CARD PROGRAM

Except as otherwise noted, charges are covered under this benefit for eligible drugs that are prescribed in writing by a Physician, Physician's Assistant, or Nurse Practitioner within the legally appointed scope of his/her license. Benefits are paid in excess of the co-payment per prescription listed in the Schedule of Benefits. If the Plan Administrator has issued an identification card for prescription drug benefits, the Covered Person must either destroy that card or surrender it to the Plan Administrator when his or her coverage terminates. The Plan limits coverage for prescription drugs for up to and including a 30-day supply (or up to and including a 90-day supply for certain maintenance drugs as determined by the Plan.

If an eligible prescription is filled at a pharmacy within the designated network, the Covered Person will be responsible only for the co-payment amount when purchasing the drug. If an eligible prescription is a) purchased at a pharmacy that is not within the designated network, or b) purchased at a pharmacy within the designated network without showing the proper coverage identification card, the Covered Person must pay the purchase price in full and then must submit the expense, with a completed prescription drug reimbursement claim form, directly to the Pharmacy Benefit Manager (PBM) EVO for processing.

Claims for prescription drugs must include the name of the prescribed medication, the patient's full name, the date that services were rendered or purchases made, and the cost per item. Reimbursement will be made at the maximum allowable charge determined by the PBM. The amount you receive may be less than the difference between the purchase price and the co-payment amount.

MAIL SERVICE PROGRAM

Except as otherwise noted, charges are covered under this benefit for eligible drugs that are provided through the Mail Service Program and that are prescribed in writing by a Physician, Physician's Assistant, or Nurse Practitioner within the legally appointed scope of his/her license. Each prescription purchase is subject to the co-payment stated in the

Schedule of Benefits. The Mail Service Program is specifically designed to provide the Covered Person with maintenance drugs for up to and including a 90-day supply.

COVERED PRODUCTS

- Compounded medications
- Contraceptives (all FDA-approved methods designated as covered by the PBM, including emergency kits, but excluding abortifacient agents)
- Diabetic supplies designated as covered by the Plan
- Federal legend drugs (unless specifically designated as excluded by the Plan)
- Immunizations designated as covered by the Plan (e.g., flu shots)
- Injectables, self-administered (unless specifically designated as excluded by the Plan; coverage for certain products may be limited based on cost)
- Products and medications listed as covered under the Prescription Agreement between the Employer and the PBM
- Smoking cessation products

EXCLUDED PRODUCTS

- Cosmetic drugs (unless specifically designated as covered by the Plan)
- Infertility drugs
- Injectables, office-based (unless specifically designated as covered by the Plan)
- Medical devices or appliances (unless specifically designated as covered by the Plan)
- Over-the-counter products (unless specifically designated as covered by the Plan)
- Weight loss drugs

PRODUCT LIMITATIONS

Quantity limits, or other coverage limitations may apply to some drugs. To obtain more information about the Plan's prescription drug benefit, including information about the coverage status or the co-payment amount applicable to a particular drug, the Covered Person can call ARORx at 833-306-4092.

PREVENTIVE PRODUCTS

In accordance with the requirements of applicable law, the Plan provides coverage for certain preventive care medications without any cost-sharing provisions such as Deductibles or co-payments. For more information about eligible preventive care medications, Covered Persons can contact ARORx at 833-306-4092. In the event a conflict arises between this provision and the information stated under the Excluded Products subsection above, the terms of this provision will rule.

APPEALS PROCESS

Any active Evo member, health care provider, or pharmacy may request an appeal after a coverage determination or prior authorization has been denied. The appeal must reach Evo no later than 180 days after receipt of the adverse determination. It must include reasons for the disagreement with the original decision, as well as any pertinent new information.

- For expedited, urgent appeals, best efforts are made to review submissions within 24 hours of receipt and written confirmation is sent to the member and prescriber within 72 hours.
- Standard, non-urgent appeals are reviewed within 30 calendar days from the appeal date.
- If the original determination is upheld, the written notification will include the principal reason(s) and information on how to file an external appeal.
- If the determination is overturned, Evo will notify the member and prescriber in writing and enter an override in our system.

Please note that all denials where an appeal may arise are either based on medical criteria for coverage inclusions and exclusions established by the Plan or on approved FDA indications. The appeal may be forwarded to the Plan Administrator for review and determination. A request is deemed urgent when the prescriber believes the member's health, life, or ability to regain maximum function may be seriously jeopardized under the standard review timeframe.

To request an appeal, complete the appeal form and submit it to Evo by email or fax. Alternately, you have the option to complete a secure webform on our website.

Attn: Evo First Appeals

Email: appeal@evofirst.com

Fax: 844-386-0001

Online: www.evofirst.com/appeal

To help us resolve the dispute, we'll need:

- A completed appeal form
- The reasons why you disagree with the original determination
- Supporting documents such as medication history, diagnostic workup, lab results, chart notes, etc.

All other provisions of the Plan shall remain in effect and unchanged.

IN WITNESS WHEREOF, the undersigned has caused this amendment to be duly adopted and effective as of January 1, 2025.

10/15/25
Date (Mandatory)

Witness

Lakota Local School District
(Authorized Representative)