

Northern School District Trust

Prescription Drug Plan Document

For employees enrolled in the South Shore School District Medical Benefit Plan

Effective: July 1, 2025

Northern School District Trust

Prescription Drug Plan

South Shore School District / NSDT ("Employer") has established the South Shore School District / NSDT Prescription Drug Plan (the "Prescription Plan"), which is part of and incorporated by reference into the Northern School District Trust Employee Benefit Plan (the "Plan") and is integrated with the medical plan, which is described in a Plan Document issued by HealthPartners.

Claims administration for the Plan is provided by Express Scripts, Inc., a claims administrator contracted by the Plan to process prescription drug claims on its behalf.

This Plan Document and Summary Plan Description ("SPD") is adopted and issued by the Employer for delivery to each covered person who is enrolled in the Plan described on the cover page. The SPD describes the main features of the prescription drug coverage provided.

You are entitled to this coverage only during the period for which if you are eligible, become covered and remain covered. A clerical error or omission will not deprive you of your coverage, affect the amount of your coverage or affect or continue coverage which would not otherwise be in force. The Plan Administrator reserves the right to amend any and all provisions of the Plan without advance notice.

A. ABOUT THE PLAN

1. How the Plan Works

If you elect medical coverage under the Plan, you are automatically enrolled in the Prescription Drug plan that corresponds with the medical option you have selected. The Plan helps pay the cost of covered prescription drugs that are medically necessary for treatment of a sickness or injury. Covered drugs must be:

- prescribed by a licensed physician or dentist and dispensed by a registered pharmacist; and
- approved by the United States Food and Drug Administration (FDA) for general use in treating the illness or injury for which they are prescribed.

2. Managed Pharmacy Network

Prescription drug benefits are provided through a managed pharmacy network. You may purchase covered prescription drugs through the network in one of two ways:

- at a network retail pharmacy; or
- through the mail-service program for maintenance medications or any prescription not needed immediately.

A list of participating pharmacies can be found at www.express-scripts.com.

B. GENERAL PROVISIONS

1. Effective Date

The benefits described in this SPD became effective on July 1, 2025.

2. Eligibility

All employees who are enrolled in medical benefits under the South Shore School District / NSDT are eligible for benefits under the Prescription Plan. This SPD describes the benefits for employees enrolled in the South Shore School District Medical Benefit Plan. The medical plan booklet describes the eligibility for medical benefits.

3. Enrollment and Termination

Once enrolled in the medical benefits, you and your dependents are automatically enrolled in the Prescription Plan. Coverage will terminate when medical coverage terminates and any changes made to your medical coverage will automatically change your coverage in the Prescription Plan, if applicable.

4. Continuation of Coverage under COBRA

You may be able to continue coverage under the Prescription Drug Plan under certain conditions if you choose to continue your Medical coverage. Medical coverage may be continued under certain circumstances under the federal Consolidated Omnibus Reconciliation Act of 1985 (COBRA). Please refer to your medical plan booklet for information on when you may be able to continue your medical (and prescription drug) coverage when it would otherwise end.

5. Continuation of Coverage for Employees in the Uniformed Services

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. The terms "Uniformed Services" or "Military Service" mean the Armed Forces (i.e., Army, Navy, Air Force, Marine Corps, Coast Guard), the reserve components of the Armed Services, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

You may be offered continuation of medical and prescription drug coverage during your military service. This benefit, which is similar to COBRA, will allow you to continue coverage for up to 24-months.

If you choose not to continue your medical (and along with it, your prescription drug) coverage while on military leave, you are entitled to reinstated medical and prescription drug coverage with no waiting periods or exclusions (however, an exception applies to service-related disabilities) when you return from leave. In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following your leave, safe transport home, and an eight-hour rest period, if you are on a military leave of less than 31 days
- Return to or reapply for employment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days
- Return to or reapply for employment within 90 days of completion of your period of duty, if your military service lasts more than 180 days.

6. Continuation of Coverage While on a Family and Medical Leave

Under the federal Family and Medical Leave Act (FMLA), employees are generally allowed to take up to 12 weeks of unpaid leave for certain family and medical situations (or 26 weeks for military caregiver leave) and continue their elected medical and prescription coverage benefits during this time. The Employer is required to maintain group health insurance coverage for an employee on FMLA leave:

- if the employee had such coverage before taking the leave, and
- on the same terms as if the employee had continued to work.

Please refer to the medical plan booklet for information on when you may be able to continue your medical (and prescription drug) coverage when you go on an FMLA leave.

C. BENEFITS AND DETAILS OF THE PRESCRIPTION DRUG PROGRAM

1. Claims Administrator

The Plan has contracted with Express Scripts to process prescription drug claims under the Plan and to provide additional services that are described in the SPD. Express Scripts uses a network of Participating Providers that are contracted to provide services at the maximum coverage level as shown on the Schedule for that benefit.

2. Identification of Network Participation

It is your responsibility when seeking benefits under the Plan to identify yourself as a covered person and to assure that the prescription is filled at a network pharmacy. Always carry and present your Prescription Drug Identification Card.

You are required to pay any copay at the time you receive or request a prescription based on the location filled and the type of prescription as set forth in each Schedule of Benefits.

3. Using a Network Retail Pharmacy

The retail pharmacy network includes most chain and many local pharmacies. Prescriptions can be filled at a network retail pharmacy for up to a 30-day supply. There are no claim forms to complete when you use a network retail pharmacy. You can find a list of participating pharmacies at www.express-scripts.com.

There may be circumstances where early or extended drugs are available. Please contact Express Scripts at 1-800-987-4911 for further information. Restrictions apply.

4. Mail-Service Program

The mail-service program is a cost-effective and convenient way to purchase up to a 90-day supply of covered medication through the mail from the Express Scripts Pharmacy. The mail-service program is used for maintenance prescription drugs, such as blood pressure medication, taken on a regular or long-term basis. It also can be used for any medication that is not needed immediately. Non-formulary drugs are not eligible to be filled through the mail service program.

To order your prescription through the mail service pharmacy, visit the express-scripts.com website or call Member Services at 1-800-987-4911 to obtain a Mail Service Pharmacy Order Form and envelope. Mail your prescription and any applicable copayment or coinsurance, along with the Mail Service Pharmacy Order Form to the address listed on the form.

Your filled prescription will be mailed directly to your home. Your order will include a preprinted envelope and a notice with instructions on how to request a refill prescription; you will not need a new prescription from your doctor if the prescription is still valid. Refills can also be conveniently refilled by phone or by using the Pharmacy Manager's website www.express-scripts.com.

5. Prescription Drug Tiers

Level 1 – Generic Drug: Using generic drugs when available can save you money. Pharmacies will dispense generic equivalent drugs, which are therapeutically equivalent to their brand-name drug in safety and effectiveness, when taken as prescribed unless your physician orders a specific brand name drug. Y

Level 2 – Preferred or Formulary Brand Name Drugs: This category includes brand-name drugs for which there are no or limited generic drug alternatives. If a generic drug is available, it will automatically be dispensed unless your physician orders a brand name drug or you request it. If you request brand-name when a generic drug is available, you will pay the difference between the generic and brand name drug and no limits will apply, if applicable.

Level 3 – Non-Preferred or Non-Formulary Brand Name Drugs: This category includes brand-name drugs for which no generic equivalent drugs and/or appropriate generic drug alternatives are available.

7. Prescription Drug Management

Your prescription drug program provides the following provisions which will determine the medical necessity and appropriateness of covered medications and supplies.

Prior Authorization

For certain medications, the Prescription Drug Plan requires a coverage review or "prior authorization" by Express Scripts before benefits will be paid. This review uses plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective.

There are other medications that may be covered, but with limits (for example, only for a certain amount or for certain uses), unless you receive approval through a coverage review. During this review, Express Scripts asks your doctor for more information than what is on the prescription before the medication may be covered under your plan.

The list of medications that require prior authorization will change from time to time, and drugs that do not require prior authorization may require it in the future. To find out whether a medication requires a coverage review, log in to www.express-scripts.com anytime. Prior authorizations, when approved, are typically approved for a one-year period, unless otherwise noted.

Your physician may call Express Scripts at 1-800-753-2851 to request a prior authorization approval or visit www.express-scripts.com/corporate/prior-authorization-resources.

Quantity Level Limits

Certain drugs may also be limited by drug-specific quantity limitations per month, benefit period, or lifetime as specified by the Plan and based on medical necessity. Other drugs may be covered under your medical benefits and will be subject to your deductible and coinsurance. If your prescription is affected by these limits, you or your pharmacist should contact Express Scripts.

Step Therapy Requirements

Step therapy is a program designed to help you save money by using the most cost-effective treatments if you have certain health conditions that require maintenance medications. It requires that you try a first line alternative, often a generic medication, to treat your medical condition. Then, based on your doctor's review, if necessary, you may be able to move to a brand-name drug. However, if a brand-name drug is dispensed and there is a generic available, you will pay the cost difference between the generic and the brand-name drug. Some of the drugs that require prior authorization as described in the "Prior Authorization" section fall into this step therapy program. Please contact Express Scripts Member Services at 1-800-987-4911 for more specific information on the program.

Managed Rx Drug Coverage

A prescription order or refill which may exceed the manufacturer's recommended dosage over a specified period of time may be denied by the Plan when presented to the pharmacy provider. Express Scripts may contact the prescribing physician to determine if the prescription drug is medically necessary and appropriate. If it is determined by Express Scripts that the prescription is medically necessary and appropriate, the prescription drug will be dispensed.

SafeGuardRx

The SafeGuardRX utilization management and cost containment program provides clinical support and patient engagement tools to assist with medication adherence and to drive healthier outcomes.

D. PRESCRIPTION DRUG SCHEDULE OF BENEFITS

Prescription drugs are covered when you purchase them through the applicable pharmacy network. For convenience and choice, these pharmacies include both major chains and independent stores.

To help contain costs, if a generic drug is available, you will be given the generic. As you probably know, generic drugs have the same chemical composition and therapeutic effects as brand names and must meet the same FDA requirements.

The chart below shows your copay amounts, out-of-network coverage, and maximum out-of-pocket amounts.

Prescription Drug Benefits	In-Network	Out-of-Network
Pharmacy Network	Retail – Express Scripts National Plus Mail Order – Express Scripts Pharmacy	N/A
Formulary	Express Scripts National Preferred	None
Benefit Period	January 1 – December 31	
Deductible (per benefit period – combined in and out of network and combined with medical deductible)	\$2,000 Individual \$4,000 Family	\$4,000 Individual \$8,000 Family
Out of Pocket Limit (combined with medical out-of-pocket limit)	\$7,350 Individual \$14,700 Family	\$7,350 Individual \$14,700 Family
Generic Prescription Drug	\$0 Copay	Retail Only: 20% Coinsurance
Brand Formulary Prescription Drug	Retail: \$15 Copay Mail: \$30 Copay	Retail Only: 20% Coinsurance
Brand/ Generic Non-Formulary Prescription Drug	Retail: \$50 Copay Mail: \$100 Copay	Retail Only: 20% Coinsurance
Specialty Drug Must be filled through the Accredo Specialty Pharmacy	\$15 Copay	Not covered
Generic Substitution	When you purchase a brand drug that has a generic equivalent you may be responsible for the brand drug copay plus the difference in cost between the brand and generic drug, unless your physician requests that the brand name drug be dispensed.	

Prescription Drug Benefits	In-Network	Out-of-Network
Preventive Medications	<p>Certain preventive medications may be available with no copay when purchased from a network pharmacy in accordance with the Affordable Care Act ("ACA"). For additional information and to confirm that a prescription is covered with no copay, please call Express Scripts Member Services at 1-800-987-4911 or visit www.express-scripts.com.</p>	

E. ELIGIBLE PRESCRIPTION DRUG EXPENSES

1. Covered Drugs

Covered prescription drugs include:

- those which, under Federal law, are required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription";
- legend drugs under applicable state law and dispensed by a licensed pharmacist;
- prescription drugs listed in your program's prescription drug formulary; including compounded medications, consisting of the mixture of at least two ingredients other than water, one of which must be a legend drug (drug that requires a pharmacist dispenses it);
- preventive drugs that are offered in accordance with a predefined schedule and are prescribed for preventive purposes. Express Scripts periodically reviews the schedule based on legislative requirements and the advice of the American Academy of Pediatrics and the U.S. Preventive Services Task Force. Therefore, the frequency and eligibility of services is subject to change. For a current schedule of covered preventive drugs, log onto the member website at www.express-scripts.com.
- self-injectable medications, including supplies such as alcohol swabs, syringes and needles;
- insulin, insulin syringes, Chemstrips, disposable insulin pens, insulin cartridges, and pen needles (non-disposable insulin pens are considered medical supplies and are covered under medical benefits);
- insulin pumps;
- drug therapy supplies including but not limited to blood/urine testing tabs/strips and lancets;
- inhaler assisting devices (eg. Inspirease, Aerochamber), whether prescription or over-the-counter;
- hemophilia factors;
- drugs for weight loss or anti-obesity;
- drugs used to treat gender dysphoria;
- off-label prescription drugs used for cancer treatment as specified by law, whether or not the drug has been approved by the federal Food and Drug Administration for the treatment of cancer if the drug is recognized for treatment of cancer in one of the standard compendia or in one article in the medical literature as specified by law;
- allergy extracts (oral only);

- impotency treatment drugs and drugs used for female sexual dysfunction;
- oral contraceptives, emergency contraceptives, implantable contraceptives, injectable contraceptives, over-the-counter contraceptives and contraceptive devices (e.g., IUDs, diaphragms and cervical caps);
- abortifacients;
- all forms of smoking-cessation aids, whether prescription type (such as Wellbutrin), or physician-prescribed over-the-counter type (such as nicotine patches and nicotine gum);
- COVID Oral Antivirals;
- vaccines, including certain eligible vaccines administered at a participating retail pharmacy;
- prescription vitamins;

1. Specialty Medications

Certain drugs are considered “specialty medications” and may only be purchased through the Accredited Specialty Pharmacy, except as required in an emergency. The following are the therapeutic classifications of specialty medications under the Plan. Please note that this is a summary and not all encompassing.

- | | |
|--------------------------|-------------------------------------|
| • Blood Modifiers | • Growth Hormones |
| • Hemophilia | • IGIV |
| • Interferon | • Oral Oncologics |
| • Pulmonary Hypertension | • Other (as determined by the Plan) |

For information on ordering specialty medications, dispensing limitations, and your cost for these drugs, contact Express Scripts by visiting the website at www.express-scripts.com or by calling Member Services at 1-800-987-4911.

3. Brand Name Preferred Formulary Program

The Plan uses a list of prescription drugs called a “formulary.”* Certain brand-name medications may not be on the preferred list. For a list of the medications on the formulary, visit www.express-scripts.com.

How the formulary works for you:

- Check the list to see if a brand-name drug you use is on the formulary identified on the Schedule of Benefits. Many brand-name medications are included on the formulary. Others might now be available as generics.
- If your brand-name prescription is on the formulary, you’ll pay the cost for the brand-name Formulary prescription.
- If your brand-name prescription is not on the list and you still want to take it, you will need to pay the cost of the brand-name non-formulary prescription.

Only you and your provider can make decisions about your healthcare. Be sure to ask your doctor about the drugs that appear on your formulary drug list so he or she can choose ones that are right for you.

*Note: Formulary drug lists are updated periodically and subject to change. Express Scripts, the claims administrator and pharmacy benefit manager, chooses which drugs are on its drug lists or excluded from its

drug lists based on numerous factors including their quality, safety and effectiveness, and overall costs. The overall cost of a drug can be impacted by volume discounts or reimbursements paid by drug manufacturers. At times, this may result in a brand name drug being included on a list while the generic of the same drug is excluded from a drug list.

F. EXCLUSIONS

Except as specifically provided in this Summary Plan Description, no benefits will be provided for:

- any prescription refilled in excess of the number of times specified by the doctor, or any refill dispensed more than one year after the doctor's original order;
- drugs or supplies covered under workers' compensation or occupational disease law or any similar law;
- drugs labeled "caution—limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual;
- drugs and medicines that may not be prescribed within the scope of the doctor's license;
- medication administered in a doctor's office or health care facility (other than contraceptive-related medications);
- Zolgensma;
- drugs used to treat or cure baldness or hair loss and hair growth stimulants (e.g., minoxidil);
- injectable/implantable medications that are not self-injectable or specialty (e.g., intravenous antibiotics administered in a hospital);
- drugs used for treatments that are cosmetic-related;
- Specialty medications not purchased from Accredo Specialty Pharmacy;
- fertility drugs, including oral, injectable and intra-vaginal medication;
- COVID over-the-counter Testing Kits;
- over-the-counter drugs and products unless specifically listed as covered expenses in the Plan;
- any prescription drug purchased through mail order but not dispensed by the Express Scripts Pharmacy;

Please refer to the Express Scripts national preferred formulary exclusions for the current plan year for a comprehensive list of drugs that are not covered.

G. CLAIMS AND APPEALS

1. General Procedures

If you receive medications from a network pharmacy and present your ID card, you will not have to file a claim. You will owe the pharmacy any copay or coinsurance that applies. If you forget your ID card when you go to a network pharmacy, the pharmacy may ask you to pay in full for the prescription.

The procedure for filing a claim is simple. Just take the following steps.

Know Your Benefits

Review this information to see if the services you received are eligible under your prescription drug program.

Get an Itemized Bill

Itemized bills must include (as applicable):

- The name and address of the service or pharmacy provider;
- The patient's full name;
- The date of purchase;
- The amount charged;
- Drug and medicine bills must show the prescription name and number and the prescribing provider's name.

Complete a Claim Form

To obtain a claim form, call Express Scripts at 1-800-987-4911 or visit <https://www.express-scripts.com> to access and print claim forms.

You should submit your claim form to:

Express Scripts
Attn: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

Your claim will be reimbursed according to the type of drug you purchased at an Express Scripts retail pharmacy.

To find out if your pharmacy is affiliated with Express Scripts, for instructions on filing claims, for refills and for status of an order, call Express Scripts Member Services at the number shown on the back of your Prescription Drug Identification Card.

2. Express Scripts Reviews and Appeals Overview

You must use and exhaust this plan's administrative claims and appeals procedure before bringing a suit in either state or federal court. Similarly, failure to follow the plan's prescribed procedures in a timely manner will also cause you to lose your right to sue regarding an adverse benefit determination.

You have the right to request an initial review for a medication that is not covered at point of sale at either retail or home delivery pharmacies to be covered or to be covered at a higher benefit (e.g., lower copay, higher quantity, etc.). The first request for coverage is called the initial coverage review. Express Scripts reviews both clinical and administrative coverage review requests:

- Clinical coverage review requests: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the plan. For example, medications that require a prior authorization.
- Administrative coverage review request: A request for coverage of a medication that is based on the plan's benefit design.

How to Request an Initial Coverage Review

The preferred method to request an initial clinical coverage review is for the prescriber to submit the prior authorization request electronically. Alternatively, the prescriber or dispensing pharmacist may call the Express Scripts Coverage Review Department at 1-800-753-2851 or the prescriber may submit a completed coverage review form by faxing it to the number provided on the form. Home delivery coverage review requests are automatically initiated by the Express Scripts Home Delivery pharmacy as part of filing the prescription.

To request an initial administrative coverage review, you, your doctor or your dispensing pharmacist must submit specific information in writing to:

Express Scripts
 Attn: Benefit Coverage Review Department
 P.O. Box 66588
 St. Louis, MO 63166-6588

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by the provider by phone at 1-800-753-2851.

How a Coverage Review Is Processed

In order to make an initial determination for a clinical coverage review request, the prescriber must submit specific information to Express Scripts for review. For an administrative coverage review request, the member must submit information to Express Scripts to support his or her request. The initial determination and notification to patient and prescriber will be made within the specified timeframes as follows:

Type of Claim	Decision Timeframe	Notification of Decision	
		Approval	Denial
Standard Pre-Service*	15 days (retail) 5 days (home delivery)	Patient: Automated call (letter if call not successful) Prescriber: Fax (letter if fax not successful)	Patient: Letter
Standard Post-Service	30 days		Prescriber: Fax (letter if fax not successful)
Urgent	72 hours**	Patient: Automated call and letter Prescriber: Fax (letter if fax not successful)	Patient: Live call and letter Prescriber: Fax (letter if fax not successful) *
*If the necessary information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to the patient and prescriber informing them that the information must be received within 45 days or the claim will be denied.			
** Assumes all information necessary is provided. If necessary information is not provided within 24 hours of receipt, a 48 hour extension will be granted.			

Denial Process

An initial coverage/administration review will be denied if the necessary information needed to make a determination is not received from the prescriber within 45 days of the decision timeframe or the information received does not meet the approval standards. An appeal request for further review can be initiated at that point.

3. How to Request Appeals after Coverage Review Has Been Denied

Level 1 Appeal

Upon receipt of a denial notice, a covered member or authorized representative can request a level 1 appeal with Express Scripts within 180 days from receipt of a denial notice. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Description of why the claimant disagrees with the denial

For clinical appeal requests, call/fax/mail to:

Express Scripts

Attn: Clinical Appeals Department

P.O. Box 66588

St. Louis, MO 63166-6588

Phone: 1-800-753-2851 (for expedited requests)

Fax: 1-877-852-4070

For administrative appeal requests, call/fax/mail to:

Express Scripts

Attn: Administrative Appeals Department

P.O. Box 66588

St. Louis, MO 63166-6588

Phone: 1-800-753-2851 (for expedited requests)

Fax: 1-877-328-9660

Notice of approval or denial will be sent out to you and your prescriber electronically or by mail.

Level 2 Appeal

If a level 1 appeal is denied, a request for a level 2 appeal may be submitted by the member or authorized representative to Express Scripts within 90 days from receipt of notice of the level 1 appeal denial notice. You should submit required information to the appropriate address (same as the level 1 appeal shown in the section above).

Alternative Options

You can decide at any time during this process to either pay out of pocket or ask your prescriber for a covered alternative.

H. RIGHT OF SUBROGATION AND REIMBURSEMENT

The plan has certain rights to subrogation and reimbursement. Please contact the Employer for more information on the Plan's rights.

I. PRIVACY OF PROTECTION HEALTH INFORMATION

The Employer will use a covered person's protected health information ("PHI") in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("the HITECH Act") only to make disclosures related to treatment, payment for healthcare, or the Healthcare Operations of the Plan or to make any other disclosures that are required by law. However, if a covered person requests to see the information or provides a signed authorization, the Plan may use and disclose PHI as permitted and directed by the request or the authorization.

With respect to PHI, the Employer will:

- Not use or further disclose PHI other than as permitted or required by this SPD or as required by law;
- Ensure that any agent or vendor, to whom the Employer or Plan provides PHI agrees to the same restrictions and conditions that apply to the Employer with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by the individual that is the subject of the PHI;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by the individual that is the subject of the PHI;
- Make PHI available to an individual in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available upon request an accounting of disclosures;
- Make available to the Secretary of the Department of Health and Human Services ("DHHS") internal practices, books and records relating to the use and disclosure of PHI received from the Plan, for purposes of determining the Plan's compliance with HIPAA;
- If feasible, return or destroy all PHI received from the Plan when such PHI is no longer needed for the purpose for which disclosure was made; and
- Use DHHS approved methods to destroy PHI that is no longer needed.

In addition, in the event of a breach of unsecured PHI, the Employer will provide written notice or a substitute notice—if the last known contact address is insufficient—for each individual within 60 days following discovery of any breach of Unsecured PHI. The notice will include:

- A brief description of what happened including the date of the breach and the date of discovery, if known;
- A description of the types of unsecured PHI that were involved in the breach;
- Any steps the individual should take to protect himself or herself from potential harm resulting from the breach;
- A brief description of what the Employer is doing to investigate the breach in accordance with HIPAA breach notification requirements;
- Contact procedures for individuals to ask questions or learn additional information
- With respect to Electronic PHI, the Employer will, if PHI is or has been stored on the Employer's computer system:
 - Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI;
 - Ensure that the firewall required by the HIPAA privacy rule is supported by reasonable and appropriate security measures;
 - Ensure that any agent or vendor to whom the Employer provides electronic PHI agrees to comply with the HIPAA Security Requirements and to provide notice to the Plan of any breach of unsecured PHI, once the breach is known to the agent or vendor or should reasonably have been known to the agent or business associate;
 - Report to the Plan any security incident of which the Employer becomes aware; and
 - Use methods to encrypt ePHI that are approved by DHHS.

Only Human Resources Department employees, Information Systems Department employees, the Privacy Officer and Agent/Broker of record may be given access to PHI. These individuals may use and disclose PHI only for plan administration functions that the Employer performs for the Plan. If any of these persons do not comply with the HIPAA provisions of this SPD, the Employer will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

J. PLAN INFORMATION

1. Name of Plan: South Shore School District / NSDT Prescription Drug Plan, which is part of the Northern School District Trust Employee Benefit Plan
2. Plan Number: 501
3. Name, and address of Plan Sponsor:
Northern School District Trust
400 Lake Shore Drive East
Ashland, WI 54806
4. Telephone number of Plan Sponsor: (715) 682-7080
5. Employer Identification Number of Plan Sponsor: 39-1500407
6. Agent for Service of Legal Process:
Northern School District Trust
400 Lake Shore Drive East
Ashland, WI 54806

Legal process may also be served on the Employer in its capacity as Plan Administrator.

7. Plan Year: July 1 – June 30
8. Type of Plan and Administration of Plan: The Plan provides welfare type benefits. Administration of the benefits the Plan offers is provided by the Employer, as plan sponsor and a third-party administrator. Claims are administered by Express Scripts, Inc.
9. Funding: This plan is self-funded by the Employer; costs and benefits are paid for in part by the employer and in part by participants on a pre-tax basis.

