ALERA GROUP, INC.
PRESCRIPTION DRUG PLAN

(PART OF THE ALERA GROUP, INC. WELFARE BENEFITS PLAN)

SUMMARY PLAN DESCRIPTION

(*Effective January 1, 2026*)

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INTRODUCTION

This summary plan description ("SPD") for the Alera Group, Inc. Prescription Drug Plan (the "Rx Plan"), which is part of the Alera Group, Inc. Welfare Benefits Plan (the "Wrap Plan"), describes the provisions of the Rx Plan that are effective as of January 1, 2026. Alera Group, Inc. (the "Company"), which is the Plan Sponsor, reserves the right to terminate or amend the Rx Plan at any time and for any reason.

This SPD summarizes the main provisions of the Rx Plan and describes the benefits available to you. A separate SPD describes the medical benefits available to you through one of the medical plans sponsored by Alera Group, Inc. which are administered by Blue Cross Blue Shield of Illinois, UnitedHealthcare, and Surest (the "Group Health Plan"). The Company has provided you with summaries of the Rx Plan benefits and introductory and enrollment materials (the "Plan Materials"), which are hereby incorporated into this SPD by reference. If you have any questions about your Rx Plan benefits, please contact the Alera Group Benefits Center or Optum Rx ("Optum") directly at 1-855-524-0381. This document is intended to serve as both the plan document and SPD for the Rx Plan. The Rx Plan does not have a separate formal plan document.

The Rx Plan will pay benefits only for the eligible expenses incurred while this coverage is in force. Benefits are not payable for eligible expenses incurred before coverage began or after coverage terminates. An expense for a service or supply is incurred on the date the service or supply is furnished or provided.

This SPD describes the general features of the Rx Plan and your rights, obligations, and benefits under the Rx Plan. In the event of a discrepancy between the SPD and any other document or oral communication, this document will govern.

All benefits provided under the Rx Plan are funded by contributions by both the Company and employees.

The Company has entered into an arrangement with Optum, which is the pharmacy benefit manager ("PBM"), to provide administrative services for the Rx Plan, including the processing of benefit claims and the provision of certain pharmacy programs. Optum Rx does not insure the benefits provided by the Rx Plan.

ELIGIBILITY AND ENROLLMENT

You are not eligible to participate in the Rx Plan unless you are a participant in the Group Health Plan. When you (and your eligible dependents) enroll in the Group Health Plan you are automatically enrolled in the Rx Plan and your coverage under this Rx Plan begins. Therefore, please refer to eligibility requirements under the Group Health Plan if you have questions about eligibility for this Rx Plan. Further, please review the Group Health Plan SPD for more information regarding coverage (including changing coverage and adding or removing dependents during the Plan Year), definition of certain general terms that apply to both the Group Health Plan and this Rx Plan (such as "copay", "coinsurance" and "deductible"), as well as certain notices that apply to benefits under this Rx Plan and the Group Health Plan.

If you are enrolled in the Rx Plan, you will receive prescription drug benefits under the plan if certain conditions, terms, or provisions of this Rx Plan are met, including: (1) your Prescription Drug has been determined to be medically necessary and obtained through a retail or mail order Pharmacy or other authorized source, as applicable, which is described in more detail in this Rx SPD; (2) your Prescription Drug is listed on the applicable Optum Rx Premium Formulary for this Rx Plan and is not a Drug that is

excluded under the terms of the Rx Plan (See the Exclusions and Limitations section of this Plan), including any special exclusions or requirements related to any Specialty Drug you are prescribed as described in the Specialty Drugs subsection of this Rx Plan; (3) any medical management or utilization review that applies to your prescribed Drug, if any, has been complied with, and (4) you pay the applicable cost sharing (copay or coinsurance) specified in the Schedule of Benefits in this Rx Plan. Benefit and fill limits, exclusions, and certain other requirements that apply to this Rx Plan are described in greater detail in the Schedule of Benefits, Filling Your Prescriptions, and Exclusions and Limitations sections of this Rx Plan.

For purposes of this Plan, "Medicine" or "Drug" means a substance intended to be used to prevent, diagnose, cure, mitigate, treat, or relieve symptoms of a disease or abnormal condition and which is legally procured pursuant to applicable laws and regulations. Moreover, "Prescription Drug" means drugs that are prescribed by a licensed health care provider who is authorized under applicable state law to prescribe Medicines or Drugs and has prescribed such Medicine or Drug to you for purchase at a Pharmacy. Prescription Drugs are regulated by the U.S. Food and Drug Administration ("FDA"). Any Medicine or Drug purchased without a prescription will be considered an "Over-the-Counter Drug" for purposes of this Rx Plan.

A "Pharmacy" is a licensed medical facility that is staffed by a Pharmacist (i.e., an individual licensed under applicable state and federal law to dispense prescribed Drugs). You are encouraged to purchase your Prescription Drugs from retail and/or mail order pharmacies, as applicable, in the Optum Rx pharmacy networks ("Network Pharmacy" or "Participating Pharmacy"). A directory of Participating Optum Rx retail pharmacies can be found at www.optumrx.com/pharmacy locator or by calling 1-855-524-0381. Prescription Drugs purchased from a non-Participating Pharmacy/Non-Network Pharmacy are not covered by this Rx Plan.

Under the Rx Plan, your cost is lower for Generic and Preferred Brand-Name or "Preferred" prescription drugs, which are subsidized at a higher percentage rate. You will have access to Optum Rx's Broad retail pharmacy network where you may receive up to a 90-day supply of medication at Participating Pharmacies. In addition, mail order prescription drug benefits are provided through Optum Home Delivery for up to a 90-day supply of maintenance medications that you take on an ongoing basis for chronic conditions such as heart disease, high blood pressure, diabetes, asthma, and other long-term health conditions. Optum Home Delivery offers the convenience of having medications shipped directly to your home and typically provides the lowest member cost share for maintenance medications. While Alera Group also allows 90-day fills at retail pharmacies, copays are lower when maintenance medications are filled through Optum Home Delivery. You can access Home Delivery services through welcome.optumrx.com or the Optum Rx App.

The cost of the Rx Plan is included in the cost of the Group Health Plan you choose. You and the Company share in the cost of the coverage. Expected costs and contributions are based on group rates – that is, they are determined by the total cost of providing medical coverage to all Group Health Plan participants.

SCHEDULE OF BENEFITS

Overview of what you will pay for Prescription Drugs (In-Network Coverage Only):

	Plan			
In-Network Coverage Only*	**$3,400 HDHP (UHC or BCBS)**	**$6,000 HDHP (UHC or BCBS)**	**PPO (UHC or BCBS)**	**Surest**
Broad Retail Network Pharmacy 1–30 day supply Generic Preferred Brand Non-Preferred Brand	*Deductible applies first $15 copay $40 copay $70 copay	*Deductible applies first $0 copay $0 copay $0 copay	*Deductible does not apply $15 copay $40 copay $70 copay	*Deductible does not apply $15 copay $40 copay $70 copay
Broad Retail Network Pharmacy 31-60 day supply Generic Preferred Brand Non-Preferred Brand	*Deductible applies first $30 copay $80 copay $140 copay	*Deductible applies first $0 copay $0 copay $0 copay	*Deductible does not apply $30 copay $80 copay $140 copay	*Deductible does not apply $30 copay $80 copay $140 copay
Broad Retail Network Pharmacy 61-90 day supply Generic Preferred Brand Non-Preferred Brand	*Deductible applies first $45 copay $120 copay $210 copay	*Deductible applies first $0 copay $0 copay $0 copay	*Deductible does not apply $45 copay $120 copay $210 copay	*Deductible does not apply $45 copay $120 copay $210 copay
Mail Order Network 1-90 day supply Generic Preferred Brand Non-Preferred Brand	*Deductible applies first $30 copay $80 copay $140 copay	*Deductible applies first $0 copay $0 copay $0 copay	*Deductible does not apply $30 copay $80 copay $140 copay	*Deductible does not apply $30 copay $80 copay $140 copay
Specialty Drugs (limited to a 30-day supply; retail only)**	*Deductible applies first 30% coinsurance; $70 min / $200 max	*Deductible applies first $0 retail	*Deductible does not apply 30% coinsurance; $70 min / $200 max	*Deductible does not apply 30% coinsurance; $70 min / $200 max

Drugs Treated as Preventive Care under Health Care Reform <u>Retail: 1-30 day supply</u> <u>Mail Order: 1-90 day supply</u> Generic Preferred Brand Non-Preferred Brand	*Deductible does not apply $15 retail / $30 mail $40 retail / $80 mail $70 retail / $140 mail	*Deductible does not apply $0 copay $40 retail / $80 mail $70 retail / $140 mail	*Deductible does not apply $0 copay $0 copay $0 copay	*Deductible does not apply $0 copay $0 copay $0 copay
OOP Maximum - Embedded Individual Family	 $5,600 $11,200	 $6,000 $12,000	 $5,000 $10,000	 $6,500 $13,000
Annual Deductible - Embedded Individual Family	 $3,400 $6,600	 $6,000 $12,000	 Deductible does not apply	 Deductible does not apply

* *INN means in-network benefits and refers to Prescription Drugs filled at a Participating Pharmacy or Network Pharmacy.*

** *See Specialty Drugs subsection of this Rx Plan for more information about Rx Plan Coverage.*

You are responsible for the applicable deductibles and/or copays listed in the above benefits grid until you reach your OOP Maximum. At that time, the Rx Plan pays 100% of eligible in-network medical and prescription drug expenses for the rest of the Plan Year.

Out-of-network prescription drugs are not covered under the Rx Plan.

FILLING YOUR PRESCRIPTION

You will receive an ID card that includes your prescription drug benefit information (separate from your medical benefit ID card). Be sure to bring the card with you when you go to the pharmacy to get a prescription filled. You can use the website welcome.optumrx.com to locate a retail pharmacy network, check drug costs, check coverage, and to print a claim form.

Choosing where to fill your prescription depends on whether you have a long-term (chronic) or short-term (acute) condition and need for the medication. For example, if you are prescribed an antibiotic, it will generally be a short-term medication, as it is taken for a limited amount of time and may have a limited number of available refills. You can fill prescriptions for short-term medications at any of the retail pharmacies in the Optum Rx pharmacy networks. A directory of participating Optum Rx retail pharmacies can be found at www.optumrx.com/pharmacy locator or by calling 1-855-524-0381.

If you are on a long-term medication, also known as a maintenance medication, that is taken regularly, like blood pressure or cholesterol medication, you can save money by ordering 90-day supplies through Optum

Rx's Mail Order Network. You can enroll online by visiting welcome.optumrx.com, by using the Optum Rx mobile app, or by calling 1-855-524-0381.

Payment of Benefits Under the Plan

If you are eligible for coverage under the Rx Plan, you will receive coverage after you pay any applicable copayment, coinsurance, and/or deductible under the Rx Plan (see Schedule of Benefits) until you reach the applicable OOP Maximum. The Rx Plan will pay the "Allowed Amount" for covered Prescription Drugs, which is generally the lower of (1) the Usual, Customary, or Reasonable Charge, which means that the Rx Plan will determine whether the charge is appropriate based upon the specified Drug provided to you and the cost of similar or identical Drugs offered in your geographic market or area. The Plan Administrator or its delegee has the sole discretion to determine what is Usual, Customary, or Reasonable for purposes of this Rx Plan; (2) the price specified on the Optum Rx maximum allowable cost ("MAC") list, or (3) the Average Wholesale Price less a contractually determined discount as well as a Dispensing Fee. "Average Wholesale Price" generally means the average price at which a wholesaler sells a Prescription Drug to a pharmacy. A "Dispensing Fee" is a fee the Pharmacy from where you purchase your Prescription Drug charges the Rx Plan for services provided to you, which may include the cost of preparing or storing the medication.

Brand Name Drugs, Generic Drugs, and Preferred Brand Drugs

A "Generic Drug" is a Drug that is created the same as an already marketed Brand Name Drug in dosage form, safety, strength, route of administration, quality, performance characteristics, and intended use. A "Brand Name Drug" or "Formulary Brand Name Drug" refers to a prescription drug that is marketed by a company under its proprietary name or trademark and that is protected by patent. A "Preferred Drug" is a Brand Name Drug that is included on the Rx Plan's Formulary and specified as a "Preferred Drug" on the Formulary. A "Non-Preferred Drug" is a Brand Name Drug that is not included on the Rx Plan's "Preferred Drug" list and is, therefore, will be subject to a higher copay or coinsurance, as applicable, as described in this Rx Plan's Schedule of Benefits.

If your doctor writes a prescription for a Brand Name Drug, you may get the brand at the brand copay. If your doctor writes a prescription for a Generic Drug and you choose the Brand Name Drug, then this Rx Plan will cover the Generic Drug. If your pharmacist does not dispense the Generic Drug prescribed by your provider (i.e., dispense the drug as written or "DAW"), then you will be assessed a penalty which is comprised of the cost difference between the Brand Name and Generic Drug. If you are required to pay a DAW penalty, then understand that the DAW penalty does not accumulate/apply towards your deductible or OOP Maximum under this Rx Plan.

Generic Drugs remain your lowest-cost choice offering you the least expensive alternative without sacrificing safety and effectiveness. Generic Drugs are safe and as effective as their brand-name counterparts, and they cost you less.

If you are taking a medication that's not on the Optum Rx Formulary list, ask your doctor to consider prescribing a lower-cost Generic or Brand Name Drug that is on the Formulary. To find out which drugs are on the Optum Rx Formulary list, log on to the member page by visiting welcome.optumrx.com.

Compound Drugs

If you are prescribed a "Compound Medication", which is a Drug that is created by combining, mixing, or altering the ingredients of two or more Drugs to create a single Medication that is tailored to the individual

patient, please contact Optum Rx at 1-855-524-0381 to determine whether and how your Prescription Drug will be covered by the Rx Plan.

Out of Pocket (OOP) Maximum

The OOP Maximum is comprised of the applicable deductibles, copayments, and coinsurance listed in the Schedule of Benefits in this Rx Plan and is the maximum amount you must pay each Plan Year for covered items and services. Each copayment, coinsurance, or deductible expense you incur accumulates towards your annual OOP Maximum. Once you reach the OOP Maximum, you will no longer incur copayments, coinsurance, or deductibles for your covered Prescription Drug benefits. In addition to other non-covered OOP expenses as may be described in this Rx Plan, the OOP Maximum does not include expenses for premiums; expenses you incur for excluded items or services; any DAW penalties assessed; expenses you incur if you do not comply with Prior Authorization or other utilization management requirements of the Rx Plan, such as Step Therapy; if you exceed any other benefit limits described under this Rx Plan; and/or expenses you incur for items or services at a Non-Network/OON Pharmacy.

The OOP Maximum for this Rx Plan is integrated with the OOP Maximum for the Group Health Plan which was described to you in the Group Health Plan materials provided separately to you. This means that the OOP Maximum for this Rx Plan is combined with the OOP limit under the Group Health Plan and you do not have to pay two separate OOP Maximums. Thus, once you reach the applicable OOP Maximum for covered medical or Prescription Drug benefits under either plan you have satisfied the OOP Maximum for both plans.

Embedded Out of Pocket (OOP) Maximum

The OOP Maximums identified in the Schedule of Benefits are embedded. This means if a member of the family meets his or her "individual" maximum OOP, then that individual will transition into the 100% coverage phase of his or her benefit. Other family members will continue paying their applicable cost share (copayment or coinsurance) for prescription drugs until the earlier of the time they meet their individual maximum OOPs or the family maximum OOP is met.

Formulary

The Formulary, also known as a "drug list", is a list of Prescription Drugs covered by this Rx Plan for individuals enrolled in the Plan who have been prescribed a Prescription Drug and who have met all applicable medical necessity and/or precertification requirements. Talk with your doctor about the medications that are available to you on the Optum Rx Formulary list. You can also call the Optum Rx member services number, 1-855-524-0381, to speak with a patient care representative about your medication coverage options.

Orphan Drugs

"Orphan Drugs" are Drugs developed pursuant to U.S. Orphan Drug Act to treat, prevent, or diagnose an Orphan Disease (i.e., a rare disease or condition affecting fewer than 200,000 persons in the United States). If you are diagnosed with an Orphan Disease, your Orphan Drug is considered a Specialty Drug under this Plan. Please refer to the Specialty Drug section of the Optum Rx Formulary, the Schedule of Benefits, and the Specialty Drug section of this Rx Plan to determine if and how the Rx Plan covers your Orphan Drug. You may contact Optum Rx at 1-855-524-0381. if you have questions about coverage for your Orphan Drug.

Home Delivery/Mail Order Delivery

Home Delivery/Mail Order Prescription Drugs are Prescription Drugs that benefits are provided through Optum Rx Mail Order Network for up to 90-day supplies of medications you take on an ongoing basis. For medications you take on an ongoing basis (such as for high blood pressure or cholesterol medications), you may benefit from a lower copay by filling through Optum Rx Mail Order Network. You may contact the Optum Rx Mail Order Network by visiting welcome.optumrx.com, by using the Optum Rx mobile app, or by calling 1-855-524-0381.

Preventive Care

The plan complies with the Affordable Care Act ("ACA") requirements to offer in-network coverage for certain preventive services at no cost share to the member. These benefits include, but are not limited to:

- Drugs used in the prevention of cardiovascular disease in men and women;
- Certain cholesterol lowering agents;
- Contraceptive medications and devices;
- Drugs used to cease the use of nicotine and tobacco; and
- Preventive vaccinations.

Prior Authorization

Certain medications may be subject to a clinical review through Optum Rx's prior authorization process before your prescription can be filled. This is called "Prior Authorization." These medications must be authorized for coverage because they are only approved or effective in treating specific illnesses, they cost more, and/or they may be prescribed for conditions for which safety and effectiveness have not been established. If your medication requires a Prior Authorization, your physician can start the review process online at welcome.optumrx.com or by contacting Optum Rx at 1-855-524-0381. Failure to meet Prior Authorization criteria for medications that require Prior Authorization will result in a denial of coverage for your prescription drug.

Quantity Limits

For safety and cost reasons, this Rx Plan may limit the amount of a Prescription Drug you are prescribed over a certain period of time. This is known as a "Quantity Limit." You may be responsible for any charges for medications you receive that exceed the Quantity Limits established under this Rx Plan.

Specialty Drugs

Specialty Drugs are high cost medications that are often used in the management of chronic and/or complex conditions. If you are prescribed a Specialty Drug, then you must fill your prescription through the Optum Specialty Pharmacy. You can reach Optum Specialty Pharmacy at 855-427-2682 or OptumRx.com. If you fail to fill your prescription drug through the Optum Specialty Pharmacy your prescription may not be covered under this Rx Plan. If a medication is designated as exclusive or limited distribution, members will be required to use certain pharmacies outside of Optum Specialty Pharmacy, in which no penalty would be enforced.

Step Therapy Program and/or Utilization Review

Step Therapy is a type of Prior Authorization which requires you to try a certain, less expensive drug on the Rx Plan's Formulary that has been proven effective for treating your specific condition before you can move or "step up" to a more expensive drug. For example, this Rx Plan may require you to try a Generic Drug before the Rx Plan will cover a Preferred Brand Name Drug.

However, if your prescriber believes that because of your medical condition it's medically necessary for you to be on a more expensive Step Therapy Drug without trying the less expensive Drug first, or if your provider believes you will experience adverse health effects if you take the less expensive Drug or the less expensive Drug will be less effective, you or your prescriber can contact Optum Rx at 1-800-711-4555 to request an exception. Your prescriber must give a statement supporting the request for exception.

The Rx Plan may use utilization review for certain Prescription Drugs, which could require certain checks and balances to be applied before a claim is paid. You will be notified if utilization review applies to your Prescription Drug; however, you may also contact Optum Rx at 1-855-524-0381 to determine whether utilization review applies to the specific drug which you are prescribed.

Other Programs

Opioid Management Base Program
This program applies clinical edits to encourage chronic users to consider safer alternatives, ensures short-acting and long-acting opioids are in alignment with tighter CDC guidelines and confirms appropriate use of opioid-based cough and cold medications. This program screens for drug-drug and drug-age interaction, pregnancy, opioid use secondary to medication assisted treatment (MAT) related prescriptions, excessive use, early refills, and stockpiling of controlled substances. This program will ensure the refill window on opioids is set at 75%, reducing the potential for stockpiling, diversion and abuse of the medications. Applying the "Enhanced DEA Edit by Scope of Practice" point-of-service prescriber monitoring restrictions ensures that prescribers are licensed and authorized to prescribe controlled drugs within the scope of their practice. Flagging prescribers with sanctions or limitations for prescribing controlled substances, claims are rejected for additional pharmacist review at the point of service. This program also ensures first-fill maximum duration limit of a three-day supply are in place for children 19 years old and younger.

Polypharmacy Management Program
The Optum Rx Polypharmacy Value Management program helps reduce the health risk and cost burden by 1) identifying opportunities to stop, adjust or change medications within the polypharmacy population, and 2) enabling pharmacists, members and physicians to discuss options and take action. These conversations can help avoid and address concerns about a medication's uncertain benefits or potential for adverse events. The program focuses on members who take at least five chronic medications, including three that are in categories known to present polypharmacy-related intervention opportunities, such as sleeping pills

(hypnotics), nerve-pain medications, anabolic steroids, and skeletal muscle relaxants. In addition, pharmacists can request physician evaluation for any medication a member is using.

EXCLUSIONS AND LIMITATIONS

In addition to the exclusions and limitations contained in the Company's Group Health Plan or the Optum Rx Formulary, the below exclusions and limitations also apply. While this is not an exhaustive list, no benefits are available under the Rx Plan for the following:

- **Pain Patches and Cream** - Prescription topical pain patches, creams, and similar compounded or non-compounded pain management products.
- **Non-FDA Approved and Out of Scope** - Drugs that are not approved by the U.S. Food and Drug Administration (FDA) or that fall outside the scope of the Plan's prescription drug benefit.
- **Clinical Duplicates** - Medications that duplicate the therapeutic effect of another covered medication being taken by the participant
- **High-Cost Brands with Generics** - Brand-name drugs may be excluded when a clinically appropriate lower-cost generic equivalent is available
- **High-Cost Generics** - Certain generic medications identified by the Plan as excessively costly compared to available therapeutic alternatives.
- **Medical Benefits Specialty List** - Specialty medications designated for coverage under the Plan's medical benefit rather than the prescription drug benefit.
- **Emerging Trend Management Program -** Selected medications identified through the Plan's Emerging Trend Management Program may be excluded to address safety concerns, clinical efficacy considerations, or rapidly increasing utilization and cost trends.
- **Vaccines -** generally excluded under the prescription drug benefit except to the extent coverage is otherwise required by applicable law or provided under the medical benefit.
- **Vitamin/Nutritional Products** - Vitamins, nutritional supplements, and other nutritional products, unless specifically covered by the Plan.
- **Homeopathic Products** - Products prepared from highly diluted natural substances and marketed under homeopathic principles for the treatment or prevention of illness.
- **Electrolyte Replacement Products** - Products used to replace electrolytes, minerals, and fluids in the body, including certain oral electrolyte solutions, rehydration products, and similar nutritional replacement therapies.
- **Anti-Obesity Medications** - Prescription medications used for weight loss or the treatment of obesity, including anti-obesity GLP-1 medications, are excluded from coverage, and no formulary exception pathway is available.

Please see your Group Health Plan for the definition of clinical trial, experimental or investigational drugs. You should consult the Optum Rx Formulary list for information on excluded medications. For more information, contact 1-855-524-0381 or check the member page by visiting Prescription drug list | OptumRx.

CUSTOMER CARE

If you have questions about your prescriptions or benefits, you can contact Optum Rx's Customer Care 24 hours a day, seven days a week, including holidays, at 1-855-524-0381 or check the member page by visiting welcome.optumrx.com.

REIMBURSEMENT / FILING A CLAIM

You should get your prescriptions filled through a participating Optum Rx network pharmacy. For a complete list of participating pharmacies, including addresses, please call 1-855-524-0381 or check the member page by visiting www. optumrx.com/pharmacy locator.

If you or your dependents purchase covered prescription drugs at a participating network retail pharmacy, you pay only the copay portion shown in the Schedule of Benefits at the time of purchase until you meet the out-of-pocket maximum for the Rx Plan. You do not need to file a claim. If you are charged more than your correct copay amount, contact Optum Rx at 1-855-524-0381 for assistance. If the participating pharmacy informs you that the Rx Plan will not cover your prescription, you may file a formal claim appeal for benefits.

If you have had to purchase a covered prescription drug at full price because you did not have your prescription card, you must give Optum Rx written proof of claim within 12 months after the date the expenses are incurred. You may obtain any required forms from the Optum Rx website at welcome.optumrx.com. Optum Rx will review your paper claim and notify you if more information is necessary. Any claims submitted more than 12 months from the date of the sale (*i.e.*, the date expenses are incurred) will not be reimbursed.

CLAIMS PROCEDURES

To receive benefits under this Rx Plan, a claimant must follow the procedures established by Optum Rx and the Plan Administrator.

Either you or your authorized representative may file claims for prescription drug benefits. An "authorized representative" means a person you authorize, in writing, to act on your behalf. You must follow Optum Rx's procedures to appoint an authorized representative. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your authorized representative. An assignment of payment to your Physician, hospital, or other health care provider does not constitute a designation of an authorized representative for this purpose and does not authorize your provider to bring legal action for Rx Plan benefits on your behalf.

Initial determinations of claims for prescription drug benefits under the Rx Plan are made by Optum Rx on behalf of the Company. If a claimant does not agree with the determination made by Optum Rx the claimant has the right to appeal any decision that denies payment for an item or service (in whole or in part). Optum Rx will review the claim itself or appoint an individual or an entity to review the claim, following these procedures.

Initial Claims for Benefits

You will receive a determination of your prescription drug claim within the time limits described in the applicable claims provisions of the Group Health Plan; however, Optum Rx is the "Claims Administrator" for the prescription drug benefit. Additionally, if and to the extent the Group Health Plan document(s) do not provide claims procedures, the following claims procedures apply:

- A pre-service claim is a request for coverage of a medication when your coverage requires you to obtain approval before a benefit will be payable. For example, a request for prior authorization is considered a pre-service claim. For these types of claims (unless urgent, as described below) you will be notified of the decision not later than 15 days after receipt of a pre-service claim that is not an urgent care claim, provided you have submitted sufficient information to decide your claim.

- A post-service claim is a request for coverage or reimbursement when you have already received the medication. For post-service claims, you will be notified of the decision no later than 30 days after receipt of the post-service claim, as long as all needed information was provided with the claim.

- The 15-day (pre-service claims) or 30-day (post-service claims) periods may be extended for no more than an additional 15 days if the Plan Administrator determines that an extension of time for processing the claim is necessary due to matters beyond the control of the Plan, in which case the Plan Administrator will notify the claimant of the extension in writing within the initial 15-day or 30-day period, and such notice of extension will indicate the circumstances requiring the extension and the date by which the Plan Administrator expects to render its decision.

- Urgent care claims will be decided as soon as possible, within 72 hours rather than within 30 days. The 72-hour deadline may not be extended. An urgent care claim is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations: (a) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (b) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

- If sufficient information to complete the review has not been provided, you will be notified that the claim is missing information within 15 days from receipt of a pre-service claim and 30 days from receipt of a post-service claim. You will have 45 days to provide the information. If all of the needed information is received within the 45-day timeframe, you will be notified of the decision no later than 15 days after the later of receipt of the information or the end of that additional time period. If you don't provide the needed information within the 45-day period, your claim is "deemed" denied, and you have the right to appeal as described below.

- If your claim is denied, in whole or in part, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes, and any additional information needed to perfect your claim. You have the right to a full and fair impartial review of your claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your claim. If you do not speak English well and require assistance in your native language to understand the letter or your claims and appeals rights, please contact Optum Rx at 1-855-524-0381. If you are not satisfied with the decision on your claim (or your claim is deemed denied), you have the right to appeal as described below.

Notice of Denial

A notice of denial will (a) be in writing (or in electronic form), (b) be written in a way to be understood by the claimant, and (c) contain the following information:

- The specific reason or reasons for denial of the claim;
- References to the specific plan provisions upon which the denial is based;

- A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- An explanation of the claim review procedures and the time limits applicable to such procedures; and
- A statement of the claimant's right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA") if the claim is denied upon review.

Appeal of Decision – Request for Review of Denial by Optum Rx

In cases where a claim for benefits payment is denied in whole or in part, the claimant may appeal the denial. A request for review must be directed to Optum Rx within 180 days after the claim payment date or the date of the notification of denial of benefits. When requesting a review, the claimant should state the reason he or she believes the claim was improperly paid or denied and submit any data or comments to support the claim.

The appeal must be in writing and submitted via fax at 1-855-524-0381, or via mail to:

Optum Rx
PO Box 650334
Dallas, TX 75265-0334
(855) 524-0381

Your appeal should include the following information:

- Name of the person filing the appeal;
- Pharmacy benefit identification number;
- Date of birth;
- Written statement of the issue(s) being appealed;
- Drug name(s) being requested; and
- Written comments, documents, records or other information relating to the claim.

A review of a denial will be made, and Optum Rx will provide the claimant with a written response within 60 days of the date Optum Rx receives the claimant's request for review. If, because of extenuating circumstances, Optum Rx is unable to complete the review process within 60 days, Optum Rx will notify the claimant of the delay within the 60-day period and provide a final written response to the request for review within 120 days of the date Optum Rx received the claimant's written request for review. Decision on Appeal deadlines for the following categories of claims are subject to special timing considerations below.

- Urgent health appeals will be decided within 72 hours rather than 60 days.
- Pre-service health appeals will be decided within 30 days rather than 60 days.
- Disability and other appeals will be decided within 45 days rather than 60 days.

Extensions of time for response on any appeal may be granted upon notice to the claimant in writing and the deadline is an additional period of the same number of days for the initial period.

If the denial is upheld, Optum Rx's written response to the claimant will:

- be written in a way to be understood by the claimant;
- include the specific reason or reasons for the decision and contain references to the specific plan provisions upon which the decision is based;
- state that the claimant is entitled to receive, upon request and free of charge, reasonable access to,

and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and
- state that the claimant may have a right to bring a civil action under Section 502(a) of ERISA.

External Review

For cases involving medical judgment or rescission, if your second level appeal is denied and you are not satisfied with the decision of the second level appeal (*i.e.*, your "final adverse benefit determination") or your initial benefit denial notice or any appeal denial notice does not contain all of the information required under ERISA, you have the right to request an external review by an Independent Review Organization (IRO). However, the right to an independent external review is only available for claims involving medical judgment or rescission. For example, claims based purely on the terms of the prescription drug coverage (*e.g.*, prescription drug coverage only covers a quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment claim.

Generally, to be eligible for an independent external review, you must exhaust the internal claims review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit claims and appeals or your appeal is urgent. In the case of an urgent appeal, you can submit your appeal in accordance with the above process and also request an external independent review at the same time, or alternatively you can submit your urgent appeal for the external independent review after you have completed the internal appeal process.

To file for an independent external review, your external review request must be received within 4 months of the date of the adverse benefit determination (if the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline is the next business day). Your request should be faxed or mailed to Optum Rx at the fax number or address listed above.

Prior Authorization Denials Appeal Process

A request to review an initial denial of Prior Authorization must be made in writing to the Plan Administrator or its outside delegee within 180 calendar days to file a Level 1 Appeal. If you do not file a Level 1 Appeal within this timeframe, you will either have to fill an alternative medication (if available), or work with your prescriber to submit a new Prior Authorization request. If you file a Level 1 Appeal within the 180-calendar day timeframe and the Level 1 Appeal is subsequently denied, a request to review the second denial of Prior Authorization must be made in writing to the Plan Administrator or its outside delegee within 180 calendar days to file a Level 2 Appeal, which is an external appeal. If you do not file a Level 2 Appeal within this timeframe, you will either have to fill an alternative medication (if available), or work with your prescriber to submit a new Prior Authorization request.

Non-Clinical Appeals Process

For appeal of non-prescription drug items, such as certain medical devices or durable medical equipment, a request for review of a denied claim must be made in writing to the Plan Administrator or its outside delegee within 60 days after receiving notice of denial.

As part of the procedure, the claimant has the right to review pertinent documents and to submit to the Plan Administrator or outside delegee in writing issues and comments. The decision upon review will be made within 60 days after the Plan Administrator's or its delegee's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 120 days after receipt of a request for review.

The Plan Administrator or its outside delegee will give the claimant, in writing, a notice of (1) its decision, (2) the specific reasons for the decision, and (3) the relevant Rx Plan provisions or insurance contract provisions on which its decision is based. If the decision is not furnished within that time, the claim will be considered denied upon review. The decision of the Plan Administrator or its outside delegee will be final and binding upon both parties.

Filing Legal Action

If the Plan Administrator or its designee denies a claim on appeal, the claimant has the right to file suit in federal court under Section 502(a) of ERISA. However, no legal action for recovery of benefits allegedly due under the Rx Plan may be commenced by or on behalf of a claimant against the Rx Plan, the Plan Administrator, or any other plan fiduciary, claims administrator, or other third party administrator unless such legal action is filed within (i) one year after the date you are notified of the final decision on your appeal; or (ii) the date that is one year from the date a cause of action accrued.

REIMBURSEMENTS / SUBROGATION, COBRA, HEALTH INFORMATION PRIVACY AND HIPAA, TERMINATION OF COVERAGE, AND USERRA

Please see the Group Health Plan SPD and/or the Wrap Plan SPD for a description of the Reimbursement/Subrogation rights, COBRA, health information privacy and HIPAA, termination of coverage, USERRA provisions and requirements, FMLA provisions and requirements, and other notices applicable to both the Group Health Plan and this Rx Plan which are incorporated by reference herein.

GENERAL RX PLAN INFORMATION

Responsibilities for Rx Plan Administration

The Company shall be the Plan Administrator. The Plan Administrator shall be the named fiduciary for purposes of ERISA. The Plan Administrator shall control and manage the operation and administration of the Rx Plan.

The Plan Administrator shall administer the Rx Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of the Rx Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Rx Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Rx Plan participant's rights, and to decide questions of interpretation of the Rx Plan and those of fact relating to the Rx Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. Service of legal process may be made upon the Plan Administrator.

Self-Funded Nature of Rx Plan

Rx Plan funding is derived from Company and employee contributions. All Rx Plan benefits are paid from the Company's general assets. No trust or other separate fund is maintained in connection with the Rx Plan. The level of any employee contributions will be set by the Company.

Rx Plan is not an Employment Contract

The Rx Plan is not to be construed as a contract of employment. Nothing contained in the Rx Plan shall give you the right to be retained in the employ of the Company or its affiliates, or to affect the right of the Company or its affiliates to discipline or discharge you at any time.

Administrative Error

If, due to an administrative error, an overpayment occurs in a reimbursement amount from the Rx Plan, the Rx Plan retains a contractual right to recover the overpayment. The person or institution receiving the overpayment will be required to return the overpayment. In the case of an Rx Plan participant, the amount of overpayment may be deducted from future benefits payable.

Amending, Modifying or Terminating the Rx Plan

If the Rx Plan is terminated, your rights are limited to covered expenses incurred before termination. If the Rx Plan is amended or modified, expenses incurred prior to the amendment or modification will be considered as provided under the terms of the Rx Plan prior to its amendment or modification.

The Company, by action evidenced in writing reserves the right, at any time, without prior notice, to amend, suspend, or terminate the Rx Plan in whole or in part. In the event of the dissolution, merger, consolidation, or reorganization of the Company, the Rx Plan automatically will terminate unless it is continued by a successor to the Company.

The Company's rights include the right to obtain coverage and/or administrative services from additional or different insurance carriers, HMOs, third-party administrators, etc., at any time, and the right to revise the amount of employee contributions. Employees will be notified of any material modifications to the Rx Plan.

Limitation on Assignment

Your rights and benefits under the Rx Plan cannot be assigned, sold or transferred to your creditors or anyone else. However, you may assign your rights to benefits under the Rx Plan to the health provider who provided the services or supplies.

Your Rights Under ERISA

- You are entitled to certain rights and protections under ERISA. ERISA specifies that you shall be entitled to examine, without charge, at the Plan Administrator's office, all Rx Plan documents and copies of all documents governing the Rx Plan, including benefit contracts and a copy of the latest annual report (Form 5500 series) filed by the Wrap 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 Wrap Plan, including benefit contracts and copies of the latest annual report (Form 5500 series) and an updated summary plan description. The Employee may have to pay a reasonable charge to the Plan Administrator to cover the cost of photocopying.
- Receive a summary of the Wrap Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

- Continue health care coverage under the Group Health Plan, including prescription drug benefits under this Rx Plan, for yourself, spouse or dependents if there is a loss of coverage under the Group Health Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the SPD and the documents governing the Group Health Plan or the Wrap Plan for the rules governing your COBRA continuation coverage rights.

Prudent Action by Plan Fiduciaries

In addition to creating rights for Rx Plan participants, ERISA imposes duties upon the individuals who are responsible for the operation of the employee benefit plan. The individuals who operate the Rx Plan, called "fiduciaries" of the Rx Plan, have a duty to do so prudently and in the interest of you and your beneficiaries. No one, including the Company, may fire you or otherwise discriminate against an Rx Plan participant in any way to prevent the Rx Plan participant from obtaining benefits under the Rx Plan or from exercising his or her rights under ERISA.

If it should happen that an Rx Plan participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Rx Plan participant is successful, the court may order the person sued to pay these costs and fees. If the Rx Plan participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

A Participant May Enforce Rights

If an Rx Plan participant's claim for a benefit is denied or ignored, in whole or in part, the participant has 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 an Rx Plan participant can take to enforce the above rights. For instance, if an Rx Plan participant requests a copy of Rx Plan documents or the latest annual report from the Rx Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Rx Plan participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If the Rx Plan participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if an Rx Plan participant disagrees with the Rx Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

Assistance with Questions

If the Rx Plan participant has any questions about the Rx Plan, he or she should contact the Plan Administrator. If the Rx Plan participant has any questions about this statement or his or her rights under ERISA, or if the Rx Plan participant needs assistance in obtaining documents from the Plan Administrator, that Rx Plan participant should contact either the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor listed in the 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, DC 20210. The Rx Plan participant may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Discretion of the Plan Administrator

In carrying out its duties under the Rx Plan, the Plan Administrator has discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Rx Plan, in all matters entrusted to it. The Plan Administrator's determinations shall be given deference and shall be final and binding on all interested parties.

How Can I Receive Further Information About the Rx Plan?

If you have further questions regarding the Rx Plan or this SPD, please contact the Plan Administrator 1-888-850-1765. Copies of all Rx Plan documents are on file with the Plan Administrator and, upon reasonable request, are available to participants and their beneficiaries for examination during regular business hours.

IMPORTANT INFORMATION ABOUT THE RX PLAN

Plan Name:	Alera Group, Inc. Prescription Drug Plan (part of the Alera Group, Inc. Welfare Benefits Plan)
Plan Year:	January 1 – December 31
Plan No.:	501
Federal Tax ID #:	81-4473358
Plan Administrator and Agent for Legal Service:	Alera Group, Inc. 3 Parkway North, Suite 500 Deerfield, IL 60015 Telephone: (847) 582-4501
Claims Administrator:	Optum Rx PO Box 650334 Dallas, TX 75265-0334 Telephone: (855) 524-0381 welcome.optumrx.com
Plan Funding:	The Rx Plan is self-funded as part of the Group Health Plan option you chose. Benefits from the Rx Plan are paid from employee contributions, as applicable, and from the general assets of Alera Group. Alera Group, Inc. has contracted with third-party administrators to administer this plan.

[*Signature Page Follows*]

IN WITNESS WHEREOF, this SPD for the Rx Plan is hereby executed as of this 22nd day of July , 2026 to be effective as of January 1, 2026.

Alera Group, Inc.

By: Latscha Petty
Latscha Petty (Jul 24, 2026 17:11:31 CDT)

Its: VP, Benefits, HRIS & Payroll