FKG Oil Company

PRESCRIPTION DRUG PLAN

Effective as of February 1, 2021

INTRODUCTION:

This document (referred to as the "Prescription Drug Plan" or simply the "Plan") describes the prescription drug benefits offered to eligible employees and dependents (referred to as "members") enrolled for coverage under FKG Oil Company group medical plan (the "Medical Plan"). The Prescription Drug Plan is a component sub-plan under the Medical Plan.

The Prescription Drug Plan is maintained for the exclusive purpose of providing prescription drug benefits to covered employees and their eligible dependents. [This document amends and restates the prior Prescription Drug Plan in its entirety.]

PHARMACY BENEFIT MANAGER:

The Employer has contracted with a pharmacy benefit manager (the "PBM") to help administer the Plan. The name of and contact information for the PBM is:

RxBenefits, Inc.
1.800.334.8134
www.caremark.com

ELIGIBILITY FOR BENEFITS:

To receive coverage under this Prescription Drug Plan, an eligible employee and the employee's eligible dependents must be enrolled under the Medical Plan. Coverage under the Prescription Drug Plan will be effective at the same time coverage under the Medical Plan begins. An individual who is enrolled for coverage is referred to a "member."

A member is neither required nor permitted to make separate enrollment elections under the Prescription Drug Plan.

Coverage under the Prescription Drug Plan will continue until the member's coverage under the Medical Plan ends. If the member timely elects to continue his or her Medical Plan coverage pursuant to the Medical Plan's COBRA or other continuation provisions, then coverage under this Plan will also continue.

PRESCRIPTION DRUG BENEFITS:

Covered Drugs

Subject to the exclusions and limitations described below, the Prescription Drug Plan covers FDA-approved drugs that by federal or state law can only be dispensed upon written prescription from an authorized prescriber (for example, a licensed physician, dentist, osteopath, podiatrist, optometrist or advanced practitioner) and dispensed by a licensed pharmacist.

The Prescription Drug Plan has adopted the PBM's formulary, including the PBM's preferred drug list, as its covered formulary. Formulary drugs are included in the list of preferred medications that a committee of pharmacists and providers deems to be the safest, most effective and most economical.

"Non-formulary" based on the PBM's current formulary may not be covered by the Plan unless the member obtains approval from the PBM for substitution of a clinically comparable drug. Such approval generally will only be made if the non-formulary drug would result in a cost savings to the Plan, is based on objective medical criteria, and is drug is prescribed by the member's treating prescriber.

A list of drugs included on the PBM' s formulary may change from time to time and is available on the PMB's website.

In all events, only medically necessary prescription drugs will be covered by the Prescription Drug Plan.

Annual Out-of-Pocket Maximums

Pharmacy expenses are included for purposes of the applying the Medical Plan's out-of-pocket maximums.

Co-Payments and Co-Insurance

Co-payments and co-insurance must be paid at the time the prescription order is submitted. If the cost of the drug is less than the co-payment or co-insurance, the member will pay the lower amount. Co-payment and co-insurance amounts are based on the type of medication the member receives. Generic and brand-name medication types are established and updated periodically by a nationally recognized drug pricing and classification source.

To confirm a co-payment and co-insurance amount before you have a prescription filled, a member should contact the PBM or consult the PBM's website.

Prescription drugs obtained through a retail pharmacy are subject to a 30-day supply limit. A 90-day supply may be obtained at a retail pharmacy, but the cost will be 3 times the 30-day copay.

Retail*	**Participant Co-payment / Co-insurance**
Tier 1 generic**	$10 copay
Tier 2 preferred brand name	$35 copay
Tier 3 non-formulary brand name	$60 copay

****Generic Policy – Dispense As Written (DAW)**: If a Brand name drug is filled when a Generic equivalent is available, you will be required to pay the Brand copay/coinsurance plus the difference in cost between the Generic and Brand name drug. The Generic Policy does not apply if your doctor indicates the Brand must be dispensed.

Preventive Medications

Your employer's plan is subject to the Affordable Care Act (ACA) which requires the coverage of a number of preventive items and services at 100% and ensures these items and services are not subject to deductibles, maximum out of pockets, or other limitations such as annual caps or limits. You may contact RxBenefits Member Services at 1.800.334.8134 if you have specific drug questions or register at *caremark.com* to check drug costs and coverage.

Compound Drugs

For compound drugs to be covered, they must satisfy certain requirements. In addition to being medically necessary and not experimental or investigative, compound drugs must not contain any ingredient on a list of excluded ingredients. Any denial of coverage of a compound drug may be appealed in the same manner as any other drug claim denial under this coverage. Compounded medications equal to or exceeding $300 per script will require prior authorization.

Third Party Payment Assistance Programs

If a third party payment assistance program is utilized (including without limitation manufacturer coupons or rebates), any assistance received by the member to help offset the member's co-payment or co-insurance obligation will not be applied to the Plan's deductible or maximum out of pocket limits.

Mail Order

Prescriptions filled through the PBM's mail order program will be subject to the following co-payments and co-insurance amounts. The supply limit for the mail order program is 90 days.

Mail Order	**Participant Co-payment / Co-insurance**
Tier 1 generic	$25 copay
Tier 2 preferred brand name	$80 copay
Tier 3 non-formulary brand name	$140 copay

Specialty Medications

Specialty medications are high-cost drugs that are often injected or infused and require special storage and monitoring. These medications must be obtained through Caremark specialty pharmacy by calling Caremark at 1.800.237.2767. Some exceptions apply. These medications are limited to a 1-30 day supply. Specialty medications largely fall into the formulary brand category but could also fall into the biosimilar or generic specialty drug category. These medications are subject to the appropriate co-insurance as listed below. Caremark Specialty Pharmacy also

offers pharmaceutical care management services designed to provide you with assistance throughout your treatment.

Biosimilar/generic	30% coinsurance
Preferred brand name	30% coinsurance
Non-formulary brand name	30% coinsurance

MCAP (Manufacture Copay Assistance Program)

PrudentRx: Specialty medications are used to treat complex chronic conditions; they mimic compounds found within the human body. These high-cost oral or injectable medications are typically biology-based and highly complex. FKG Oil Company is offering the PrudentRx Co-Pay program to help you manage the cost of these medications by applying financial co-pay assistance from drug manufacturers. By enrolling in the PrudentRx program, your out-of-pocket costs for covered medications would be $0.

If you currently take one or more medications included in the PrudentRx Program Drug List, you'll receive a welcome letter and phone call from PrudentRx with specific information about the program and your medication. The PrudentRx patient advocate will help you enroll in the PrudentRx Co-Pay Program if you choose, along with other available manufacturer co-pay assistance programs. For more information, please contact PrudentRx at 1.888.203.1768

Formulary

A list of Federal Drug Administration (FDA) approved Prescription Drugs and supplies developed by a Pharmacy and Therapeutics Committee, and/or customized by Caremark RxClaim or RxBenefits. This list reflects the current clinical judgment of practicing health care practitioners based on a review of current data, medical journals, and research information. In your prescription drug coverage, the Formulary Drug list is used as a guide for determining your costs for each prescription. Drugs not listed on the Standard with ACSF Formulary may not be covered. Your formulary is Standard with ACSF.

The following lists are not all-inclusive, but rather are lists of the most commonly used prescription drugs. These lists are subject to change. The Caremark RxClaim formulary provides an up-to-date list of medications that may be covered by the program. The Caremark RxClaim formulary may be found online at caremark.com. You may also contact RxBenefits Member Services at 1.800.334.8134 to learn whether a specific drug is covered.

Covered Drugs and Supplies

The following examples of Covered Drugs and supplies may be available with your prescription benefit coverage. FDA-approved pharmaceuticals requiring a written prescription, issued by a licensed physician, dentist, osteopath, podiatrist, optometrist (licensed professionals) or licensed advance practice certified nurse and dispensed by a

licensed pharmacist. Please contact RxBenefits Member Services at 1.800.334.8134 if you have specific drug questions or register at caremark.com to check coverage.

- ACA Preventative Services List
- ADHD/ADD
- Androgen
- Blood Products/Blood Serum
- Bulk Powder Compounds
- Contraceptives
- Diabetic Medication (Insulin/Non-Insulin)
- Diabetic Supplies (Lancets, Test Strips)
- Diabetic Supplies (Syringes & Needles)
- Fluoride
- Growth Hormones
- Insomnia/Sedatives/Hypnotics
- Legend Drug Compounds
- Legend Vitamins (Rx)
- Migraine Medications
- Medical / Therapeutic Devices (Inc. DME)
- Narcolepsy
- Non-ACA Vaccines
- Pain/Narcotics/Opioids
- Smoking Cessation Products
- Specialty Medications
- Topical Acne Medications

Covered Drug Limitations

Certain Prescription Drugs are covered up to preset limits. These limits are based upon standard FDA approved dosing for the medications. If you request that a prescription be filled for a drug that is subject to quantity limitations, the prescription will be filled up to the preset limits. In some cases, it may be medically necessary for you to exceed the preset limits. In those instances, Prior Authorization is required. In such cases your doctor may initiate Prior Authorization by calling RxBenefits toll-free at 1.800.334.8134. Several hundred drugs are subject to quantity limitations for patient safety based on FDA guidelines. Your plan has identified the following drug categories for Quantity Limits.

- ADD/ADHD
- Gastrointestinal-Antimetics
- Influenza
- Insomnia/Sedative Hypnotics
- Migraines
- Narcolepsy
- Opioids

For more information about specific drugs subject to coverage limitations, please call RxBenefits Member Services at 1.800.334.8134 or visit caremark.com.

Prior Authorization and Appeals

If a prescription drug claim is wholly or partially denied, you or your authorized representative has the right to appeal the decision. You or your authorized representative may appeal the denial no later than 180 days after receiving notice of an adverse claim decision. Appeals of prescription drug claims are handled by RxBenefits and are decided in accordance with the terms of the plan document. Following a clinical review, one of four actions will occur: the medication is approved, the medication claim is denied, the doctor may decide to withdraw and prescribe a different medication, or the reviewer can dismiss the claim due to lack of communication from the prescriber. If denied, the appeal process is available.

The following medications may require a prior authorization under your plan:

- ADD/ADHD
- Anabolic Steroids
- Androgens
- Growth Hormones
- Narcolepsy
- Oral/Intranasal Fentanyl
- Topical Acne

The Appeal Process

If denied, the member may appeal the decision. Upon appeal, a second pharmacist reviewer will evaluate the prior authorization and make a decision (approved/denied). If denied a second time, a final appeal may be made, which is forwarded to an outside medical reviewer. If denied, there are no further appeals.

Your doctor may initiate the Prior Authorization, quantity limit, high dollar claim review or any other rejection process by calling RxBenefits at 1.800.334.8134. Specific Exclusions/Limitations

Exclusions

Coverage is not provided for:

- Allergy Serums (Injectable & Oral)
- Anabolic Steroids
- Anti-Obesity/Anorexiants/Appetite Suppressant
- Cosmetics
- Erectile Dysfunction
- Fertility Medications (Injectable & Oral)
- HSDD (i.e., Addyi)
- Nutritional Supplements
- Periodontal Products

Retail and Mail Order Pharmacies

FKG Oil Company participates in the Caremark RxClaim pharmacy network. Contact RxBenefits Member Services at 1.800.334.8134 to inquire about a specific pharmacy.

Pharmacy Identification Card (ID Card)

Your pharmacy ID card enables you to participate in the prescription drug card program. Present your combined medical and pharmacy ID card to the pharmacist when obtaining a prescription to ensure you get the benefit of the prescription drug card program. Please contact your medical insurance carrier for a replacement ID card.

Definitions:

Co-Insurance
The percentage of charges a Participant is required to pay for covered prescription drugs.

Copayment (Copay)
The specified charge you are required to pay for a Covered Drug.

Brand-Name
A Prescription Drug that is protected by a patent, supplied by a single company and marketed under the manufacturer's brand name.

Generic Drug
A generic drug is identical to a brand name drug in dosage form, safety, strength, route of administration, quality, performance characteristics, and intended use. Although a generic drug is chemically identical to its branded counterpart, it is typically sold at substantial discounts from the branded drug's price.

Over-the-Counter Drug (OTC)
Any medical substance that can be purchased without a prescription. OTC medications are not covered by your plan unless otherwise stated.

Non-Preferred Brand
Non-Preferred Brand is a Brand Name prescription drug that does not appear on the formulary of Brand Name Drugs designated by Caremark RxClaim as Preferred. Members may pay a higher cost for Non-Preferred Brand-Name Prescription Drugs than for Preferred Brand-Name prescription Drugs.

Preferred Brand Drug
Preferred Brand Drug is a prescription drug that appears on the formulary of Brand-Name Prescription Drugs designated by Caremark RxClaim Preferred. This list is subject to periodic review and modifications by Caremark RxClaim. Members may obtain a copy of this list by contacting RxBenefits Member Services at 1.800.334.8134 or by registering on caremark.com. Members pay a lower Copayment for Preferred Brand-Name Prescription Drugs than for Non-Preferred Brand-Name Prescription Drugs.

PLAN SPONSOR:

FKG Oil Company is the plan sponsor. The plan sponsor's telephone number is: 618.223.6754. The plan sponsor's Federal tax identification number is 37-0974528.

PLAN ADMINISTRATOR:

FKG Oil Company is the designated "Plan Administrator" for purpose of the Employee Retirement Income Security Act ("ERISA"). You may also contact your local human resources department if you have any questions.

To the maximum extent permitted under ERISA and other applicable law, the Plan Administrator has full discretionary power to administer the Prescription Drug Plan in all of its details. For this purpose, the Plan Administrator's discretionary powers will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by this Prescription Drug Plan:

- To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Prescription Drug Plan, including the establishment of any claims procedures that may be required by applicable provisions of law;
- To interpret the Prescription Drug Plan;
- To decide all questions concerning the Prescription Drug Plan and the eligibility of any person to participate in the Prescription Drug Plan;
- To compute the amount of benefits which will be payable to any member or other person in accordance with the provisions of the Prescription Drug Plan, and to determine the person or persons to whom such benefits will be paid;
- To authorize the payment of benefits;
- To appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Prescription Drug Plan; and
- To delegate its responsibilities under the Prescription Drug Plan and to designate other persons to carry out any of its responsibilities under the Prescription Drug Plan, any such delegation or designation to be in writing.

The Plan Administrator may choose to delegate some or all of its administrator authority to the PBM or another party. Any determination by the Plan Administrator, or any authorized delegate, will be final and binding on all persons, in the absence of clear and convincing evidence that the Plan Administrator or authorized delegate acted arbitrarily and capriciously.

FUNDING OF BENEFITS:

The benefits offered under the Prescription Drug Plan are provided on a self-insured basis and are paid through a combination of Employer and employee contributions.

TRUST FUND AND TRUSTEES:

Benefits are paid through the plan sponsor's general assets and there is no separate trust with respect to the Plan.

HIPAA PRIVACY AND SECURITY PROTECTIONS:

The HIPAA protections identified in the Medical Plan will also apply to this Prescription Drug Plan.

ERISA PLAN YEAR:

The Prescription Drug Plan is administered and maintained based on each 12-month period beginning January 1 and ending on the following December 31.

AMENDMENT OR TERMINATION OF PLAN:

The plan sponsor reserves the right to amend, modify, or terminate the Prescription Drug Plan, including but not limited to terms and conditions of eligibility and benefits, in whole or in part at any time.

NO VESTED RIGHTS:

No employee nor any spouse or other dependent of an employee will have any vested rights to benefits under the Prescription Drug Plan at any time. Further, nothing in this document creates any right to an employee's continued employment with the plan sponsor or any other participating employer.

NON ALIENATION OF BENEFITS:

Except as provided in Qualified Medical Child Support Orders, no benefit, right or interest of any person will be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law.

Without limiting the foregoing, a member may not assign to any party, including without limitation to a provider of healthcare services/items, such member's right to benefits under the Plan, nor may the member assign any administrative, statutory, or legal rights or causes of action he or she may have under ERISA, including, but not limited to, any right to make a claim for Plan benefits, to request Plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights will be void and unenforceable under all circumstances.

REVIEW AND APPEALS PROCESS:

All eligibility-related claims and appeals must be made in accordance with the claims procedures prescribed for the Medical Plan.

All benefit-related claims and appeals (e.g., clinical coverage issues, requests for coverage of a particular medication) will be administered by the PBM as described below. The PBM's claims procedures may vary slightly from the procedures set forth below so members and prescribers are strongly encouraged to contact the PMB or Plan Administrator for the most recent claims procedures. If there are any inconsistencies with the claims procedures outlined below and claims procedures set forth in other document provided by the PBM, the PBM will have the sole discretion to interpret, administer and resolve the inconsistencies.

A member must use and exhaust the administrative claims and appeals procedure set forth below before bringing a suit in either state or federal court. Similarly, failure to follow the prescribed procedures in a timely manner will also cause the member to lose his or her right to sue regarding an adverse benefit determination.

Initial coverage review

The preferred method to request an initial coverage review is for the member or prescriber to submit a prior authorization request electronically or to call the PBM directly.

If the member'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 attending provider, the member's health may be in serious jeopardy or the member may experience pain that cannot be adequately controlled while the member waits for a decision on the review.

The PBM's initial determination and notification to the member and prescriber will be made within the specified timeframes as follows:

Type of Claim	**Decision Timeframe** **Decisions are completed as soon as possible from receipt of request, but no later than:**
Standard Pre-Service*	15 days
Standard Post-Service*	30 days
Urgent**	72 hours

*If necessary, this period may be extended one-time for up to 15 days if the extension is necessary due to matters beyond the control of the PBM and the member is notified prior to the expiration of the initial review period. If an extension is necessary because the member failed to provide the necessary information needed to make a determination, the member will have 45 days from receipt of the notice within which to provide the needed information. The claim will be denied in full if the member fails to timely provide the information within 45 days.

**If additional information is necessary to make a determination, the member will be notified within 24 hours of receipt of the initial claim and will be provided a 48 hour extension to provide the information.

Appeal of adverse benefit determinations

When an initial coverage review has been denied (referred to as an "adverse benefit determination"), a request for appeal may be submitted by the member or authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the PBM's appeals department and include the following information:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements, letters, bills or any other documents.

An urgent appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the member or the member's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

How an appeal is processed

The PBM will review and respond to any appeal of an adverse benefit determination in accordance with the PBM's customary appeal policies which will conform with federal regulations. Depending on the type of appeal, appeal decisions will be made by a PBM pharmacist, physician, panel of clinicians, trained prior authorization staff member, or independent utilization management company. If the initial adverse benefit determination is upheld on appeal, the PBM will explain the reason for the denial and identify pertinent Plan provision upon which the denial is based.

Appeal decisions and notifications will be made within the following timeframes:

Type of Claim	**Decision Timeframe** **Decisions are completed as soon as possible from receipt of request, but no later than:**
Standard Pre-Service	15 days
Standard Post-Service	30 days
Urgent*	72 hours

*If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the member and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

Additional voluntary appeals

The PBM may allow a member to request a second level (voluntary) appeal following receipt of notice of an adverse benefit determination. Members and prescribers should contact the PBM to inquire as to the availability of any voluntary appeal following receipt of notice of the initial adverse benefit determination on appeal. This inquiry should be made as soon as possible and in no event later than 90 days following receipt of notice of the initial adverse benefit determination on appeal.

Right to external review

A member has the right to request an independent external review for an adverse benefit determination involving medical judgment, or a decision based on medical information, including determinations involving treatment that is considered experimental or investigational. Generally, all internal appeal rights must be first exhausted prior to requesting an external review. An external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim.

How an External Review is processed

If a member's claim is eligible for external review and the member (or prescriber) timely makes such a request, the claim will be forwarded to an independent review organization (IRO). The request will randomly be assigned to an

IRO and the appeal information will be compiled and sent to the IRO. The IRO will review the claim (generally within 45 calendar days from receipt) of the request and will send the claimant, the Plan and the PBM written notice of the IRO's decision. Urgent claims will be processed in expedited manner within the time frames prescribed by federal law.

STATEMENT OF ERISA RIGHTS:

Eligible persons covered under the Prescription Drug Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all members will be entitled to:

Receive Information About Your Plan and Benefits:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Prescription Drug Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Prescription Drug Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Prescription Drug Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The plan administrator may charge a reasonable fee for the copies.
- Receive a summary of the Prescription Drug 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 Group Health Plan Coverage:

- Continue health care coverage for yourself, covered spouse or other Dependents if there is a loss of coverage under the Prescription Drug Plan as a result of a qualifying event. You or your covered Dependents may have to pay for such coverage. Review this document and the Component Documents for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries:

- In addition to creating rights for covered Eligible Employees, ERISA imposes duties upon the people who are responsible for the operation of the Prescription Drug Plan. The people who operate your Plan, called "fiduciaries" of the Prescription Drug Plan, have a duty to do so prudently and in the interest of you and other members. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights:

- If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Prescription Drug Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Prescription Drug Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator.
- If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Prescription Drug Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions:

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

******