Northern Light Health

Employee Health Plan Document and Summary Plan Description

Effective January 1, 2020

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YOUR MEDICAL COVERAGE

Many employees consider health care coverage to be one of their most valuable benefits. To help ensure you have the type of medical care coverage best suited to your needs, Northern Light Health gives you the choice of two medical options.

This booklet, called a summary plan description or "SPD", for short, describes how the medical options work and explains your rights if you enroll in one of these options. It also serves as the plan document that governs the administration of the Northern Light Health Employee Health Plan (the "Plan"). The Plan's third party administrator (TPA) is Beacon Direct ("Beacon"). The Plan/TPA may engage service providers for certain services as noted in the table below.

WHERE TO FIND MORE INFORMATION

For Information About ….	**Go to …**
Covered services	Call Customer Service at 1-855-429-1023
Prescription drug benefits	Call the Geisinger Pharmacy Customer Service department at 1-800-988-4861
In-network and preferred pharmacies	Log onto www.thehealthplan.com/northernlighthealth. Click **FIND** on the left navigational bar to search for participating pharmacies.
Mail order Pharmacy	northernlighthealth.org/pharmacy or (800)-639-8801
Health Reimbursement Account (HRA)	Call Connect Your Care Customer Service at 1-877-292-4040
Online access to your current HRA fund balance, past transactions and claim status	Visit www.connectyourcare.com ▪ Click **New User** ▪ Enter required information, making sure to select button next to "my account does not have a payment card associated with it" ▪ Click **Submit Information** ▪ Create user account and password ▪ Select **Submit**
To establish your Northern Light Health Employee Health Plan member account	Visit employeehealthplan.northernlighthealth.org ▪ Under the "Members" drop down box, click **Login for Portal** and then navigate down the page to click on **Member Login** ▪ Click on the **Click Here to Register** button ▪ Click **I am a Member** ▪ Review Terms and Conditions and agree

	▪ Enter the required information -- first name, last name, date of birth, and member ID number (from your member ID card) ▪ Enter user account information (username, password, email, etc.) ▪ Log in
In-network and preferred providers	Visit employeehealthplan.northernlighthealth.org ▪ Once logged into your member account, navigate to the "Tools and Resources" menu ▪ Click "Provider Directory Search"
COBRA Administrator	Benefit Strategies www.benstrat.com/participants_cobra.php and 1-888-401-3539
Wellness Services	Northern Light Health HR Service Center (207) 973-4000 / (855) 660-0202 or hrservicecenter@northernlight.org
Northern Light Health HR Service Center – for general benefits and human resources related questions	(207) 973-4000 / (855) 660-0202 or hrservicecenter@northernlight.org

ELIGIBILITY AND ENROLLMENT

Who Is Eligible

You are generally eligible to participate in the Plan if you are a regular full-time or regular part-time employee of a Northern Light Health member organization that has elected to participate in the Plan. Further, you are eligible to participate in the Plan if you are considered an Affordable Care Act full-time employee ("ACA FT Employee") under Northern Light Health System Policy #17-025, a copy of which is attached hereto as Exhibit D.

For purposes of this SPD, the term "Northern Light Health employee" refers to all employees of a Northern Light Health member organization who have elected to participate in this Plan. In addition, certain retirees may be eligible to continue participating in the Plan upon retirement.

Retiree Eligibility: In order to be eligible for continued coverage under this Plan, a retiree must meet each of the following requirements:

1. Must be under age 65 and not eligible for Medicare;
2. Must have retired with a benefit under the Eastern Maine Medical Center Retirement Partnership Plan (formerly the Eastern Maine Medical Center Pension Plan) and have retired with at least fifteen (15) credited years of service at or after age fifty-five (55); and
3. Must enter such retirement status directly from an active employment status with Eastern Maine Medical Center or a member organization participating in the EMHS

Retirement Partnership Plan, excluding CA Dean and Blue Hill Memorial Hospital; and

4. Must be, on the day prior to the retirement effective date, enrolled in one (1) of the options sponsored by the Northern Light Health Employee Health Plan; and
5. Must agree to pay any applicable premiums, as required; and
6. Must have a date of hire prior to January 1, 2005 with no break in service after January 1, 2005. Employer initiated transfers do not impact eligibility.

Retirees and dependents that are covered under the Plan are eligible to continue coverage under the Northern Light Health Retiree Medical Plan or the Northern Light Health Retiree Health Reimbursement Arrangement ("the Retiree Plans") when they become eligible for Medicare. The Northern Light Health Retiree Health Reimbursement Arrangement has an effective date of January 1, 2020. Such participants are required to enroll in Medicare Part A and Medicare Part B in order to participate in the Retiree Plans.

The Plan will be primary for retirees and their dependents until a retiree or retiree's dependent obtains Medicare; at which time the Retiree Plans will pay secondary to Medicare.

Should a retiree, enrolled under the continuation provisions noted above, opt to terminate from this Plan, such enrollee and his/her dependents will be eligible for COBRA coverage under the applicable provisions of the law. Cancellation of coverage will result in loss of future eligibility under the Retiree Plans.

Eligible Dependents

You may enroll your eligible dependents. Your eligible dependents include:

Your legal spouse (same-sex or opposite-sex).

Your child who has not attained age 26 OR who has attained age 26 but is incapable of self-sustaining employment because of a documented mental or physical handicap that began before the child reached age 26. (You must submit documentation of the child's handicap no later than 31 days after your child turns age 26).

For purposes of this document, the definition of "child" means an adopted child, stepchild and any child placed in your home by state or other authority for legal adoption or for whom you have legal guardianship.

Choosing Your Coverage Level

When you enroll, you must decide whom you want to cover. You may choose from four coverage levels:

- Employee only.
- Employee plus spouse.
- Employee plus child(ren) or

- Family (which covers you, your spouse and your eligible child(ren).

No one may be considered a child of more than one employee; therefore, if your spouse works at a Northern Light Health member organization, only one of you may cover your child(ren) under the Plan and you may not cover each other.

Paying for Coverage

Northern Light Health pays a portion of the cost for your medical coverage but may ask that you share in the cost as well. If applicable, your share of the contribution is automatically deducted from your paycheck each pay period. Your contribution is generally made on a pre-tax basis (see "If You Are a New Hire" for post-tax option for new hires). This means that the amount of your contribution is deducted before federal, state income taxes, and Social Security taxes are withheld. This lowers your taxable income, which, in turn, lowers the amount you pay in taxes. The bottom line is that pre-tax contributions lower your overall cost of coverage.

Payments are initiated on the first paycheck in which coverage begins and will stop on the last paycheck of the month in which your coverage ends.

Should you not have sufficient pay to cover your premiums in a pay check; Northern Light Health will collect your payments from future paychecks automatically through its payroll/HRIS software.

For more information, including information on the enrollment process, please contact the Northern Light Health HR Service Center at (207) 973-4000 or (855) 660-0202.

In the event it is determined that the Plan incorrectly calculated the amount of premium payments that you should have paid, the Plan retains the right to seek reimbursement from you for the full amount of the missed premiums.

If you are an eligible retiree, you are not eligible to pay for coverage on a pre-tax basis, but you are responsible for remitting timely payment of premiums on a monthly basis.

How to Enroll

If You Are an Existing Employee. Each year, during open enrollment, you will receive information about your benefits and the cost of medical coverage. At that point, you will decide whether you would like to make a new enrollment decision for the upcoming calendar year. If so, your election takes effect on January 1 of the next calendar year. Due to federal tax regulations, your election must remain in effect for the entire year, unless you have a "qualified status change" during the year, such as marriage or the birth of a child. If you experience a qualified status change, you may be eligible to make changes consistent with the qualified status change. See *When You Can Change Coverage* for more details. If you are enrolled in the Plan and do not make an election during open enrollment, your current coverage will automatically continue into the new calendar year (subject to change with notification).

If You Are a New Hire. When you begin employment, you will attend an orientation session, have the opportunity to learn more about your benefits, and receive information about how to enroll. As a newly hired employee, in order to pay your premiums on a pre-tax basis, you must make an enrollment election no later than 31 days after your date of hire.

Once you complete the enrollment process, you will participate in the Plan on the first day of the month following your date of hire, or on the first day of the month if your date of hire is coincident with the first of that month. If you miss the 31 day deadline, you may make a post-tax election to enroll; however, PLEASE NOTE that the post-tax election is ONLY available until the next open enrollment at which time you will need to make a pre-tax election. The post-tax election, if any, will take place the first day of the month following the election or on the first day of the month if your date of election is coincident with the first of that month. Your next opportunity to enroll pre-tax will occur during open enrollment (held each year). You may also qualify to enroll during a special enrollment period described under the *Health Insurance Portability and Accountability Act (HIPAA) Notice*.

If you are a Covered Retiree. Annual enrollment occurs during the fall each year. You may change coverage elections during that time.

Eligibility – Effective Dates

You will generally become eligible for coverage on the first day of the month following your date of hire, on the first day of the month following the day on which you became eligible for coverage, or on the first day of the month if your date of hire or the day on which you became eligible for coverage is coincident with the first of that month.

When You Can Change Coverage

If you have a "qualified status change" during the year, you can make certain changes consistent with the qualified status change that takes into account some of the more common life events including, but not limited to:

- Marriage, divorce, legal separation or annulment
- Birth, legal adoption, legal guardianship, or placement of foster or stepchildren (by competent legal authority)
- Death of your spouse or child
- An employment status change for the employee that specifically triggers eligibility for the Plan (moving from a non-benefit eligible position to a benefit eligible position)
- A change in coverage under another employer's plan (loss of coverage or receipt of new coverage – including open enrollment)
- Loss of eligibility for a dependent due to turning age 26
- A significant change in the employee's required medical premium (a significant change means a change of 10% or more)
- Commencement of or return from a qualified leave of absence (FMLA) or leave of absence
- A judgment, decree or order in a domestic relations proceeding, including a Qualified Medical Child Support Order, requiring health coverage be provided to a child
- The employee/spouse/ child is permitted to make a special enrollment in a medical or health care plan

- Receipt of or loss of Medicare/Medicaid

Important Note: All changes must be consistent with your qualified status change and you must show proof of the qualified status change (marriage certificate, birth certificate, death certificate or divorce decree). Please contact the HR Service Center for further information. If you have a qualified status change and want to make a consistent change to your benefit elections, you must make the change no later than 31 days after the change; provided, however, that in the case of birth or adoption, you will have 90 days from the date of birth of adoption to make a consistent change to your benefit elections. Changes to your Plan due to a qualified status change will, in most cases (the exception being births and adoptions), become effective on the first of the month following the qualified status change and submission of the qualified status change form to the HR Service Center. All premium changes will be effective in your first paycheck following the start of your benefit(s) on the first of the month following the qualified status change. If your change is processed retroactively, any missed premiums will be collected from future paychecks. To make an election, you must contact the HR Service Center and complete the appropriate paperwork.

Otherwise, you will have to wait until the next open enrollment, which occurs each year, to change your benefit elections and your elections will be effective on January 1 of the following year.

When Coverage Ends

Generally, your medical coverage ends at the end of the month in which your employment ends. Coverage may also end for other reasons, such as:

- You are no longer eligible to participate in the benefits program
- Northern Light Health terminates the plan
- You die
- You voluntarily participate in an organized work stoppage (strike) against your company. If so, your coverage will end due to a reduction of hours because of your participation in the strike. However, you may be eligible for COBRA
- Northern Light Health terminates all dependent coverage under a plan
- Your child or spouse becomes covered on the Plan as an employee
- Your dependent is no longer eligible for benefits
- You fail to make any required contributions (Northern Light Health reserves the right to collect unpaid premiums for active and terminated employees)
- Your coverage terminates or
- Your dependent dies

You may be able to continue medical coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA). Refer to the *Your COBRA Rights* section of this document. You may also be able to continue coverage if you are on an approved Family and Medical Leave

Act (FMLA) leave or are on military leave.

Rescissions

Your coverage may not be rescinded (retroactively terminated) unless: (1) the plan sponsor or an individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud; or (2) the plan sponsor or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

HOW THE MEDICAL PLAN WORKS

You can elect to participate in either of the two medical plan options: Base and Buy-up options. Both options are offered through the Northern Light Employee Health Plan.

Both plans cover the same range of health services and supplies, including office visits, hospitalization, emergency care, mental health services, substance use disorder treatment, preventive care and prescription drugs. Please refer to Exhibit B for coverage details.

Receiving Your Care

Under both medical plan options, you are free to receive your care from the provider of your choice. Both medical plan options consist of the same network of health care providers, including doctors, hospitals, laboratories and other health care facilities in your area.

Each plan provides three tiers of provider coverage: preferred, in-network, and out-of-network. These three tiers provide you the freedom to see any qualified provider you wish. The following is a description of the differences between the three tiers:

- ***Preferred*** refers to providers whose services are rendered and billed by any facility or provider listed as preferred on the online provider directory maintained by Beacon. When you use ***preferred*** providers, you receive the highest level of benefits and you will not have to file claims.

- ***In-network*** refers to providers who are listed as in-network on the online provider directory maintained by Beacon. When you use ***in-network*** providers, you receive the next highest level of benefits and again, you will not have to file claims.

- **Out-of-network** refers to providers who are not preferred or in-network. When you use out-of-network providers, you receive the lowest level of benefits. Your out-of-pocket costs will be higher because your cost is based on reasonable and customary charges (not negotiated rates) and you may be balance billed for charges above reasonable and customary. In addition, you may have to file claims for reimbursement. **Members who receive services from an out-of-network provider are responsible for obtaining prior authorization for specific services in order to have coverage (see prior authorization section). If you receive services from an out-of-network provider or facility that require prior authorization, you are financially responsible when you receive these services if a prior authorization is not obtained. You'll be responsible for 100 percent of the cost without co-insurance and without the cost going towards your deductible or out-of-pocket maximum if: (a) A prior authorization has been requested by a provider or facility and been denied, or (b)**

You obtain services out-of-network without going through the prior authorization process, or c) If a service is on the prior authorization list, but is reviewed by Medical Management and is determined to be not medically necessary. A complete listing of services requiring prior authorization can be found at employeehealthplan.northernlighthealth.org.

To receive coverage at the in-network benefit level under this Plan for care outside of the Northern Light Health service area, you or your provider must call the number on the back of your medical plan's ID card to request authorization for out-of-network provider coverage. If you obtain a prior authorization from the Plan for services provided by an out-of-network provider, benefits for those services will be covered at the in-network benefit level. Refer to the Prior Authorization List (available at employeehealthplan.northernlighthealth.org) for more information. A paper copy is available upon request. Please contact the HR Service Center (hrservicecenter@northernlight.org or 207-973-4000).

Please refer back to "Where to Find More Information" at the beginning of this booklet for information on locating preferred and in-network providers.

What to Consider When Selecting Your Plan Option

Each option varies in the amount you pay in your payroll contributions. As you evaluate each option, take into account:

- **The amount of the annual deductible** (what you pay before the Plan pays benefits).
- **The coinsurance** (your share of the cost when you receive care). In particular, consider the services you and your family typically use most often — whether it is preventive care, routine care requiring office visits or inpatient care to address ongoing or chronic treatment.
- **Whether or not you expect to receive care** from a provider that is listed on the online provider directory maintained by Beacon. Under both medical plan options, benefits are the most generous when you receive care from a preferred provider.

Identification Cards

Shortly after enrollment, you will receive a health plan ID card from Beacon and a prescription plan ID card from Geisinger. Your ID card will have your name on it. In addition, your ID number and the customer service phone number will be listed. When you visit your provider, be sure to present your member identification card. That way, your provider will have all the information needed to file your claim.

Terms You Should Know

- **Coinsurance** means the percentage of covered expenses that you are required to pay under this Plan after you have met your deductible.
- **Copayment** is the flat dollar amount that covers prescription drug costs (usually collected at the time you fill your prescription) or certain office visits as stated in this SPD.

- **Deductible** is the amount you pay first before your Plan begins to share expenses. Prescription drug costs and office visit copays do not apply toward satisfying the Plan deductible.

- **Deductible Gap** is the amount you pay after your HRA helps you meet your annual deductible. This would be the “gap” between the HRA and the full deductible.

- **Preferred** refers to providers whose services are rendered and billed by any facility or provider listed as preferred on the online provider directory maintained by Beacon. When you use preferred providers, you receive the highest level of benefits and you will not have to file claims.

- **In-network** refers to providers who are listed as in-network on the online provider directory maintained by Beacon. When you use in-network providers, you receive the next highest level of benefits and again, you will not have to file claims.

- **Out-of-network** refers to providers who are not preferred or in-network. When you use out-of-network providers, you receive the lowest level of benefits. Your out-of-pocket costs will be higher because your cost is based on reasonable and customary charges (not negotiated rates) and you may be balance billed for charges above reasonable and customary. In addition, you may have to file claims for reimbursement. Members who receive services from an out-of-network provider are responsible for obtaining prior authorization for specific services in order to have coverage (see prior authorization section). If you receive services from an out-of-network provider or facility that require prior authorization, you are financially responsible when you receive these services if a prior authorization is not obtained. You’ll be responsible for 100 percent of the cost without co-insurance and without the cost going towards your deductible or out-of-pocket maximum if: (a) A prior authorization has been requested by a provider or facility and been denied, or (b) You obtain services out-of-network without going through the prior authorization process, or c) If a service is on the prior authorization list, but is reviewed by Medical Management and is determined to be not medically necessary. A complete listing of services requiring prior authorization can be found at employeehealthplan.northernlighthealth.org. A paper copy is available upon request. Please contact the HR Service Center (hrservicecenter@northernlight.org or 207-973-4000).

  Out-of-network emergency, urgent, and ambulance services are processed at the in-network level of coverage. Total charges for out-of-network urgent and emergency claims are paid as the allowable rate for processing.

- **Out-of-Pocket Maximum** is the most you will pay each year (including your deductible, coinsurance and copay amounts and net of your HRA balance). All Plan deductibles and out-of-pocket amounts, benefit maximums and service-specific maximums will cross-accumulate among preferred, in- network and out-of-network services, unless otherwise noted. Note: Prescription drug costs and office visit copays do not apply to deductible, but do apply to out-of-pocket maximum.

- **Health Reimbursement Account (HRA)** is the employer funded account used to help pay for covered services. The HRA will be applied towards the Plan deductible and out-of-pocket maximum. HRA dollars cannot be used to pay prescription drug copayments.

There are three components of the HRA:

Foundational HRA Contribution: This employer contribution will be added to your HRA on the first day of your medical coverage. No employee action is required. If you have Employee Only coverage and add a dependent mid-year due to a qualifying event, you will receive an additional deposit to reflect the coverage change. No employee action is required.

HRA Supplement Contribution: This employer contribution is provided to full-time and part-time employees whose Northern Light Health wages are at or below 250% of the individual Federal Poverty level (https://www.healthcare.gov/glossary/federal-poverty-level-FPL/). No employee action is required.

Preferred PCP Contribution: *Employees and spouses* covered by the Northern Light Employee Health Plan can obtain an additional Preferred Primary Care Provider (PCP) HRA contribution when they attest to being established with or having scheduled a new patient appointment with a Preferred PCP. Preferred PCPs are part of Northern Light Health Member Organizations (Blue Hill Hospital, CA Dean Hospital, Eastern Maine Medical Center, Inland Hospital, Maine Cost Hospital, Mercy Hospital, Sebasticook Valley Hospital, and AR Gould) and additional select primary care partners. Exceptions apply based on distance from preferred PCP locations and access limitations. Visit the Northern Light Health Benefits Portal at benefits.northernlight.org on the Northern Light Health intranet for a complete list of Preferred PCPs, exceptions, and the link to submit your online attestation.

Health Reimbursement Account (HRA) Contribution		
	Total Foundational HRA Contribution (automatic)	**Total with Preferred PCP Contribution *Additional $500/$1000* (action required)**
Employee Only	$500	$1,000
Employee & Spouse or Full Family	$1,000	$1,500 (employee OR spouse attests)
		$2000 (BOTH employee AND spouse attest)
Employee & Children	$1,500	$2,000 (employee attests)
HRA Supplement Program for employees earning $15.01 or less per hour		
	Total Foundational HRA Contribution (automatic)	**Total with Preferred PCP Contribution *Additional $500/$1000* (action required)**
Employee Only	$1,100	$1,600
Employee & Spouse or Full Family	$2,200	$2,700 (employee OR spouse attests)
		$3,200 (BOTH employee AND spouse attest)
Employee & Children	$2,700	$3,200 (employee attests)

Qualifying Religious Organizations (Mercy Hospital)

In keeping with its status as a Qualifying Religious Organization as provided under the Affordable Care Act (ACA) safe harbor provisions, and in keeping with the Ethical and Religious Directives for Catholic Health Care Services (ERD), Mercy Hospital claims exemption from the Act's mandate to provide contraceptive services to its covered employees and dependents. All other preventive services will be provided in accordance with the provisions of the ACA. Covered employees and dependents may access contraceptive services, as mandated by the ACA, by contacting Beacon. These contraceptive services are not covered or funded by Mercy Hospital.

SUMMARY OF COVERED SERVICES

Exhibits B and C at the end of this SPD shows how each medical plan option covers available services. For more details about certain services — such as prescription drug coverage and preventive care — refer to the section called *A Closer Look at Covered Services*.

A CLOSER LOOK AT COVERED SERVICES

More About Prescription Drug Coverage

All of the Plan options include prescription drug coverage. Under all the options, you pay a copayment each time you fill a prescription. The amount of your copayment varies depending on whether you select a Tier 1 (generic brand), Tier 2 (preferred brand) or Tier 3 (non-preferred brand) drug. The Plan also provides a Tier 0 (zero copay) in order to remove financial barriers for certain generic prescription drugs and medical supplies. A searchable directory of covered prescription drugs is located on Geisinger's website.

- **Tier 0 (copay waiver drugs)** are Zero Copay Drugs that are available for certain generic prescription drugs and durable medical equipment (DME) supplies to members for the following chronic conditions without a prescription drug copay/member cost share:
    - Coronary Artery Disease
    - Diabetes
    - Depression
    - Hypertension
- **Tier 1 (generic drugs) are labeled with the medication's basic chemical name and** usually have a brand-name equivalent. The U.S. Food and Drug Administration (FDA) require that generic drugs have the same active chemical composition, same potency and be offered in the same form as their brand-name equivalents. Generic drugs must meet the same FDA standards as brand-name drugs and are tested and certified by the FDA to be as effective as their brand-name counterparts.
- **Tier 2 (preferred brands)** generally have no generic equivalent but includes a few select generic drugs. You are covered for these medications at the preferred brand copayment under this benefit.
- **Tier 3 (non-preferred brands)** are brand-name drugs that generally either have equally effective and less costly generic equivalents and/or one or more preferred brand

(second-tier) options. They also include drugs that are designated as non-preferred.

Copay Levels

Each plan maintains three levels of copay: preferred, in-network and zero copay drugs. These three levels provide you the ability to obtain your prescriptions from any participating pharmacy. The following is a description of the differences between the three tiers:

- **Preferred** refers to Northern Light Pharmacy and pharmacies participating at the preferred level. When you use ***preferred*** pharmacies, you receive the highest level of benefits and you will not have to file claims. Northern Light Pharmacy locations may be found on northernlighthealth.org/pharmacy.

- **In-network** refers to any participating pharmacy not on the preferred level. When you use ***in-network*** pharmacies, you receive the next highest level of benefits and, again, you will not have to file claims. An online directory of participating pharmacies in the state of Maine is maintained by Geisinger.

Participating Retail Pharmacies

- **Thirty-day (or less) Supplies** Thirty-day supplies at the preferred level are available through the Northern Light Health pharmacy, Northern Light Pharmacy, and selected pharmacies outside the Bangor and Portland areas. Thirty-day supplies or less are also available the higher in-network copays at participating in-network pharmacies across Maine and the rest of the country.

- **31 Day to 90 Day Supplies:** You must fill your supplies through Northern Light Pharmacy, either by walk-in or mail order. If you reside outside the state of Maine, you may obtain your 31 day to 90 day supply through a participating in-network pharmacy.

- **Maintenance Drugs:** Maintenance drugs are those taken routinely, often for a chronic condition. You may fill up to two 30-day supplies of a maintenance drug at your participating preferred or in-network pharmacy. All following prescriptions must be filled through Northern Light Pharmacy, either by mail order or by visiting one of the Northern Light Pharmacy locations.

- **Specialty Drugs:** Specialty drugs are those drugs, such as injectables, that are listed as specialty drugs on the online specialty drug list maintained by Beacon and Geisinger. Your access to specialty drugs is through Northern Light Pharmacy. If Northern Light Pharmacy does not stock the specialty drug, they will arrange for you to obtain alternative access. Most specialty drugs are limited to a maximum of 34-day supply.

- An online directory of participating pharmacies in the state of Maine is maintained by Geisinger. Outside of the state of Maine, members may contact Geisinger on the telephone number on the back of their prescription ID card or visit a MedImpact participating pharmacy to fill their prescriptions at the in-network level.

Coverage for certain prescription drugs and related supplies requires your provider to obtain authorization prior to prescribing. Step therapy encourages the use of cost-effective therapeutically appropriate medications before other more costly prescription medication options are considered.

The Northern Light Employee Health Plan requires participants to obtain certain ongoing

infusion drugs from a **Designated Infusion Network** (Network)**.** This Network includes Northern Light Health preferred facilities. These infusion drugs are listed on the Northern Light Employee Health Plan Prior Authorization List (List) (available on the web at employeehealthplan.northernlighthealth.org or via paper copy upon request -- please contact the HR Service Center: hrservicecenter@northernlight.org or 207-973-4000). Specific injectable codes are enumerated on the List as a) needing prior authorization and b) covered only at preferred facilities. If you choose to go to non-preferred facility, the drugs will be process as non-covered (See section entitled "What's Not Covered").

Important Note: Certain expenses are excluded from payment under this Plan. They are listed under the section entitled *What's Not Covered*.

How Preventive Care Is Covered

- Both plan options cover the same preventive care services without cost sharing when the care is provided preferred or in-network. Preventive care services provided out-of-network are subject to cost sharing.

Preventive care services generally include:

- Routine well exams
- Well-woman exams
- Mammograms
- Well-child visits and immunizations
- Colonoscopies

Refer to Exhibit C, Preventive Health Coverage for a complete listing of preventive health services.

MORE ABOUT THE TWO MEDICAL PLAN OPTIONS

Both plan choices offer an employer-funded Health Reimbursement Account (HRA). Here are some key features of the plan options:

- Preventive care is covered at 100% when it is provided preferred or in-network. Preventive care is covered subject to deductible and 50% coinsurance if provided out-of-network.
- You must pay the cost of all other covered services, up to the amount of the annual deductible.
- The HRA is applied toward your annual deductible. After you meet your annual deductible, any remaining amounts in your HRA will be applied towards the coinsurance on covered expenses (i.e., the coinsurance for most services is 20% preferred, 30% in-network or 50% out-of-network). You may opt out of receiving the HRA by contacting the Northern Light HR Service Center.
- Once you reach your annual out-of-pocket maximum, the Plan pays 100% of any additional covered expenses for the rest of the calendar year (100% of the *allowed amount* only when services are rendered by an out-of-network provider – See Exhibit B).
- If you do not use all the money in your account, the balance will roll over to the next

plan year (total HRA maximum is $5,500 for an individual or $11,000 for a family)

- Your office visit copays for primary care office visits and preferred OB/GYN office visits will be paid through your HRA. If you do not have sufficient funds in your HRA, you will receive a bill from your provider. *Office visit copays DO NOT apply to your deductible.*
- If an employee adds a dependent mid-year and NLH's eligibility file indicates an added dependent and an increase in HRA funding assignment.
- COBRA allows members to continue their HRA benefits as long as they are paying their premiums.

How the Health Reimbursement Account (HRA) Works

HRA

- Northern Light Health funds the account
- This account is applied toward your annual deductible and coinsurance
- If you don't use it, you can save it for future years (to the maximum allowed)

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Preventive Care

100% covered if provided preferred or in-network

All Other Services (Excluding Prescriptions and Office Visit Copays)

You pay the full cost up to the amount of your annual deductible (using HRA dollars if applicable).

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Cost Sharing (co-insurance)

Once you meet your annual deductible, you and the Plan share the cost of expenses until you reach the out-of-pocket maximum.

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Out-of-Pocket Maximum

Once your expenses (including your annual deductible) reach this amount, the Plan pays 100% of eligible expenses for the rest of the calendar year.

- **When you incur an eligible medical expense,** your HRA is available to pay 100% of the cost up to the annual account limit. **Any funds remaining at the end of the year will roll over to next year's HRA.** The maximum amount you can have in your HRA is $5,500 for an individual or $11,000 for a family. Over time, you can accumulate significant savings that can be used to help pay for future qualified medical expenses.
- **This benefit is not portable**, so you will not be able to take the value of your account with you when you terminate your employment at Northern Light Health. Eligible retired employees and their dependents participating in the Plan will retain benefits under the HRA. There is no benefit under the Retiree Plan.

How Claims Are Paid

A preferred or in-network provider will not collect any money from you at the time of your office visit. Instead, your provider sends the claim directly to Beacon. Beacon maintains online

access to your past transactions and claim status through its member website.

Beacon will process the claim and send you an Explanation of Benefits (EOB) that will tell you:

- If the Plan covers the services you received; and if so,
- What part of the covered services the Plan pays.
- If you have not met your deductible or the expense is not covered, the EOB will tell you how much you may owe your provider.

If there are dollars in your HRA, they are used to pay your provider directly for eligible expenses. Your provider will receive an Explanation of Payment (EOP) that will confirm payment. You can log in to your account at connectyourcare.com or contact Connect Your Care at 1-833-799-1781 for information about your balance and payments made to providers.

If there are not enough dollars remaining in your HRA, or the expense is not eligible for payment from the fund, you will receive an EOB that explains your responsibility for payment. You can log in to your account or contact Connect Your Care to stay up to date on your balance.

If you receive a bill from your provider, make sure the claim has been sent to Beacon and routed through your HRA before you pay the bill. You can do this by:

- Checking your fund activity online through Connect Your Care.
- Calling Member Services at the toll-free number on your ID card to find out the status of your claim.

In the event of an overpayment of claims due to administrative error, the Plan may seek repayment from you.

Prior Authorization

The term “prior authorization” means the approval from the Plan’s medical management review process prior to services being rendered in order for certain services and benefits to be covered under this Plan.

- **Prior Authorization (provider responsibility):** It is the responsibility of your preferred or in-network provider or the facility in which you will be receiving care to receive prior authorization for the following services:
    - Inpatient hospital stays;
    - Inpatient services at any other participating health care facility;
    - Residential treatment;
    - Intensive outpatient programs including certain outpatient surgeries;

- Nonemergency ambulance; or
- Transplant services
- Durable Medical Equipment
- Medical pharmacy (such as injectable drugs for chemotherapy or rheumatoid arthritis)

A complete listing of required prior authorization for you and/or your provider's review is located on the Provider online service center and on the Northern Light Employee Health Plan website: employeehealthplan.northernlighthealth.org. A paper copy is available upon request. Please contact the HR Service Center (hrservicecenter@northernlight.org or 207-973-4000).

If you receive services from an out-of-network provider or facility that require prior authorization, you are financially responsible when you receive these services if a prior authorization is not obtained. You'll be responsible for 100 percent of the cost without co-insurance and without the cost going towards your deductible or out-of-pocket maximum if: (a) A prior authorization has been requested by a provider or facility and been denied, or (b) You obtain services out-of-network without going through the prior authorization process, or c) If a service is on the prior authorization list, but is reviewed by Medical Management and is determined to be not medically necessary. A complete listing of services requiring prior authorization can be found at employeehealthplan.northernlighthealth.org.

COVERED EXPENSES

The term "covered expenses" refers to charges for services or supplies that are recommended by a provider and are deemed medically necessary by a Plan Medical Director. They include:

- Charges by a hospital for bed and board and other necessary services and supplies.
- Charges for licensed ambulance service to or from the nearest hospital where the needed medical care can be provided.
- Charges by a hospital for medical care and treatment received as an outpatient.
- Charges by a freestanding surgical facility for medical care and treatment.
- Charges by another health care facility (including a skilled nursing facility, a rehabilitation hospital, or a subacute facility) for medical care and treatment. Charges for services that are custodial in nature (e.g., basic non-medical needs such as bathing and eating) are not covered (regardless of where they are provided).
- Charges for emergency services and urgent care.
- Charges by a physician or a psychologist for professional services.
- Charges for eVisits at the preferred and in-network levels.
- Charges for anesthetics and their administration.
- Diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope

treatment; chemotherapy.

- Blood transfusions; and oxygen and other gases and their administration.
- Charges for a mammogram at any age for women at risk, when recommended by a physician.
- For plan members other than employees of Mercy Hospital and their covered dependents: Charges for appropriate counseling and medical services connected with surgical sterilization therapies, including vasectomy and tubal ligation.
- Charges for laboratory services, radiation therapy, and other diagnostic and therapeutic radiological procedures.
- For plan members other than employees of Mercy Hospital and their covered dependents: Charges for family planning, including medical history; physical exam; related laboratory tests; medical supervision in accordance with generally accepted medical practice; other medical services, information, and counseling on contraception; and implanted/injected contraceptives. Implanted/injected contraceptive covered only in conjunction with an office visit.
- For covered employees of Mercy Hospital and their dependents only: Charges for family planning, including medical history; physical exam; related laboratory tests; medical supervision in accordance with generally accepted medical practice.
- For plan members other than employees of Mercy Hospital and their dependents: Charges for medically necessary abortions.
- Charges for routine preventive care at the preferred, in-network and out-of-network levels, which includes well-child care, health care assessments, preventive care visits, immunizations and any related services.
- Charges by an ophthalmologist or optometrist for one complete routine eye examination each calendar year.
- Charges for one childbirth class per lifetime, documentation of completion required.
- Charges for lactation consultations after childbirth.
- Charges for circumcision, regardless of age.
- Charges for pediatric hearing aids up to and include the age of 18. Coverage is dependent upon prior authorization for medical necessity. Age 0-18 years, coverage limit is $3,000 per ear, every 36 months.
- Rental charges for or purchase of a breast pump. Refer to plan highlights for lifetime maximum.
- Hair prostheses (wigs) when prescribed by a physician for a patient who suffers hair loss as a result of disease.
- Charges for medical and surgical services for the treatment or control of clinically severe (morbid) obesity, if the services are demonstrated, through existing, peer-reviewed, evidence-based, scientific literature and scientifically based guidelines, to

be safe and effective for the treatment or control of the condition. Charges for bariatric surgery performed at Eastern Maine Medical Center of Excellence. Bariatric surgery at any other facility is not covered. Bariatric Surgery for morbid obesity is covered at the Preferred level when medical necessity criteria have been met and the surgical procedure is performed at the Eastern Maine Medical Center Bariatric Surgery Center of Excellence. All other requests for Bariatric Surgery will not be covered.

- Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided:
    - The deformity or disfigurement is accompanied by a documented, clinically significant, functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
    - The orthognathic surgery is medically necessary as a result of tumor, trauma, disease or;
    - The orthognathic surgery is performed prior to a person attaining age 19 and is required because of severe congenital facial deformity or congenital condition.
    - Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by a Health Plan Medical Director.
- **Clinical Trials -** Charges made for patient services associated with cancer clinical trials approved and sponsored by the federal government in accordance to the Patient Protection and Affordable Care Act (PPACA).
- **Genetic Testing -** Charges made for genetic testing that uses a proven testing method for the identification of genetically linked inheritable disease. Genetic testing is covered only if:
    - A person has symptoms or signs of a genetically-linked inheritable disease;
    - It has been determined that a person is at risk for carrier status as supported by existing, peer-reviewed, evidence based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
    - The therapeutic purpose is to identify specific genetic mutation that has been demonstrated, in the existing, peer-reviewed, evidence-based, scientific literature, to directly impact treatment options.
    - Genetic counseling is covered if a person is undergoing approved genetic testing or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to three visits per calendar year for both pre and post-genetic testing.
- **Nutritional Evaluation -** Charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease (i.e., when medically necessary).

- **The WOW program –** Charges made for this multi-disciplined, family-centered program for children and adolescents (aged 15 months to 19 years) at a higher risk for weight-related health problems. This program is available to eligible children (eligibility determined by measures outlined by the WOW clinic, visit https://www.emmc.org/Way-to-Optimal-Weight.aspx for information) and adolescents with zero copay. The WOW Clinic is located at Cutler Health Center, University of Maine Orono Campus.

- **Oral Surgery -** Charges for the surgical removal of bony impacted teeth are a covered expense when medically necessary.

- **Internal Prosthetic/Medical Appliances -** Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctioning body parts. Medically necessary repair, maintenance, or replacement of a covered appliance is also covered. Includes cochlear implants and Osseointegrated Hearing Devices (e.g. Bone Anchored hearing Aid (BAHA) Hearing Device) when medically necessary.

- **Home Health Services -** Charges made for home health services when you: (a) require skilled care; (b) are unable to obtain the required care as an ambulatory outpatient; and (c) do not require confinement in a hospital or another health care facility.

    - Home health services are provided only if the Plan has determined that the home is a medically appropriate setting. If you are a minor or an adult, who is dependent upon others for non-skilled care and/or custodial services (e.g., bathing, eating, and toileting), home health services will be provided for you only during times when there is a family member or caregiver present in the home to meet your non-skilled care and/or custodial service needs.

    - Home health services are skilled health care services that can be provided during visits by health care professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by other health care professionals. A visit is defined as a period of two hours or less. Home health services are subject to a maximum of 16 hours in total per day. Home infusion therapy administered or used by health care professionals in providing home health services are covered. Home health services and skilled nursing services provided in the home do *not* include services by a person who is a member of your family or your dependent's family, or who normally resides in your home or your dependent's home, even if that person is another health care professional. Physical, occupational, and other short-term rehabilitative therapy services provided in the home, however, are not subject to the home health services benefit provisions, but to the provisions and limitations applicable to short-term rehabilitative therapy in this Plan. *Private duty nursing services are not covered under this Plan.*

- **Hospice Care Services -** Charges made for the following hospice care services for a person who has been diagnosed as having six months or less to live. They include charges:

    - By a hospice facility for bed and board and services and supplies. Covered

expenses will not include that portion of charges which is more than the hospice bed and board daily limit;

- For hospice care services provided on an outpatient basis;
- By a physician for professional services;
- By a psychologist, social worker, family counselor, or ordained minister for individual and family counseling;
- For pain relief treatment, including drugs, medicines and medical supplies;
- By another health care facility for:
  - Part-time or intermittent nursing care by or under the supervision of a nurse;
  - Part-time or intermittent services of another health care professional;
  - Physical, occupational and speech therapy to a limit of 60 days per calendar year
  - Medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been confined in a hospital or hospice facility.

NOTE: The following charges for hospice care services are not included as covered expenses:

- For services rendered by a person who is a member of your family or your dependent's family, or who normally resides in your home or your dependent's home;
- For any period when you or your dependent is not under the care of a physician;
- For services or supplies not listed in the hospice care program;
- For any curative or life-prolonging procedures related to the hospice diagnosis;
- For services or supplies primarily to aid you or your dependent in daily living.

Mental Health and Substance Use Disorder Services

- ***Inpatient Mental Health Services*** are services provided by a hospital, while you or your dependent is confined for the treatment and evaluation of mental health. Inpatient mental health services include partial hospitalization and mental health residential treatment services.
- ***Mental Health Residential Treatment Services*** are services provided by a state licensed provider of mental health services for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute mental health conditions.
- ***Mental Health Residential Treatment Center*** means an institution which: (a) specializes in the treatment of psychological and social disturbances that are the

result of mental health conditions; (b) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate, legally authorized agency as a residential treatment center.

- A person is considered confined in a mental health residential treatment center when she/he is a registered bed patient in a mental health residential treatment center upon the recommendation of a physician.

- ***Outpatient Mental Health Services*** means services of providers who are qualified to treat mental health, when treatment is provided on an outpatient basis, in an individual, group, or mental health intensive outpatient therapy program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; suicidal or homicidal threats or acts; eating disorders; acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention); and outpatient testing and assessment.

  - A mental health intensive outpatient therapy program consists of distinct levels or phases of treatment that are provided by a certified/licensed mental health program. Intensive outpatient therapy programs provide a combination of individual, family, and/or group therapy.

- ***Substance Use Disorder*** is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for abuse or addiction of alcohol or drugs will not be considered to be charges made for treatment of substance abuse.

- ***Inpatient Substance Use Disorder Rehabilitation Services*** are services provided for rehabilitation, while you or your dependent is confined in a hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient substance use disorder services include partial hospitalization sessions and residential treatment services.

- ***Substance Use Disorder Residential Treatment Services*** are services provided by a state licensed provider of residential substance use disorder services for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute substance use disorders.

  - Substance use disorder residential treatment center means an institution which: (a) specializes in the treatment of psychological and social disturbances that are the result of substance abuse; (b) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate, legally authorized agency as a residential treatment center. A person is

considered confined in a substance use disorder residential treatment center when she/he is a registered bed patient in a substance use disorder residential treatment center upon the recommendation of a physician.

- ***Outpatient Substance Use Disorder Rehabilitation Services*** refer to providers qualified to diagnose and treat misuse of or addiction to alcohol and/or drugs, when rendered on an outpatient basis, including rehabilitation through individual therapy or a substance use disorder intensive outpatient therapy program.
- A ***Substance Use Disorder Intensive Outpatient Therapy Program*** consists of distinct levels or phases of treatment that are provided by a certified/licensed substance use disorder program. Intensive outpatient therapy programs provide a combination of individual, family, and/or group therapy in a day.
- ***Substance Use Disorder Detoxification Services*.** Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Beacon will decide, based on the medical necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.
- **Methadone Treatment.** Charges for methadone treatment are covered when rendered and billed at a preferred or an in-network facility.

- **Durable Medical Equipment**

  - Charges made for the purchase or rental of durable medical equipment that is ordered or prescribed by a provider for use outside a hospital or other health care facility. Coverage for repair, replacement, or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from misuse are the covered person's responsibility. Coverage for durable medical equipment is limited to the most cost-effective alternative, as determined by the utilization review physician.
  - Durable medical equipment is defined as items which: (a) are designed for, and able to withstand repeated use by more than one person; (b) customarily serve a medical purpose; (c) generally are not useful in the absence of injury or sickness; (d) are appropriate for use in the home; and (e) are not disposable. Such equipment includes, but is not limited to crutches, hospital beds, respirators, wheel chairs, and dialysis machines.
  - Note: Certain DME for the management of Diabetes is covered with no member cost sharing. Please refer to the Tier 0 section on page 14.

- **External Prosthetic Appliances and Devices -** Charges made or ordered by a provider for the initial purchase and fitting of external prosthetic appliances and devices available only by prescription that is necessary for the alleviation or correction of injury, sickness or congenital defect.

  Coverage for external prosthetic appliances is limited to the most appropriate and cost-effective alternative. External prosthetic appliances and devices shall include

prostheses/prosthetic appliances and devices; orthoses and orthotic devices; braces; and splints. Either a mandibular oral appliance or a CPAP machine is covered when medically necessary or when meet criteria.

- **Prostheses/Prosthetic Appliances and Devices -** Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts.

  Prostheses/prosthetic appliances and devices include, but are not limited to:

  - Basic limb prostheses;
  - Terminal devices, such as hands or hooks; and
  - Speech prostheses.

- **Orthoses and Orthotic Devices**

  - **Nonfoot orthoses** – only the following nonfoot orthoses are covered:
    - Rigid and semi rigid custom fabricated orthoses,
    - Semi rigid prefabricated and flexible orthoses; and
    - Rigid prefabricated orthoses, including preparation, fitting, and basic additions, such as bars and joints.
  - **Custom Foot Orthoses** – custom foot orthoses are only covered as follows:
    - For persons with impaired peripheral sensation and/or altered peripheral circulation (e.g., diabetic neuropathy and peripheral vascular disease);
    - When the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
    - Orthopedic shoes (preferred and in-network only).
    - When the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g., amputated toes) and is necessary for the alleviation or correction of injury, sickness or congenital defect; and
    - For persons with a neurological or neuromuscular condition (e.g., cerebral palsy, hemiplegia, spina bifida) producing spasticity, misalignment, or pathological positioning of the foot, and there is reasonable expectation of improvement.

    The following are specifically excluded from coverage as orthoses:

    - Prefabricated foot orthoses;
    - Cranial Banding and/or cranial orthoses. Excluded except when used post-surgically for synostotic plagiocepaly or positional (deformational) plagiocephaly that failed conservative therapy AND is considered moderate to severe based on objective measurements and standard interpretation. When used for synostotic plagiocephaly, the cranial orthosis will be subject

to the limitations and maximums of the external prosthetic appliance benefit;

- Orthotic shoes, shoe additions, shoe modifications, and transfers;
- Orthoses primarily used for cosmetic, rather than functional, reasons; and
- Orthoses primarily for improved athletic performance or sports participation.

- **Braces -** An orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body, and that allows for motion of that part. Copes scoliosis braces are specifically excluded.
- **Splints -** An appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- Replacement due to regular wear. Replacement for damage due to abuse or misuse will not be covered.
- Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy, and/or growth.
- Replacement due to a surgical alteration or revision of the site.
- Coverage for replacement is limited as follows:
  - Once every 24 months for persons 19 years of age or older; and
  - Once every 12 months for persons 18 years of age or younger.
- The following are specifically excluded from coverage as external prosthetic appliances and devices:
  - External and internal power enhancements, or power controls for prosthetic limbs and terminal devices; and
  - Myoelectric prostheses peripheral nerve stimulator

- **Infertility Services -** Charges made for services related to diagnosis and treatment of infertility. Services include, but are not limited to approved surgeries and other therapeutic procedures that have been demonstrated, in existing, peer-reviewed, evidence-based, scientific literature, to have a reasonable likelihood of resulting in pregnancy; laboratory tests; and diagnostic evaluations.
  - Infertility is defined as the inability to achieve conception after one year. This benefit includes diagnosis and treatment of both male and female infertility. The following are specifically excluded from coverage as infertility services:
    - Infertility drugs;

- In vitro fertilization (IVF); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT); and any variations of these procedures;
- Artificial insemination, including donor charges and services;
- Cryopreservation of donor sperm and eggs; and
- Any experimental, investigational, or unproven infertility procedures or therapies.

- **Short-Term Rehabilitative Therapy -** Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

  Occupational therapy is only covered for purposes of enabling persons to perform the activities of daily living after an injury or sickness.

  Short-term rehabilitative therapy services that are not covered include, but are not limited to:

  - Sensory integration therapy; group therapy; treatment of dyslexia; behavior modification; or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions, without evidence of an underlying medical condition or neurological disorder;
  - Treatment for functional articulation disorders, such as correction of tongue thrust; lisp; verbal apraxia; or swallowing dysfunction that is not based on an underlying diagnosed medical condition or injury; and
  - Maintenance or preventive treatment consisting of routine, long-term, or non-medically necessary care provided to prevent recurrence or to maintain the patient's current status.

- **Chiropractic Care Services -** Charges made for maintenance, diagnostic and treatment services utilized in an office setting by chiropractic physicians to a limit of 20 days per calendar year.

  Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function.

  Chiropractic care services that are not covered include, but are not limited to:

  - Services of a chiropractic physician which are not within their scope of practice, as defined by law;
  - Imaging in the chiropractic office.
  - Charges for care not provided in an office setting;
  - Vitamin and nutrition therapy.

- **Transplant Services -** Charges made for human organ and tissue transplant services, which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories.

  This coverage is subject to the following conditions and limitations:

  - Transplant services include the recipient's medical, surgical, and hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human-to-human organ or tissue transplants: allogeneic bone marrow/stem cell; autologous bone marrow/stem cell; corneal; heart/lung; kidney; kidney/pancreas; liver; lung; pancreas; or intestine (which includes small bowel, liver, or multiple viscera).

  - All transplant services, other than corneal, are payable at 100% when authorized by the Plan and through Optum/Transplant Resource Network and/or other contracted transplant provider. Cornea transplants are not covered through URN/Transplant Resource Network. Benefits for transplant services, when received from participating provider facilities other than Optum/Transplant Resource Network are payable at the in-network benefit level. Non-authorized transplant services will *not* be covered.
    - Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation, and the transportation, hospitalization, and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if medically necessary. Costs related to the search for, and identification of, a bone marrow or stem cell donor for an allogeneic transplant are also covered.

- **Transplant Travel Services -** Charges made for reasonable travel expenses incurred in connection with a pre-approved organ/tissue transplant are covered (refer to Exhibit B for daily and lifetime maximums), subject to the following conditions and limitations:

  - Transplant travel benefits are not available for corneal transplants. Benefits for transportation, lodging, and food are available only to the recipient of a pre-approved organ/tissue transplant through the Optum/Transplant Resource Network and/or other contracted transplant provider. The term "recipient" includes a person receiving authorized transplant- related services during any of the following: (a) evaluation; (b) candidacy; (c) transplant event; or (d) post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); lodging while at, or traveling to and from, the transplant site; and food while at, or traveling to and from, the transplant site.

  - In addition to the recipient's coverage for the charges associated with these items, travel expenses for one companion to accompany the recipient are also covered. The term "companion" includes the recipient's spouse; a member of the family; a legal guardian; or any person not related to the recipient, but actively involved as a caregiver. The following travel expenses are excluded: costs incurred due to travel within 60 miles of your home; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach

class rates.

- These benefits are only available when the covered person is the recipient of an organ transplant. No benefits are available when the covered person is a donor.
- For information on submitting receipts, contact Beacon's Customer Service Team at the telephone number on the back of the member's identification card.

- **Breast Reconstruction and Breast Prostheses -** Charges made for reconstructive surgery following a mastectomy.

  Benefits are payable for: (a) surgical services for reconstruction of the breast on which surgery was performed; (b) surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance; (c) post-operative breast prostheses; and (d) mastectomy bras and external prosthetics, limited to the most cost-effective alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

  Breast reduction surgery (reduction mammoplasty) may be considered when determined to be medically necessary and covered when prior authorized in advance and specific clinical criteria are met.

- **Reconstructive Surgery -** Charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement that is accompanied by functional deficit.

  Coverage is provided when: (a) the surgery or therapy restores or improves function; (b) reconstruction is required as a result of medically necessary, non-cosmetic surgery; or (c) the surgery or therapy is performed prior to the person attaining age 19, and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement, as determined by the utilization review physician.

Telemedicine

- Telemedicine and tele-behavioral health with a preferred provider. In-network and out-of-network tele-behavioral health is subject to prior authorization.

Health and Wellness Services

- **Care Management** – For members with chronic conditions, the Plan offers services of care managers through Beacon Health. These services are available regardless of whether a member seeks primary care services at the preferred, in-network, or out-of-network level.

- **Behavioral Health Care Management --** The Plan offers support to members who are affected by behavioral health symptoms. Beacon Health Community Care Team staff, including nurses and social workers, provide navigation to resources, support to cope with and manage negative/unwanted symptoms, and education to understand treatment and intervention options. Support is patient focused, coordinated with

primary care (with permission), and focused towards helping members with functional improvements.

- **Incentives** – The Plan offers incentives to enrolled employees and spouses for compliance with health and wellness initiatives as outlined below:
  - Participation in annual biometric screening or for providing blood pressure, height, weight, glucose and cholesterol results if testing already took place the applicable calendar year.
  - Participation in 10 out of 12 Weight Watchers classes.
  - Having a body mass index (BMI) of less than 29 or by participating in a qualified engagement program (Beacon Health wellness coaching, tobacco cessation, diabetes prevention).

Incentive amounts and programs may change from year to year and details are available through the Northern Light Health Benefits Guide and on the Total Health portal (totalhealth.northernlighthealth.org, on the Northern Light Health intranet).

The following wellness services provided by Beacon Health are available at no cost to Plan Members age 18 and older:

- **Wellness Coaching** - Coaching encompasses the components of wellness that are important to you and provides individual support and encouragement to assist you in achieving your personal goals. Your coach will help you overcome challenges and you will work together to develop a plan that is personally tailored to your unique circumstances and capabilities. If coaching is offered for a Plan Year, it may be done on work time, but please check with your department manager regarding your department's policies. Wellness coaching is confidential.
- **Tobacco Cessation and Weight Management Programs** – These programs are designed to provide accountability, direction, and support in the areas of weight management and tobacco cessation. They employ evidence-based best practices including group coaching, one-on-one coaching, and action-based group and individual goal setting.
- **National Diabetes Prevention Program** –– A program to support individuals with prediabetes and allow them to participate in lifestyle change programs to reduce their risk of type 2 diabetes and improve their overall health.

Contact Beacon Health at beaconwellness@northernlight.org or visit beaconhealth.me for more information about these wellness services.

COORDINATION OF BENEFITS (COB)

If you or your dependents are covered under more than one plan, your benefits will be subject to coordination of benefits (COB) provisions. This means this Plan coordinates benefits with other

medical plans under which you or a dependent may be covered. For example, assume you and your spouse both work, and each of you covers your family under your respective plans. Unless benefits are coordinated, the combined benefits under both plans could exceed the actual cost of a covered expense. COB ensures that payments from all plans do not exceed the allowable charge for that service.

With coordination of benefits, the plan that provides benefits first is known as the "primary plan" and is responsible for providing benefits to the full extent of coverage allowed by its program. The Plan is your primary plan, provided you are enrolled. (Your spouse's plan is always primary for your spouse provided he or she is enrolled in that plan). The plan that provides benefits next is known as the "secondary plan." The secondary plan provides benefits toward any remaining covered services as long as the payment, when added to the primary plan's payment, is not more than the total amount of the covered benefit expenses.

The birthday rule applies to COB for children's coverage. The birthday rule means that if you and your spouse are both covering your children, whoever's birthday comes first in the year will be the primary plan for the children.

The total of the payments made for covered medical services will not be more than the total of the allowed charge for those covered services.

The Plan will not provide duplicate payment of benefits for the same services. If you have any questions about coordination, you may call the customer service department at the telephone number on the back of your medical ID card.

In the event benefits are improperly paid by the Plan, this Plan retains the right to seek reimbursement from you for the benefits that were improperly paid. The Plan will pay as the secondary plan as permitted by the Social Security Act of 1965 as amended for the following:

(a) a former employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this Plan;

(b) a former employee's dependent, or former dependent spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this Plan;

(c) an employee, retired employee, employee's dependent or retired employee's dependent that is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

Recovery of Payments

If you receive payment for a medical service from a third party, this Plan will not pay benefits and can obtain a refund from you for any benefits that were already paid. For example, if you were injured and you required medical services, these services could be paid by the party responsible for the injury or by an insurance policy. In this case, this Plan would not pay benefits, or you will be asked to reimburse the Plan for the benefits you had already received.

HOW TO FILE A CLAIM

Generally, you do not have to file a claim in order to receive your benefits. As long as you receive care from a preferred or in-network provider, claims will be submitted for you.

For more information on claims procedures, please see the Plan's Claims Procedures and Appeals Process attached hereto as Exhibit F. For the appeals process applicable to pharmacy claims please see the Plan's Appeals Process – Pharmacy attached hereto as Exhibit F.

When You Receive Care from an Out-of-Network Provider

When you receive care from a provider who is not a preferred or in-network provider, you must complete and submit a claim. Along with your completed claim form, you must attach your original itemized bill and send them to:

The Northern Light Employee Health Plan
c/o Beacon Direct
PO Box 21116
Eagan, MN 55121
Attention: Claims Department

You may be responsible for paying the full cost of services up front to your provider. The Northern Light Employee Health Plan's payment will then be sent directly to you. *You must file a claim within one year of the date you received the covered service.*

WHAT'S NOT COVERED

Your Plan provides coverage for medically necessary services per medical policies. Your Plan does not provide coverage for the following except as required by law:

- Expenses for supplies, care, treatment, or surgery that is not medically necessary.
- Services rendered by Naturopathic Doctors (ND degree) or other naturopathic providers that are not credentialed for other professional status within our network.
- Bariatric surgery rendered at any location other than the Eastern Maine Medical Center of Excellence
- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an illness or injury that is due to war, declared or undeclared.
- Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Plan.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other custodial services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Plan's medical director to be:
    - Not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed;

- Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
- The subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the "Clinical Trials" section under "*Covered Expenses.*"

- Cosmetic surgery and therapies that are defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; abdominoplasty; panniculectomy; redundant skin surgery; removal of skin tags; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Varicose vein treatments, rhinoplasty and blepharoplasty are not covered unless medically necessary as determined by the Plan.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch. Coverage includes removal of bony impacted teeth.
- Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
- Court ordered treatment or hospitalization, unless such treatment is being sought by a participating provider or otherwise indicated under "*Covered Expenses.*"
- Infertility services including gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- Reversals of tubal ligations or vasectomies.
- Any services or supplies, for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
- Medical and hospital care and costs for the child of a dependent, unless this child is otherwise eligible under the Plan.
- Non-medical counseling or ancillary services, including, but not limited to custodial

services, education, training, vocational rehabilitation, behavioral training, neurofeedback, hypnosis, sleep therapy, employment counseling, back to school, return-to-work services, work hardening programs, and driving safety. In addition, services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism spectrum disorder or mental retardation.

- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

- Exclusions to Mental Health and Substance Use Disorder Services

    - The following are specifically excluded from coverage as mental health and substance abuse services:

        - Any court-ordered treatment or therapy; or any treatment or therapy ordered as a condition of parole, probation, or custody or visitation evaluations, unless medically necessary and otherwise covered under this Plan.
        - Developmental disorders or delays, including, but not limited to developmental reading disorders; developmental arithmetic disorders; developmental language disorders; developmental articulation disorders; or autism spectrum disorders. NOTE: Evaluation for rehabilitative services (Physical Therapy, Occupational Therapy, and Speech Therapy) is covered without prior authorization for members with developmental disorders or delays, including, but not limited to developmental reading disorders; developmental arithmetic disorders, developmental language disorders, developmental articulation disorders, or autism spectrum disorder." Ongoing therapy is not covered.
        - Counseling for activities of an educational nature.
        - Counseling for borderline intellectual functioning.
        - Counseling for occupational problems.
        - Counseling related to consciousness-raising.
        - Vocational or religious counseling.
        - I.Q. testing.
        - Custodial care, including, but not limited to, geriatric day care.
        - Psychological testing on children requested by or for a school system.
        - Occupational/recreational therapy programs, even if combined with supportive therapy for age-related cognitive decline.

- Durable medical equipment items that are not covered include, but are not limited to:
  - Bed-Related Items: bed trays, over-the-bed tables, bed wedges, pillows, custom bedroom equipment, and mattresses (including non-power mattresses, custom mattresses, and posturepedic mattresses).
  - Bath-Related Items: bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand-held showers, paraffin baths, bath mats, and spas.
  - Chairs, Lifts and Standing Devices: specialized computerized or gyroscopic mobility systems, roll-about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized; manual hydraulic lifts are covered if the patient is a two-person transfer), and auto-tilt chairs.
  - Fixtures to Real Property: ceiling lifts and wheelchair ramps.
  - Car/Van Modifications
  - Air Quality Items: room humidifiers, vaporizers, air purifiers, and electrostatic machines.
  - Blood/Injection Related Items: blood pressure cuffs and centrifuges
  - Other Equipment: heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, and any exercise equipment and diathermy machines.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, and skin preparations, except as specified in the "*Covered Expenses*" section.
- The following are specifically excluded from coverage as orthoses:
  - Prefabricated foot orthoses;
  - Cranial banding and/or cranial orthoses. Other similar devices are excluded, except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the external prosthetic appliances benefit;
  - Orthotic shoes, shoe additions, shoe modifications, and transfers;
  - Orthoses primarily used for cosmetic, rather than functional, reasons; and
  - Orthoses primarily for improved athletic performance or sports participation.
- Private duty nursing except as provided under the Plan.
- Personal or comfort items such as personal care kits provided on admission to a

hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.

- Artificial aids, including but not limited to, arch supports, compression stockings (unless stockings deemed medically necessary), garter belts, corsets and dentures.
- Hearing aids for any plan member over the age of 18, including, but not limited to semi-implantable hearing devices and audient bone conductors. A hearing aid is any device that amplifies sound. The Plan provides coverage for cochlear implants and Osseointegrated Hearing Devices (e.g. Bone Anchored hearing Aid (BAHA) Hearing Device) when medically necessary.
- Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books. Speech generating devices are covered, but recorded speech devices are not.
- Eyeglass lenses and frames (including sunglasses) and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- All non-injectable prescription drugs and injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.
- Membership costs or fees associated with health clubs and weight loss programs. There are, however, incentives available for Plan members that participate in qualifying programs such as wellness coaching or weight management. Please visit the section for Northern Light Employee Health Plan enrollees at totalhealth.northernlighthealth.org for more information.
- Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Medical Plan's medical director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Immunization agents; biological products for allergy immunizations; biological sera; blood, blood plasma, and other blood products or fractions; and medicines used for travel prophylaxis

- Cosmetics, dietary supplements and health and beauty aids.
- All oral nutritional supplements and formula are excluded, except for specialized infant formulas professionally prescribed for the treatment of inborn errors of metabolism. All enteral feedings provided as tube feedings which serve as the sole source of nutrition are covered.
- Expenses incurred for medical treatment by a person age 65 or older, who is covered under this Plan as a retiree, or their dependents, when payment is denied by the Medicare Plan because treatment was received from a provider who has opted out of the Medicare Plan.
- Expenses incurred for medical treatment when this Plan is secondary and when payment is denied by the primary plan because treatment was not received from a participating provider of the primary plan.
- Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
- Telephone consultations. Internet consultations and telemedicine/tele-behavioral health, except when using a preferred provider.
- Massage therapy.
- Acupuncture, acupressure, and non-traditional medical therapies.
- If you or any of your dependents is, in any way, paid (or entitled to payment) for the expenses by or through a public program (other than Medicaid).
- If payment is unlawful where the covered person resides when the expenses are incurred.
- Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity.
- Weight loss programs or treatments, whether or not prescribed or recommended by a physician under medical supervision other than the WOW program, a multi-disciplined, family-centered program for children and adolescents (aged 15 months to 19 years) at a higher risk for weight-related health problems. See “Covered Expenses” section.
- Liposuction or reconstructive surgery, except as described in the Covered Services section of the document.
- Out-of-network expenses to the extent that the charges upon which they are based are more than the maximum reimbursable charge.
- Expenses incurred outside of the United States or Canada, unless you or your dependent is a U.S. resident and the charges are incurred while traveling on business or for pleasure.
- Charges made by any covered provider who is a member of your family or your

dependent's family.

- Any expenses incurred out-of-network to the extent of the exclusions imposed by the certification requirements.
- Illegal Activity. Covered services required as a result of a Member's commission of or attempt to commit a felony or being engaged in an illegal occupation, are not covered.
- Riot or Insurrection. Covered service(s) required as a result of a Member's participation in a riot or insurrection is not covered.

Prescription Drug Limitations and Exclusions

In addition, *no* payment will be made for the following expenses:

- Replacement of prescription drugs and related supplies due to loss or theft.
- Drugs purchased from a retail non-participating pharmacy or a non-participating mail-order pharmacy.
- Drugs available over-the-counter that do not require a prescription by federal or state law.
- Non-sedating antihistamines.
- Any drug that is a pharmaceutical alternative to an over-the-counter drug (other than insulin).
- Any drug from a drug class in which at least one of the drugs is available over-the-counter, and the drugs in that class are deemed to be therapeutically equivalent.
- Any drugs used for infertility treatment.
- Some, but not all injectable drugs may not be covered when administered by a physician during an office visit, especially when considered self-administering. Some injectables may be covered if administered by a pharmacist.
- The Plan requires participants to obtain certain ongoing infusion drugs from a Designated Infusion Network (the "Network"). These infusion drugs are listed on the Plan Prior Authorization List (the "List"). Specific injectable codes are enumerated on the prior authorization List (available at employeehealthplan.northernlighthealth.org) as a) needing prior authorization and b) are covered only at preferred facilities. If a member chooses to go to non-preferred facility, the drugs will process as non-covered.
- Any drugs that are experimental or investigational.
- Food and Drug Administration (FDA)-approved drugs used for purposes other than those approved by the FDA, unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (i.e., The United States Pharmacopeia Drug Information; The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in peer-reviewed, national, professional medical journals.

- Prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances (other than related supplies).
- Implantable contraceptive products (note: these are covered in medical offices, but not through pharmacy).
- Drugs for erectile dysfunction.
- Any infertility drugs (oral or injectable).
- Prescription vitamins (other than prenatal), dietary supplements, and fluoride products.
- Drugs used for cosmetic purposes, such as reducing wrinkles, promoting hair growth, or controlling perspiration, drugs for onychomycosis, as well as fade cream products.
- Diet pills or appetite suppressants (anorectics).
- Biological products for allergy immunizations; biological sera; blood, blood plasma and other blood products or fractions; and medications used for travel prophylaxis.
- Drugs used to enhance athletic performance.
- Medications which are to be taken by (or administered to) you while you are a patient in a licensed hospital, skilled nursing facility, rest home, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Prescriptions more than one year from the original date of issue.

Pre-Existing Conditions Limitations

The Plan does not have pre-existing condition limitations.

PLAN ADMINISTRATION

Administration Information

This section contains some additional information about how the Plan is administered. This information about plan administration is provided in compliance with the Employee Retirement Income Security Act (ERISA) of 1974, as amended. ERISA was designed to protect your rights under your benefit program. While you should not need these details on a regular basis, the information may be useful if you have specific questions. For the purpose of this SPD, the term “Northern Light Health employee” refers to all employees of Northern Light Health member organizations who have elected to participate in this Plan.

Plan Year

The Plan is maintained on a calendar year basis, with Plan records running from January 1 to December 31 each year. Fiscal year records also are maintained from January 1 to December 31 each year.

Plan Identification Numbers

The Northern Light Health Employer Identification Number, as filed with the Department of Labor, is 01- 0527066. The ERISA plan name and number is the Northern Light Employee Health Plan, number 501.

Plan Sponsor and Administrator

Northern Light Health is the official sponsor and administrator of the Plan described in this SPD. The Plan administrator has the sole authority to interpret the terms of the benefit program. You may contact the Plan sponsor and administrator at:

Northern Light Health c/o HR Operations and
Rewards Department
43 Whiting Hill Road, Suite 200
Brewer, ME 04412

Agent for the Service of Legal Process
The agent for service of legal process is the:

Vice President, HR Operations and Rewards
Northern Light Health
43 Whiting Hill Road, Suite 200
Brewer, ME 04412

Service of legal process can also be served on the Plan administrator.

Plan Insurance and Funding

The Plan is self-insured. This means Northern Light Health pays medical benefits directly, using the TPA as the Plan administrator. You may share in the cost of medical coverage you elect during the annual enrollment period. The employer/employee contribution methodology is based upon a percentage of total costs.

Plan Documents

This document serves as the summary plan description or SPD and the Plan document. It describes the main provisions of the Plan in non-technical language. Some additional features of the Plans - particularly those that apply to very few employees or in special circumstances - may not be included here.

All documents filed with the U.S. Department of Labor, such as detailed annual reports and summary plan descriptions, are available for review without charge at the following location during normal business hours:

Northern Light Health

HR Operations and Rewards 43
Whiting Hill Road, Suite 200
Brewer, ME 04412

Upon written request to the above address, copies of these documents will be furnished to you within 30 days.

Your eligibility for or your right to benefits under the Plan should not be regarded as an expressed or implied contract or as a guarantee of continued employment at Northern Light Health or one of its member organizations.

Future of the Plan

Northern Light Health expects to continue the Plan described in this document indefinitely, but reserves the right to amend, modify, suspend or terminate it in whole or in part at any time. Any such action would be taken in writing and maintained with the records of the Plan. A decision to change or end the Plan may be due to changes in the laws governing employee benefits, the requirements of the Internal Revenue Code or ERISA, or for any other reason.

If the Plan is terminated, any eligible claims incurred before the date of termination will be paid to the extent assets held by the company are available (or according to the insurance contract for coverage), if submitted to the claims administrator within a reasonable period of time, as established by the Plan administrator.

Subrogation and Reimbursement of Claims

If the Plan pays benefits for any claim you incur as the result of negligence, willful misconduct, or other actions of a third party, the Plan will be subrogated to all your rights of recovery. You will be required to reimburse the Plan for amounts paid for claims out of any monies recovered from a third party, including, but not limited to, your own insurance company as the result of judgment, settlement or otherwise.

In addition, the Plan is entitled to reimbursement of any claim paid for which you receive compensation from a third party, other than a family member, for expenses that have been paid by the Plan.

Limitations on Assignment

Your rights and benefits under this Plan cannot be assigned, sold, transferred or pledged by you or reached by your creditors or anyone else except under limited circumstances (e.g., qualified domestic relations order).

Payment of Administrative Expenses

All reasonable expenses incurred in administering the Plan, including but not limited to administrative fees and expenses owing to any third-party administrative service provider, actuary, consultant, accountant, specialist, or other person or organization that may be employed by the Plan administrator in connection with the administration thereof, shall be paid out of plan assets, and, if plan assets are insufficient, by Northern Light Health.

YOUR COBRA RIGHTS

According to the Consolidated Omnibus Budget Reconciliation Act, commonly known as COBRA, you, your spouse and your children may elect to temporarily continue medical coverage if you lose your benefits under certain circumstances. You will be required to pay the full cost of coverage plus an administrative fee.

About COBRA Coverage

Individuals entitled to COBRA continuation (called qualified beneficiaries) are you, your spouse and your children, who are covered at the time of the event. In addition, a child who is born to you, adopted, or placed for adoption with you during the COBRA coverage period is also a qualified beneficiary.

Continued coverage is available for a maximum of 18, 29 or 36 months, depending on the circumstances called the “qualifying events” under which you are eligible for the continuation.

The maximum continuation period, if multiple circumstances occur, is a total of 36 months. This means that, if your dependents experience a second qualifying event within the original 18-month period, they (but not you) may extend the COBRA continuation period for up to an additional 18 months (for a total of up to 36 months from the original qualifying event).

COBRA CONTINUATION PERIOD

	Maximum Continuation Period:		
Qualifying Event	**Employee**	**Spouse**	**Child**
Employee loses coverage because of reduced work hours	18 months	18 months	18 months
Employee terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
Employee becomes entitled to Medicare	N/A	36 months	36 months
Employee or dependent is disabled (as defined by Title II or XVI of the Social Security Act) at the same time of the qualifying event or becomes disabled within the first 60 days of COBRA continuation coverage that begins as a result of termination or reduction in work hours	29 months	29 months	29 months
Employee dies	N/A	36 months	36 months
Employee and spouse legally separate or divorce	N/A	36 months	36 months
Employee becomes eligible for Medicare within 18 months prior to a second qualifying event (e.g., termination of employment or reduction in work hours)	N/A	36 months*	36 months*
Child attains age 26	N/A	N/A	36 months

*36-month period is counted from the date the employee becomes entitled to Medicare

Notification of COBRA Rights

The COBRA administrator will notify you by mail of your COBRA election rights when the qualifying event is a reduction in hours, a termination of employment, or you become eligible for Medicare.

You will receive instructions on how to continue your medical benefits under COBRA. In the event of your death, the COBRA administrator will notify your qualified beneficiaries (such as a spouse or child) as to continuing health coverage.

If you or a qualified beneficiary loses coverage due to divorce, legal separation or attainment of age 26, you (or a family member) must notify the HR Service Center within 60 days of the later of the event or the date the individual would lose coverage so that COBRA can be offered and election rights can be mailed to your qualified beneficiaries.

Also, to extend coverage beyond 18 months because of disability, notice of the Social Security Administration's determination of disability must be provided to the COBRA administrator during the initial 18-month period and within 60 days after the determination is issued. This extension will apply to each qualified beneficiary, whether disabled or not.

If Social Security determines that the qualified beneficiary is no longer disabled, the COBRA administrator must be notified within 30 days after this determination.

Electing and Paying for COBRA Coverage

You and/or your qualified beneficiaries must choose to continue coverage within 60 days after the later of the following dates:

- The date you and/or your qualified beneficiaries would lose coverage as a result of the qualifying event or
- The date the COBRA administrator notifies you and/or your qualified beneficiaries of your right to choose to continue coverage as a result of the qualifying event.

If you elect COBRA continuation coverage, you must pay the initial premium (including all premiums due but not paid) within 45 days after your election. Thereafter, COBRA premiums must be paid monthly and within 30 days of each due date. If you elect COBRA continuation but then fail to pay premium due within the initial 45-day grace period, or you fail to pay any subsequent premium within 30 days after the date it is due, your coverage will be terminated retroactively to the last day for which timely payment was made.

Cost

The cost of coverage under COBRA is 102% of the full group cost of Plan coverage per covered person. A dependent making separate elections will be charged the same rate as a single employee, plus 2%.

The cost of coverage from the 19th through the 29th months of coverage under the disability extension is the same, except as provided below:

- Up to a maximum of 150% of the full cost of coverage for all family members participating in the same coverage option as the disabled individual, and
- Up to a maximum of 102% for any family members participating in a different coverage option than the disabled individual.

However, if a second qualifying event occurs during the first 18 months of coverage, the 102% rate applies to the full 36 months even if the individual is disabled. If a second qualifying event occurs during the 19th through 29th month, then the rate for the 19th through 36th months of the COBRA continuation period is:

- The 150% rate for all family members participating in the same coverage option as the disabled individual, and

- The 102% rate for any family members in a different coverage option than the disabled individual.

When COBRA Ends

COBRA continuation for any person will end when the first of the following occurs:

- The applicable continuation period ends
- The initial premium for continued coverage is not paid within 45 days after the date COBRA is elected, or any subsequent premium is not paid within 30 days after it is due
- After the date COBRA is elected, the qualified beneficiary first becomes covered (as an employee or otherwise) under another group health plan not offered by Northern Light Health that does not contain an exclusion or limitation affecting the person's pre-existing condition, or the other plan's pre-existing condition limit or exclusion does not apply or is satisfied because of the HIPAA rules
- After the date COBRA is elected, the qualified beneficiary first becomes entitled to Medicare. (This does not apply to other qualified beneficiaries who are not entitled to Medicare.)
- In the case of the extended coverage period due to a disability, there has been a final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled. In such a case, the COBRA coverage ceases on the first day of the month that begins more than 30 days after the final determination is issued, unless a second qualifying event has occurred during the first 18 months
- For newborns and children adopted by or placed for adoption with you (the employee) during your COBRA continuation period, the date your COBRA continuation period ends unless a second qualifying event has occurred and
- The company terminates its group health coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

INITIAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
**** CONTINUATION COVERAGE RIGHTS UNDER COBRA****

Northern Light Health Employee Health Plan

Introduction

You're getting this notice because you recently gained coverage under the Northern Light Health Employee Health Plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should contact the HR Service Center.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage? COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. In providing this notice, you must use the Plan's form entitled Northern Light Health Medical/Dental/Flex Spending Account Enrollment/Change Form and attach required documentation (you may obtain a copy of this form from Northern Light Health at no charge, or you can download the form at benefits.emh.org). If these procedures are not followed or if the notice is not provided to Northern Light Health during the 60-day notice period, *THEN ALL QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHT TO ELECT COBRA.*

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify Benefit Strategies in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

The disability extension is available only if you notify Benefit Strategies in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction of hours; and
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of The Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. To provide proper notice, you must contact Benefit Strategies directly at 1-888-401-3539 and provide a copy of your Social Security Administration disability determination. If these procedures are not followed or if the notice is not provided to Benefit Strategies during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, ***THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE***

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

You may obtain information about the Plan and COBRA coverage on request from:

Northern Light Health HR Operations and Rewards
43 Whiting Hill Road
Suite 200
Brewer, ME 04412
207.973.4000 or 1-855-660-0202
hrservicecenter@northernlight.org

This contact information for the Plan may change from time to time. The most recent information has been included in this document.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

As required by the Women's Health and Cancer Rights Act of 1998, benefits are provided for mastectomy, including reconstruction and surgery to achieve symmetry between breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving benefits in connection with a mastectomy, benefits are also provided for the following covered services, as you determine appropriate with your provider:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for these covered services (including copayments and any annual deductible) are the same as are required for any other covered service. Limitations on benefits are the same as for any other covered service.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group medical plans and health insurance issuers generally may not restrict, under federal law, benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's providers, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not require, under federal law, that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

MEDICAL COVERAGE WHILE ON LEAVE

Coverage under the Family and Medical Leave Act (FMLA)

If you are currently employed by Northern Light Health or one of the member organizations that has adopted this Plan and if you have at least: one year of service with your current employer and have worked at least 1,250 hours in the previous 12 months for that employer, you may take unpaid family or medical leave for up to 12 weeks in a 12-month period (measured backward from the date any FMLA is used).

This leave may be used for:

- Parenting after the birth of your child (within the first 12 months of the child's life)
- Adoption or foster care of a child (within the first 12 months of adoption or foster placement)
- A serious health condition, either your own or an immediate family member's, such as spouse, child or parent, or a child for whom you stand *in loco parentis,* or an adult who stood *in loco parentis* to you when you were a child

Unless the need for absence is not foreseeable (e.g., an emergency medical situation), a request for an FMLA leave should be requested by completing an online leave request form, which is available on the Northern Light Health HR Landing Page > Leaves of Absence > Online Leave Request Tool. You may also call the HR Service Center for assistance processing the request or obtaining necessary forms. In the event a medical certification is required, you will need to provide either a completed US Department of Labor *Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)* or *Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)* as applicable. During the approved FMLA leave, an employee's position will be held open to the extent required by the FMLA, and the employer will maintain the employee's coverage under the Plan. It is the employee's responsibility to pay their share of applicable premiums.

Coverage under USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible individuals who enter military service. Generally, if you are on a military leave covered under USERRA, you are entitled to the same rights and benefits that Northern Light Health provides to similarly situated employees on other types of leave.

Under the Northern Light Health Military Leave Policy, your medical coverage continues for 12 weeks. You may continue your coverage by paying the same amount charged to active employees for the same coverage.

If your leave is for a longer period of time, you can elect to continue your coverage under COBRA. You will be charged up to the full cost of coverage. The maximum period of continuation coverage under COBRA available to you and your eligible dependents is the lesser of 18 months after the leave begins or the day the leave ends.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full regularly scheduled work day following your leave, safe transport home and an 8-hour rest period if you are on a military leave of less than 31 days
- Return to or reapply for reemployment 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 reemployment within 90 days of completion of your period of duty if your military service is for longer than 180 days

For more information on your USERRA rights, please contact the Northern Light Health HR Service Center.

COORDINATION WITH MEDICARE

If you are (1) retired and qualify for Medicare, or if you are (2) disabled, under age 65, not working and qualify for Medicare, and (3) you are covered under the Plan, Medicare is generally your primary coverage and the Plan is secondary. This means that Medicare will pay benefits first, and then your remaining expenses will be considered for reimbursement under the Plan. The Plan will pay the difference between what Medicare would pay and what the Plan would pay. Your claim will always be paid as if you are receiving any Medicare benefits for which you are eligible, even if you are not actually enrolled.

If you are an active employee who is disabled and covered under the Plan, the Plan is generally your primary coverage and Medicare is secondary. This means that the Plan will pay benefits first, and then your remaining expenses will be considered for reimbursement under Medicare. However, if you or a covered dependent became covered under Medicare on or after February 1, 1996, solely because of end stage renal (kidney) disease, then the Plan will continue to be your (or your covered dependent's) primary coverage for the first 30 months. After this time period, Medicare becomes your primary source of coverage.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

This Plan will comply with the terms of a qualified medical child support order (QMCSO). A QMCSO is an order or judgment from a court or administrative body directing the Plan to cover a child of a participant under the Plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a qualified medical child support order. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of receipt of the order and a copy of the Plan's procedure for determining if the order is valid. Coverage under the Plan pursuant to a QMCSO will not become effective until the Plan administrator determines that

the order is a valid QMCSO. If you have any questions or would like to receive, without charge, a copy of the written procedure for determining whether a QMCSO is valid, please contact the Northern Light Health HR Service Center.

COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PRIVACY AND SECURITY REGULATIONS

Special Enrollment Period

If you decline medical coverage for yourself or your dependents (including your spouse) because of other health insurance or group medical plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other non-COBRA coverage). However, you must request enrollment no later than 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Loss of eligibility for coverage includes (but is not limited to):

- Loss of eligibility as a result of legal separation, divorce, termination of dependent status (such as attaining the maximum age to be eligible as a child under the Plan), death of an employee, termination of employment, or reduction in the number of work hours of employment,
- In the case of coverage offered through an HMO, or other arrangement, in the individual or group market that does not provide benefits to individuals who no longer reside, live or work in the service area (whether or not within the choice of the individual), and with respect to an HMO in the group market, no other benefit package is available to the individual,
- A situation in which you incur a claim that would meet or exceed a lifetime limit on all benefits, in which case you will have 31 days after a claim is denied due to such a lifetime limit to special enroll in this Plan,
- In the case of an individual who has COBRA continuation coverage, at the time the COBRA continuation coverage is exhausted.
- If you acquire a new dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: employee only; employee and spouse; employee and child(ren); family. Enrollment of child(ren) is limited to the newborn or adopted child(ren) or child(ren) who became child(ren) of the employee due to marriage. Child(ren) of the employee not currently enrolled in the Plan are not entitled to special enrollment.
- If you and/or your dependents were covered under a state Medicaid or a Children's Health Insurance Program (CHIP) Plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- If you and/or your dependent(s) become eligible for assistance with group medical plan premium payments under a state Medicaid or CHIP Plan, you may request special enrollment for yourself and any affected dependent(s) that are not already enrolled in

the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

- Except as stated above, special enrollment must be requested within 31 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a child, coverage will be effective immediately on the date of the birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment or in the first of the month if the request is coincident with the first.

- Individuals who enroll in the Plan due to a special enrollment event will not be denied enrollment. You will not be enrolled in this Plan if you do not enroll within 31 days of the date you become eligible, unless you are eligible for special enrollment.

However, loss of eligibility for other coverage **does not include** a loss of coverage due to:

- The failure of you or your dependent to pay premiums on a timely basis,
- Voluntary disenrollment from a Plan, or
- Termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan).

HIPAA Certificate of Creditable Coverage

If you lose your coverage under this Plan, you will automatically be sent a HIPAA certificate of creditable coverage showing how long you had been covered. This document will provide the proof of coverage you may need to reduce any subsequent medical plan's preexisting medical condition limitation period that might otherwise apply to you. If you elect COBRA continuation coverage, when that coverage ends, you will automatically receive another certificate of creditable coverage.

You may also request a HIPAA certificate of creditable coverage at any time while covered under the Plan and up to 24 months after your coverage has ended.

To request a HIPAA certificate of creditable coverage, you must contact Beacon directly.

Permitted Use and Disclosure of Protected Health Information

Northern Light Health may only use and disclose protected health information it receives from the Plan as permitted and as is consistent with the HIPAA Privacy and Security regulations found at 45 CFR Part 164. This includes, but is not limited to, the right to use and disclose participant's protected health information (including electronic protected health information) in connection with payment, treatment and health care operations.

We agree to:

- Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law
- Ensure that any agents, including a subcontractor, to whom it gives protected health information, agrees to the same restrictions and conditions that apply to Northern Light Health with respect to such information

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan
- Not to use or disclose the information for employment-related actions and decisions or in connection with any other Northern Light Health benefit or employee benefit plan
- Report any use or disclosure of the information that is inconsistent with the uses or disclosures
- Report any security incident
- Make available protected health information in accordance with individuals' rights to review their protected health information
- Make available protected health information for amendment and incorporate any amendments to protected health information consistent with the HIPAA rules
- Make available the information required to provide an accounting of disclosures in accordance with the HIPAA rules
- Make its internal practices, books and records relating to the use and disclosure of protected information available to the Secretary of HHS for purposes of determining compliance
- If feasible, return or destroy all protected health information. Northern Light Health will not retain copies of protected health information when no longer needed for the purpose for which disclosure was made
- Not use genetic information for underwriting purposes
- Obtain the subject's authorization before using PHI for marketing purposes and before selling PHI

The Northern Light Employee Health Plan is required by law to make a copy of the Notice of Privacy Practices for the Northern Light Employee Health Plan available to you on request. For a free copy, please log on to the Northern Light Health Benefits intranet portal or call 207-973-4000 or 1-855-660-0202. You may request a copy in writing to Northern Light Health HR Operations and Rewards, 43 Whiting Hill Rd., Suite #200, Brewer, ME 04412.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State

listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility.

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/

Phone: 573-751-2005	Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

YOUR ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

- Receive assistance from EBSA's regional offices in obtaining documents from the Plan administrator, under which the Plan is established or operated.
- Obtain, upon written request to the Plan administrator, copies of all documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The administrator is required by law to furnish this report to each participant.
- Receive a certificate of creditable coverage, free of charge, from your group Medical Plan or medical insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases. You should request it before losing coverage or no later than 24 months after losing coverage. This certificate is designed to reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group medical plan. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion (if one exists) for 12 months (18 months for late enrollees) after you enroll in your new coverage.

Continue Group Medical Plan Coverage

Continue group health coverage for yourself or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD for the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group medical plan or medical insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who

are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for your denial. You have the right to have the administrator review and reconsider your claim.

Enforce Your Rights

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in federal court.

In such a case, the court may require the Plan administrator to provide materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reason beyond the control of the Plan administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you have the right to bring a civil action under section 502(a) of ERISA. Plan participants and beneficiaries may also obtain, without a charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order ("QMCSO") determinations. Participants and beneficiaries have the right to have matters involving the qualified status of medical child support orders resolved in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds 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, or you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office for the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

APPROVED AND ACCEPTED

This Plan Document, known as the Northern Light Employee Health Plan, is hereby executed at: Brewer, Maine 1/1/2020
(City) (State) (Date)

BY: _____
Jaime Nicole Audet

TITLE: VP, HR Operations and Total Rewards

Exhibit A

Key Benefit Information

	Base Plan			Buy-up Plan		
	Preferred	**In-Network**	**Out-of-Network**	**Preferred**	**In-Network**	**Out-of-Network**
Annual Employee Funded Health Reimbursement Account (HRA)	Specific information about HRA contributions can be found on page 12 of the Summary Plan Document					
Annual Deductible	$2,500 Ind $5,000 Fam	$3,000 Ind $6,000 Fam	$4,000 Ind $8,000 Fam	$1,500 Ind $3,000 Fam	$2,000 Ind $4,000 Fam	$3,000 Ind $6,000 Fam
Annual Out of Pocket Maximum	$4,000 Ind $8,000 Fam	$4,500 Ind $9,000 Fam	$5,500 Ind $11,000 Fam	$3,000 Ind $6,000 Fam	$3,500 Ind $7,000 Fam	$4,500 Ind $9,000 Fam
Preventive Care Services	100% Paid		50% after deductible	100% Paid		50% after deductible
Office Visit: Primary Care Provider (PCP)	$25 copay	30% after deductible	50% after deductible	$25 copay	30% after deductible	50% after deductible
Office Visit: OB/GYN	$25 copay	30% after deductible	50% after deductible	$25 copay	30% after deductible	50% after deductible
Outpatient Mental Health services: Provided by a licensed behavioral health professional (includes Individual and Group Therapy)	$25 copay	30% after deductible	50% after deductible	$25 copay	30% after deductible	50% after deductible
Urgent Care Services	20% after deductible			20% after deductible		
Emergency Care Services Note: In-network and out-of-network Emergency and Urgent Care services are processed at the in-network level of coverage regardless of location	30% after deductible			30% after deductible		
Other Services: - Specialist Office Visit - Inpatient & Outpatient Services (i.e. inpatient hospital services; laboratory; x-ray; MRI; PET, and CAT scans, maternity services, and durable medical equipment)	20% after deductible	30% after deductible	50% after deductible	20% after deductible	30% after deductible	50% after deductible
Prescription Benefits						
1 to 30 day supply	$0/$10/$30/$50	$0/$20/$40/$60	Not covered	$0/$10/$30/$50	$0/$20/$40/$60	Not covered
Maintenance drugs (Miller Drug -- 90 day supply)	$0/$20/$60/$100	Not covered	Not covered	$0/$20/$60/$100	Not covered	Not covered
Mail Order (Miller Drug -- 90 day supply)	$0/$20/$60/$100	Not covered	Not covered	$0/$20/$60/$100	Not covered	Not covered

Percentages indicate employee share of coinsurance after deductible

Exhibit B
Benefit Highlights for all Plans

Service	PREFERRED (Employee Pays)	IN-NETWORK (Employee Pays)	OUT-OF-NETWORK* (Employee Pays)
Primary Care Physician (PCP) & OB/GYN			
Office Visit: PCP	$25 copay**	30% of charges	50% of charges
Office Visit: OB-GYN	$25 copay**	30% of charges	50% of charges
Allergy Treatment/Injections - PCP or Specialty Physician	20% of charges	30% of charges	50% of charges
Allergy Serum (dispensed by physician in office)	20% of charges	30% of charges	50% of charges
eVisits: covered up to a maximum of $35 per eVisit	Plan pays at 100%, no Plan deductible		n/a
Specialty Physician Office Visit			
Visits, Consultations, and Referral Physician Services	20% of charges	30% of charges	50% of charges
Chiropractic Care Up to a maximum of 20 days per calendar year	20% of charges	30% of charges	50% of charges
Preventive Care (See Exhibit C for complete guidelines)			
Routine Preventive Care Includes Well Baby and Well Child Care	Plan pays at 100%, no Plan deductible		50% of charges
Immunizations	Plan pays at 100%, no Plan deductible		50% of charges
Colon cancer screening	Plan pays at 100%, no Plan deductible		50% of charges
Mammograms, PSAs, Pap Tests - Preventive Screenings	Plan pays at 100%, no Plan deductible		50% of charges
Colonoscopy, Mammogram, PSA, Pap Test - Diagnostic (follow-up services) Note: Diagnostic related services are paid at the same level of benefits as other x-ray and lab services	20% of charges	30% of charges	50% of charges
Vision Care One eye (refraction) exam covered every calendar year	Plan pays at 100%; no deductible		Plan pays at 100%; no deductible
Emergency and Urgent Care Services Note: In-network and out-of-network Emergency and Urgent Care services, including ambulance, are processed at the in-network level of coverage. Total charges for out-of-network urgent and emergency claims are paid as the allowable rate for processing.			
Urgent Care Facility	20% of charges		
Hospital Emergency Room***	30% of charges		
Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician)	30% of charges		
Ambulance	30% of charges		

Service	PREFERRED (Employee Pays)	IN-NETWORK (Employee Pays)	OUT-OF-NETWORK* (Employee Pays)
Outpatient Services			
Outpatient Facility Services includes: Operating Room, Recovery Room, Procedure Room, Treatment Room, and Observation Room, including: Diagnostic/Therapeutic Lab and X-Rays; Anesthesia and Inhalation Therapy	20% of charges	30% of charges	50% of charges
Physician & Outpatient Professional Services	20% of charges	30% of charges	50% of charges
Outpatient Cardiac Rehabilitation	20% of charges	30% of charges	50% of charges
Transplant Services	100% of charges through Optum/Transplant Resource Network	30% of charges	Not covered
Travel benefits for authorized transplants are limited to $200 per day and a $5,000 maximum per transplant episode	Plan pays 100%, no deductible		Not covered
Inpatient Services			
Inpatient Hospital Services including: Semi-Private Room & Board Diagnostic/Therapeutic Lab & X-Ray Drugs & Medication Operating & Recovery Room Radiation Therapy & Chemotherapy Anesthesia & Inhalation Therapy MRIs, MRAs, CAT Scans, PET Scans, etc.	20% of charges	30% of charges	50% of charges
Inpatient Hospital Doctor's Visits / Consultations	20% of charges	30% of charges	50% of charges
Inpatient Hospital Professional Services	20% of charges	30% of charges	50% of charges
Inpatient Services at Other Health Care Facilities Skilled Nursing, Rehabilitation and Sub-Acute Facilities up to a maximum of 121 days per calendar year	20% of charges	30% of charges	50% of charges
Laboratory & Radiology Services (includes preadmission testing)			
Physician's Office: PCP	20% of charges	30% of charges	Not covered
Physician's Office: OB-GYN	20% of charges	30% of charges	50% of charges
Physician's Office: Specialist	20% of charges	30% of charges	50% of charges
Outpatient Hospital Facility	20% of charges	30% of charges	50% of charges
Urgent Care Facility	20% of charges		
Emergency Room	30% of charges		

Service	PREFERRED (Employee Pays)	IN-NETWORK (Employee Pays)	OUT-OF-NETWORK* (Employee Pays)
Independent X-ray and/or Lab Facility	20% of charges	30% of charges	50% of charges
Independent X-ray and/or Lab Facility (in conjunction with an Emergency Room visit)	30% of charges		
Advanced Radiological Imaging (MRIs, MRAs, CAT Scans, PET Scans, etc.)			
Physician's Office	20% of charges	30% of charges	50% of charges
Outpatient Facility	20% of charges	30% of charges	50% of charges
Emergency Room (billed by facility as part of the Emergency Room visit)	30% of charges		
Family Planning Services* (Exclusion for Mercy employees and dependents: Refer to Plan Document sections on Qualifying Religious Organizations)			
Office Visits (tests, counseling)	Plan pays at 100%, no Plan deductible		50% of charges
Tubal Ligation	Plan pays at 100%, no Plan deductible		50% of charges
Vasectomy	Plan pays at 100%, no Plan deductible		50% of charges
Infertility Services (Exclusion for Mercy employees and dependents: Refer to Plan Document sections on Qualifying Religious Organizations)			
Office Visit: PCP	$25 copay**	30% of charges	50% of charges
Physician's Office: OB-GYN	$25 copay**	30% of charges	50% of charges
Physician's Office: Specialist (lab & radiology tests, counseling)	20% of charges	30% of charges	50% of charges
Treatment/Surgery (excludes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.)	20% of charges	30% of charges	50% of charges
Maternity Care Services			
Initial Office Visit to Confirm Pregnancy: PCP	$25 copay**	30% of charges	50% of charges
Initial Office Visit to Confirm Pregnancy: OB-GYN	$25 copay**	30% of charges	50% of charges
Initial Office Visit to Confirm Pregnancy: Specialist	20% of charges	30% of charges	50% of charges
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee)	20% of charges	30% of charges	50% of charges
Office Visits not included in the total maternity fee performed by OB or Specialty Physician: PCP	$25 copay**	30% of charges	50% of charges
Office Visits not included in the total maternity fee performed by OB or Specialty Physician: OB-GYN	$25 copay**	30% of charges	50% of charges
Office Visits not included in the total maternity fee performed by OB or Specialty Physician: Specialist	20% of charges	30% of charges	50% of charges
Delivery - Facility (Inpatient Hospital/Birthing Center Charges) Note: Home births are covered at the preferred level only	20% of charges	30% of charges	50% of charges

Service	PREFERRED (Employee Pays)	IN-NETWORK (Employee Pays)	OUT-OF-NETWORK* (Employee Pays)
Childbirth Classes (one class per lifetime; up to a maximum of $100)	Plan pays 100%, no deductible		
Lactation Consultations	Plan pays 100%	30% of charges	50% of charges
Breast Pumps Rentals: covered at 100% Purchase of a breast pump: covered up to a maximum of $300 per lifetime	Plan pays 100%	30% of charges	50% of charges
Bariatric Surgery			
Bariatric Surgery	20% of charges	Not covered	Not covered
Outpatient Mental Health****			
Outpatient Mental Health services provided by a licensed behavioral health professional (includes Individual and Group Therapy)	$25 copay**	30% of charges	50% of charges
Inpatient Mental Health****			
Inpatient Mental Health services (includes Inpatient facility & professional services)	20% of charges	30% of charges	50% of charges
Outpatient Substance Abuse			
Outpatient Substance Abuse services (includes screening and intervention services)	$25 copay**	30% of charges	50% of charges
Inpatient Substance Abuse			
Inpatient Substance Abuse services (includes detoxification and non-hospital residential rehabilitation)	20% of charges	30% of charges	50% of charges
Home Health Services			
Home Health Services a. 16 hour maximum per day b. Private duty not covered	20% of charges	30% of charges	50% of charges
Rehabilitation			
Short-Term Rehabilitative --(includes physical, speech, occupational, pulmonary rehab & cognitive therapy) Combined maximum of 60 days per calendar year (not per modality). Notes: a. Therapy sessions provided as part of Home Health Care accumulate toward the Short-Term Rehab Therapy maximum benefit. b. If more than one visit or service within a day, it will only count as one day toward the maximum.	20% of charges	30% of charges	50% of charges

Service	PREFERRED (Employee Pays)	IN-NETWORK (Employee Pays)	OUT-OF-NETWORK* (Employee Pays)
Durable Medical Equipment			
Durable Medical Equipment	20% of charges	30% of charges	50% of charges
External Prosthetic Appliances	20% of charges	30% of charges	50% of charges
Hair Prostheses (wigs) When prescribed by a physician for a patient who suffers hair loss as a result of disease. Up to an annual maximum of $350 will be paid.	Plan pays 100%	Plan pays 100%	Plan pays 100%
Orthotics	20% of charges	30% of charges	50% of charges

Footnotes:

Note: All co-insurance percentages are the member's share of the cost and are paid after deductible has been met.

* Out of Network: (a) prior-authorization may be required to obtain coverage, refer to Summary Plan Description for additional information;
(b) out-of-pocket costs will be higher because cost is based on reasonable and customary charges (not negotiated rates) and subject to balance billing for charges above and beyond reasonable and customary. In addition, members may have to file claims for reimbursement.

** Copay applies only to the office visit charge. There may be additional services rendered (i.e., labs, x-rays, etc.) during the office visit that may be billed separately and will be applied to the Plan deductible and out-of-pocket maximum. Copays do not apply to plan deductible.

*** When certain services, such as labs, radiology, and CT scans for example, are provided in conjunction with an ER visit during which the subscriber is held in observation prior to or without hospital admittance, those charges may be billed as part of the ER visit and generally will not be billed separately as outpatient procedures.

**** Acadia Hospital employees have access to In-Network inpatient mental health providers at the Preferred level.

Exhibit C

Preventive Health Coverage

Effective 010120

Members have access to these preventive care services without copay or co-insurance when provided by a preferred or in-network provider. While preventive care services are also covered when provided out-of-network, they are covered at a lower coinsurance rate and are subject to the Plan deductible.

These preventive health services are based on requirements from the Patient Protection and Affordable Care Act (PPACA) and *re*commendations from the U.S. Preventive Services Task Force (USPSTF), the Human Resources & Services Administration (HRSA), the Advisory Committee on Immunization Practices (ACIP) for immunizations, the American Academy of Pediatrics' (AAP) Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, and the American Academy of Family Practice (AAFP). For additional information on immunizations, visit the immunization schedule section of www.cdc.gov.

Wellness Exams and Immunizations				
	Birth to 2 years	**Ages 3 to 10**	**Ages 11 to 21**	**Ages 22 and older**
Well-baby/well-child/well-person exams: includesheight, weight, head circumference, BMI, history, anticipatory guidance, education regarding risk reduction, psychological/behavioral assessment. Note: There may be member cost sharing for some services dependent on your benefit plan	Birth, 1, 2, 4, 6, 9, 12, 15, 18, 24 and 30 months. Additional visit at 3-5 days after birth and within 72 hours after discharge	Once a year	Once a year	Periodic visits, depending on age
Diphtheria, tetanus toxoids and acellular pertussis (DTaP)	2, 4 and 6 months and 15-18 months	Ages 4-6	Tetanus, diphtheria, acellular pertussis (Tdap) given once, ages 11-64	Tetanus and diptheria toxoids booster (Td) every 10 years; Tdap given once, ages 11-64
Haemophilus influenza type b conjugate (Hib)	2, 4 and 6 months and 12-15 months			
Hepatitis A (HepA)	12-23 months			May be required for persons at risk
Hepatitis B (HepB)	At birth, 1-4 months and 6-18 months	Ages 3-10 if not previously immunized	Ages 11-18 if not previously immunized	May be required for persons at risk

	Birth to 2 years	Ages 3 to 10	Ages 11 to 21	Ages 22 and older
Human papillomavirus (HPV): limit 3 per lifetime		Ages 9-10 per provider	Ages 11-12, catch-up, ages 13-26	Catch-up, through age 26
Influenza vaccine	Annually at 6 months	Annually	Annually	Annually
Measles, mumps and rubella (MMR)	Ages 12-15 months (first dose)	Ages 4-6 (second dose) or 11 and 12 if not given earlier	Per Provider	Per Provider
Meningococcal (MCV)	Ages 2 months – 10 years per provider		All persons ages 11-18 (two doses if given before 16 years)	Per Provider
Men B		Age 10 per provider	Per Provider	22-25 per provider
Pneumococcal (pneumonia)	PCV 13: 2, 4 and 6 months and 12-15 months PPSV 23: per provider	PPSV 23: per provider	Ages 19-64 PCV 13 one dose per provider	Ages 65 and older PCV 13 one dose if not previously vaccinated PPSV 23 one dose at least one year after PCV 13 Revaccination per provider for those with risk factors.
Poliovirus (IPV)	2 and 4 months and 6-18 months	Ages 4-6	Per provider	Per provider
Rotavirus	RV 5 (3 doses) at 2, 4, and 6 months RV 1 (2 doses) at 2 and 4 months			
Varicella (chickenpox)	Ages 12-15 months (first dose)	Ages 4-6 (second dose)	Age 13+: 2 doses if never vaccinated or never had chickenpox	Age 13+: 2 doses if never vaccinated or never had chickenpox
Zoster (Shingles)				Ages 50 and older: two doses of recombinant vaccine Ages 60 and older: one dose of live vaccine per provider if can't tolerate recombinant vaccine

Health screenings and interventions				
	Birth to 2 years	**Ages 3 to 10**	**Ages 11 to 21**	**Ages 22 and older**
Alcohol, Drugs, & Tobacco Assessments			Ages 11+: per provider	All adults per provider
Autism	18, 24 months			
Blood pressure		Annually	Annually	Annually
Cholesterol/lipid disorders	Age 2 per provider	Age 10 Ages 4, 6, 8, 9 per provider	Age 20 Ages 11-19: per provider	Ages 40-75: per provider
Colon cancer screening				The following tests will be covered for colorectal cancer screening, ages 45 -85 (or at any age if risk factors): 1. Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) annually 2. Flexible sigmoidoscopy every 5 years 3. Colonoscopy every 10 years
Congenital hypothyroidism screening	Birth			
Depression screening			Ages 12-21	Per provider
Developmental screening	9, 18 months	30 months		

	Birth to 2 years	Ages 3 to 10	Ages 11 to 21	Ages 22 and older
Developmental surveillance	Newborn, 1, 2, 4, 6, 12, 15, 24 months	Annually	Annually	
Diabetes care: includes HbA1c screening, LDL-C screening and nephropathy screening	Per provider	Per provider	Per provider	Per provider
Diabetes screening – 82947, 82951, 82952				Ages 40-70 who are overweight or obese
Fluoride supplementation	Ages 6m+: per provider	Per provider	Ages 11-16: per provider	
Lung Cancer Screening with Low Dose Computerized Tomography (LDCT)				Adults Aged 55-80, with a 30 pack year history of smoking, are currently smoking or quit within the past 15 years. Stop screening once smoke-free for 15 years.
Hearing screening: not complete hearing examination	Birth, 3-5 days Ages 4,6,9,12,15,18,24,30m: per provider	Ages: 4,5,6,8 and 10, Ages 3,7,9y: per provider	Ages 13,16,20 Ages 11-21: per provider	
Hemoglobin or hematocrit	12 months Ages 4, 15+m: per provider	Ages 3+: per provider	Ages 11+: per provider	Per Provider
Hepatitis B Screening			Per Provider	Per Provider
Hepatitis C Screening			Per Provider	Per Provider
HIV Screening			Age 17 Ages 11-21: per provider	Per Provider
Iron supplementation	Ages 6m+: per provider			
Labs – BMP, CMP, TSH CBC		Per Provider	Per Provider	Per Provider

	Birth to 2 years	Ages 3 to 10	Ages 11 to 21	Ages 22 and older
Lead screening	Ages 12,24 months Ages 6,9,18m: per provider	Ages 3-6: per provider		
Metabolic/hemoglobinopathies: according to state law	Birth			
Nutrition counseling			Adults with hyperlipidemia, those at risk for cardiovascular disease or diet- related chronic disease per provider	Adults with hyperlipidemia, those at risk for cardiovascular disease or diet- related chronic disease per provider
Obesity Screening and Counseling		Age 6 +: per provider	Per provider	Per provider
PKU screening	Birth			
Prophylactic ocular (eye) medication to prevent blindness	Birth			
Prostate cancer screening (PSA)				Men Ages 55-69: per provider
Sexually transmitted infections (STI)			Ages 11-21: per provider	Per provider
Sickle cell disease screening	Birth			
Syphilis Screening			Per provider	Per provider
Tobacco use/cessation interventions			All adults	All adults
Tuberculin test	Per provider	Per provider	Per provider	Per provider
Ultrasound aortic abdominal aneurysm screening				Men ages 65-75 who have ever smoked; limited to one per lifetime
Vision Screening	Per provider	Ages: 3,4,5,6,8 and 10 Other Ages: per provider	Ages: 12, Other Ages: per provider	

Women's Health Screenings and Interventions	
Anemia screening	Pregnant women
Bacteriuria screening	Pregnant women in the 12th-16th week of gestation or during the first prenatal visit, if such a visit is later than the 12th-16th week period
Breast cancer screening (mammogram)	Age 40+: up to annually, per provider (HRSA)
Breastfeeding promotion	During pregnancy and after birth
Breastfeeding support, supplies and counseling	Provide interventions during pregnancy and after birth to support breastfeeding, including rental costs for breastfeeding equipment.
Cervical cancer screening	Ages 21-65: Pap Test (Cytology) every 3 years or Ages 30-65: High Risk Human Papilloma Virus (hrhpv) DNA Testing with or without Pap Test (Cytology) every 5 years or Age 30+ with normal cytology, hrhpv DNA Testing every 3+ years (HRSA)
Chlamydia screening	Sexually active women ages 24 or younger, and older women per provider based on risk
Contraceptive Methods & Counseling	All FDA approved methods and sterilizations procedures, and patient education per provider
Culture for Group B strep	Pregnant women
Discussion/referral for counseling related to BRCA1/ BRCA2 test	Women at risk
Discussion about potential benefits/risk of breast cancer preventive medication	Women at risk
Domestic Violence Screening & Counseling	Per Provider

Folic acid supplementation: a written or oral prescription must be provided by a provider and presented to a preferred pharmacy or preferred mail order pharmacy for coverage by the plan	Women planning or capable of pregnancy
Gestational diabetes screening	Pregnant women between 24 and 28 weeks of pregnancy and at the first prenatal visit for women at high risk
Gonorrhea screening	Sexually active women ages 24 and younger, and older women per provider based on risk
Hepatitis B screening	Pregnant women at first prenatal visit
HIV Screening	All pregnant women and annually for all sexually active women
HIV counseling	Annually for all sexually active women
Osteoporosis (bone density) screening	Age 65 and older and Age under 65 with increased risk of osteoporosis based on formal clinical risk assessment tool.
Rh incompatibility test	Rh (D) blood typing and antibody testing for all pregnant women during the first prenatal visit and a repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks of gestation, as required
Syphilis screening	Pregnant women and women at risk
Tobacco use/cessation interventions	Pregnant women and other tobacco users
Urine tests	Pregnant women
Vitamins and supplements	Pregnant women
Wellness	Annual

Revised: January 1, 2020

Northern Light Health - System Policy

Policy #: 17-025 Date: 2/4/2016
Date last reviewed: 2/2016
Supersedes#: New Dated:

Title: Affordable Care Act

Author: Peter Close, VP HR Operations & Rewards
Executive Sponsor: VP & General
Counsel (For Human Resources)
Northern Light Health President/CEO

APPLICABILITY

☒Northern Light Health adopts the following Policy (and any Attachment(s)) for all its Member Organizations, specifically including those listed below:
☐Northern Light Health adopts the following Policy (and any Attachment(s)) for its Member Organizations selected below:

☐ Acadia Healthcare ☐ Lakewood Continuing Care Center
☐ Acadia Hospital ☐ Maine Coast Memorial Hospital
☐ Affiliated Lab ☐ Mercy Hospital
☐ Beacon Health ☐ Meridian Mobile Health
☐ Blue Hill Memorial Hospital ☐ Miller Drug
☐ CA Dean Memorial Hospital ☐ Sebasticook Valley
☐ Eastern Maine Medical Center ☐ The Aroostook Medical Center
☐ Northern Light Health Foundation ☐ VNA Home Health & Hospice
☐ Northern Light Health Home Office ☐ WorkHealth
☐ Inland Hospital ☐ Other (list): _____

This policy was approved by those noted below on the date(s) as noted:
Northern Light Health Leadership Council, 01/19/2016
HR Policy Standardization Task Group, 11/20/2015

RELATED REFERENCE(S)

System Policy 17-022, Non-Statutory Leaves of Absence
System Policy 17-023, Federal and State Military Leaves of Absence
System Policy 17-024, Federal and State Family and Medical Leaves of Absence
Employee Health & Welfare Benefits
Employee Status

DEFINITIONS

ACA: The Patient Protection and Affordable Care Act.

ACA FT Employee: An employee who either i) is hired to work 130+ hours per month (30+ hours per week) or ii) averages 130+ hours per month (30+ hours per week) during a

Measurement Period. All hours worked, including OT, plus paid leave and statutory leave are included.

ACA PT Employee: An employee who is neither i) hired to work 130+ hours per month (30+ hours per week) nor ii) averages 130+ hours per month (30+ hours per week) during a Measurement Period. All hours worked, including OT, plus paid leave and statutory leave are included.

ACA Seasonal Employee: An employee hired into a position for which the customary annual employment is six months or less. "Customary" means that: 1) by the nature of the position an employee typically works for a period of six months or less, and 2) the period of employment should begin each calendar year in approximately the same part of the year, such as summer or winter.

ACA Variable Hour Employee: A newly hired employee whose hours are variable or uncertain such that, based on the facts and circumstances on the employee's start date, an employer cannot determine whether such employee is reasonably expected to work an average of at least 30 hours per week during the initial Measurement Period.

Administrative Period: The period during which employers are to process the measurement period numbers and offer coverage to ACA FT Employees. Northern Light Health uses a 2 month Administrative Period.

Break-in-Service: A period of 13 consecutive weeks during which an ACA FT Employee has no hours worked and/or is on non-statutory, unpaid leave. If an ACA FT Employee returns after a Break-in-Service, he or she is treated as a new employee for benefits enrollment purposes.

Hours of Service: Each hour for which an employee is paid, or entitled to payment, for the performance of duties for an Northern Light Health Member Organization, and each hour for which an employee is paid, or entitled to payment, by a Northern Light Health Member Organization for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence.

On-Going Employee: Incumbent employees.

Plan: The Northern Light Employee Medical Plan.

Measurement Period: The period used to calculate average hours in order to determine whether an employee is an ACA FT Employee. Northern Light Health uses a 12 month Measurement Period.

Stability Period: A period equal in duration to the Measurement Period during which an employee's status must remain set as an ACA FT or PT Employee regardless of whether the employee's hours change.

Temporary Employees: Referred to as short-term employees under the ACA, are those employees hired into a position that is less than 12 months in length. If reasonably expected to average 130+ hours per month (30 hours per week), temporary employees should be classified as ACA FT and eligible for medical coverage and offered coverage the first day of the month following 60 days from date of hire.

For more information on temporary employees, refer to the HR policy on Employee Status.

POLICY EFFECTIVE: January 1, 2016

PURPOSE
To offer medical insurance coverage in accordance with the ACA.

POLICY
All new employees expected to work an average of 130 hours or more a month when hired are eligible to participate in the Plan beginning the first of the month following date of hire. On-Going Employees who average 130 hours or more per month during a Measurement Period will be eligible to participate in the Plan during a Stability Period. This policy does not change the existing Northern Light Health Member Organization benefits eligibility as stated in the HR policy "Employee Status" to the extent such policy is more generous.

EMPLOYEES COVERED BY COLLECTIVE BARGAINING AGREEMENTS
Collective bargaining agreements may contain provisions that either supersede or are supplemental to the provisions of this policy. Managers with staff covered by a collective bargaining agreement should refer to the provisions of the applicable collective bargaining agreement.

PROCEDURE
1. This policy does not change the existing Northern Light Health Member Organization benefits eligibility as stated in the HR policy "Employee Status" to the extent such policy is more generous.

2. Determining ACA FT Employees:
    a. Northern Light Health has adopted the look back measurement method in order to determine whether or not an employee is an ACA FT Employee.
    b. Variable Hour and ACA PT Employees will be measured according to the initial Measurement Period, described below. Northern Light Health will continue to track employee hours under the Measurement Period for On-Going Employees as long as the employees are employed.

3. ACA FT Employees, who are not in Northern Light Health benefits-eligible budgeted position, will be offered coverage under the Plan at a Northern Light Health system-wide employee-only cost-share premium. These employees may add their dependent children to their coverage without an employer subsidy. Premiums will be communicated directly to employees at the time the Northern Light Health HR Service Center contacts them to offer medical insurance coverage.

4. Measurement, Stability, and Administrative Periods – On-Going Employees:
Northern Light Health has adopted a look back Measurement Period in order to determine whether or not an On-Going Employee is an ACA FT Employee. During the Measurement Period, Northern Light Health will average an employee's Hours of Service in order to determine whether he/she is an ACA FT Employee. The Measurement Period is followed by a subsequent Stability Period during which the employee will be deemed to have worked the same hours as he or she did during the Measurement Period. The Administrative Period gives Northern Light Health time to measure whether an employee is an ACA FT Employee. The use of this look back method avoids fluctuations in full-time status for employees during the Stability Period. The beginning and ending dates for these periods are as follows:

- Measurement Period: The Measurement Period for On-Going Employees is November 1 through October 31 of each year.
- Administrative Period: The Administrative Period for On-Going Employees will begin on November 1 and will end on December 31 of each year.
- Stability Period: The Stability Period for On-Going Employees will start on January 1 and end on December 31 of each year.

5. Measurement, Stability, and Administrative Periods – New Employees:
New variable, part-time and seasonal employees who are not considered ACA FT Employees on their start date will be monitored during an initial Measurement Period to determine whether they will be ACA FT Employees during the subsequent Stability Period. Once an employee has been employed for an entire standard Measurement Period, the employee will be considered an On-Going Employee for subsequent Measurement Periods.

- Measurement Period: The initial Measurement Period will begin on the first day of the month following the new employee's date of hire and will end on the last day of the 11^{th} month following date of hire.
- Administrative Period: The Administrative Period for New Employees is two months following the end of the Initial Measurement Period.
- Stability Period: The initial Stability Period is the 12 month period beginning on the first day of the third calendar month after the end of the initial Measurement Period.

6. Change in Status for On-Going Employee: An employee changing from Northern Light Health benefits-eligible to ACA PT Employee status will continue to be eligible for coverage for three months at the Northern Light Health system-wide employee-only cost-share premium and cover his or her dependent children at 100% cost without employer subsidy. At the end of the three months, if the employee did not average 130+ hours per month, the employee will cease to be eligible for medical insurance coverage. If the employee averages 130+ hours per month during the three month period, medical insurance coverage will continue through the Stability Period and be treated as an On-Going Employee, eligible to receive the Northern Light Health system-wide employee-only cost-share premium and cover his or dependent children at 100% cost without employer subsidy.

ATTACHMENT(S): None.

Northern Light Employee Health Plan
Medical Benefit Claims and Appeals Procedures

1. Introduction

1.1 Introduction

Under Department of Labor (“DOL”) regulations, claimants are entitled to full and fair review of any claims made under the Northern Light Employee Health Plan (the "Plan"). The procedures described in this document are intended to comply with DOL regulations by providing reasonable procedures governing the filing of claims for Plan benefits, notification of benefit decisions, and appeal of adverse benefit determinations.

1.2 Purpose of This Document

This document, which is a separate document that accompanies the Northern Light Employee Health Plan Document and Summary Plan Description (“SPD”), describes how benefit claims and appeals are made and decided under the Plan. The SPD describes the benefits provided under the Plan. For a description of the appeals process for pharmacy claims, please see Plan’s Appeals Process – Pharmacy attached to the SPD Exhibit H.

2. Definitions

Certain words and phrases that are used frequently throughout this document are explained below. If you are uncertain about the meaning of a word or phrase, contact the Plan Administrator for further clarification.

2.1 Claim

A "Claim" is any request for a Plan benefit or benefits made in accordance with these claims procedures. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a Claim under these procedures. Any request for Plan benefits that is not made in accordance with these claims procedures is considered an incorrectly filed claim.

2.2 Claimant

You become a "Claimant" when you make a request for a Plan benefit or benefits in accordance with these claims procedures.

2.3 Plan

The "Plan" is the Northern Light Employee Health Plan.

2.4 Plan Administrator and Named Fiduciary

Northern Light Health is the "Plan Administrator" and "Named Fiduciary" under the Plan with the ultimate responsibility for making claim and appeal decisions. Northern Light Health has the discretionary authority to interpret the Plan in order to make benefit decisions as it may determine in its sole discretion. Northern Light Health also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan. Northern Light Health has contracted with Beacon Health to assist in the claims processing and appeals process, but has not delegated final decision making to Beacon Health.

3. Types of Claims

3.1 Different Rules Apply

As described below, there are four categories of Claims that can be made under the Plan, each with somewhat different claim and appeal rules. The DOL regulations set different requirements based on the type of Claim involved. The primary difference is the timeframe within which claims and appeals must be determined. It is very important to follow the requirements that apply to your particular type of Claim. If you have any questions regarding what type of Claim and/or what claims procedure to follow, contact the Plan at the address indicated under "General Filing Rules."

3.2 Four Claim Types

3.2.1 Pre-Service Claim

A Claim is a pre-service claim if the SPD specifically conditions receipt of the benefit, in whole or in part, on receiving approval in advance of obtaining the medical care-unless the Claim involves urgent care, as defined below. Benefits under the Plan that require approval in advance are specifically noted in the SPD as being "subject to prior authorization" and “pre-certification.” For benefits not noted as being "subject to “prior authorization” or “pre-certification," no advance approval is necessary, and any request for advance approval will not be treated as a Claim.

3.2.2 Urgent Care Claim

An urgent care claim is a special type of pre-service claim. A Claim involving urgent care is any pre-service claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to pre-service claims could seriously jeopardize the Claimant's life or health or ability to regain maximum function, or would-in the opinion of a physician with knowledge of the Claimant's medical condition-subject the Claimant to severe pain that cannot be adequately managed

without the care or treatment that is the subject of the Claim.

On receipt of a pre-service claim, the Plan will make a determination as to whether it involves urgent care; in any event, a Claim will be treated as an urgent care claim if a physician with knowledge of the Claimant's medical condition indicates that the Claim involves urgent care.

3.2.3 Post-Service Claim

A post-service claim is any Claim for a benefit under the Plan that is not a pre-service claim, an urgent care claim, or a concurrent care claim.

3.2.4 Concurrent Care Claim

A concurrent care decision occurs where the Plan approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (a) where reconsideration of previously approved care results in a reduction or termination of the initially approved period of time or number of treatments; and (b) where an extension is requested beyond the initially approved period of time or number of treatments.

3.3 Change in Claim Type

The Claim type is determined initially when the Claim is filed. However, if the nature of the Claim changes as it proceeds through the claims process, the Claim may be re-characterized. For example, a Claim may initially be an urgent care claim. If the urgency subsides, it may be re-characterized by the Plan as a pre-service claim.

4. How to File a Claim for Benefits

4.1 General Filing Rules

Except for urgent care claims, discussed below, a Claim for Plan benefits is made when a Claimant submits a written Claim for Benefits form to:

The Northern Light Employee Health Plan
C/o Beacon Health
PO Box 21116
Eagan, MN 55121
Attention: Claims Department
Phone 855-429-1023

Claim forms may be obtained by contacting 1-855-429-1023. A Claim for Benefits form will be treated as received by the Plan on the date that it is deposited in the U.S. Mail for first-class delivery in a properly stamped envelope addressed to the above name and address. The postmark on any such envelope will be proof of the date of mailing. Claims must be submitted by the applicable deadlines for the type of Claim as indicated in these procedures. Unless otherwise indicated, when used in these claims procedures, the term "day" means a calendar day. Any questions about these claims procedures may be directed to the Plan at the above address and phone number.

4.2 Designating an Authorized Representative

An authorized representative may act on behalf of a Claimant with respect to a benefit Claim or appeal under these claims procedures. No person (including a treating health care professional) will be recognized as an authorized representative until the Plan receives an Appointment of Authorized Representative form signed by the Claimant, except that for urgent care claims the Plan shall, even in the absence of a signed Appointment of Authorized Representative form, recognize a health care professional with knowledge of the Claimant's medical condition (e.g., the treating physician) as the Claimant's authorized representative unless the Claimant provides specific written direction otherwise.

An Appointment of Authorized Representative form may be obtained from, and completed forms must be submitted to, the Plan at the address indicated under "General Filing Rules." Once an authorized representative is appointed, the Plan shall direct all information, notification, etc. regarding the Claim to the authorized representative. The Claimant shall be copied on all notifications regarding decisions, unless the Claimant provides specific written direction otherwise. Where appropriate, references in these claims procedures to Claimant include the Claimant's authorized representative.

An assignment for purposes of payment (e.g., to a health care professional) does not constitute appointment of an authorized representative under these claims procedures.

4.3 Special Filing Rules for Certain Claim Types

4.3.1 Post-Service Claims

A post-service claim must be filed within 90 days following receipt of the medical service, treatment or product to which the Claim relates unless (a) it was not reasonably possible to file the Claim within such time; and (b) the Claim is filed as soon as possible and in no event (except in the case of legal incapacity of the Claimant) later than 12 months after the date of receipt of the service, treatment, or product to which the Claim relates.

4.3.2 Urgent Care Claims

In light of the expedited timeframes for decision of urgent care claims, an urgent care claim for benefits may be submitted by telephone at 1-855-429-1023. The Claim should include at least the following information:

- the identity of the Claimant;
- a specific medical condition or symptom; and
- a specific treatment, service, or product for which approval or payment is requested.

4.4 Incorrectly Filed Claims

These claims procedures do not apply to any request for benefits that is not made in accordance with these claims procedures, except that (a) in the case of an incorrectly filed pre-service claim, the Claimant shall be notified as soon as possible but no later than 5 days following receipt by the Plan of the incorrectly filed claim; and (b) in the case of an incorrectly filed urgent care claim, the Claimant shall be notified as soon as possible but no later than 24 hours following receipt by the Plan of the incorrectly filed claim. The notice shall explain that the request is not a Claim and describe the proper procedures for filing a Claim. The notice may be oral unless written notice is specifically requested by the Claimant.

4.5 Incomplete Claims

If any information needed to process a Claim is missing, as determined by the Plan, the Claim shall be treated as an incomplete claim.

4.5.1 Incomplete Urgent Care Claims

If an urgent care claim is incomplete, the Plan shall notify the Claimant as soon as possible, but no later than 24 hours following receipt of the incomplete claim. The notification may be made orally to the Claimant unless the Claimant requests written notice. The notification will describe the information necessary to complete the Claim and specify a reasonable time, no less than 48 hours, within which the Claim must be completed. The Plan shall decide the Claim as soon as possible but not later than 48 hours after the earlier of (a) receipt of the specified information; or (b) the end of the period of time provided to submit the specified information.

4.5.2 Other Incomplete Claims

If a pre-service or post-service claim is incomplete, the Plan may deny the Claim or may take an extension of time, as described below. If the Plan takes an extension of

time, the extension notice shall include a description of the missing information and shall specify a period, of no less than 45 days, within which the necessary information must be provided. The timeframe for deciding the Claim shall be suspended from the date the extension notice is received by the Claimant until the date the missing necessary information is provided to the Plan. If the requested information is provided, the Plan shall decide the Claim within the extended period specified in the extension notice. If the requested information is not provided within the time specified, the Claim may be decided without that information.

5. Deciding Initial Benefit Claims

5.1 Benefit Interpretation and Administration

In its consideration of a Claim, the Plan or Beacon Health as the case may be, will consult the Plan documents and governing instruments, and all other documents that may have a bearing on the interpretation of the Plan or benefit, including past interpretations or claims of the same general type. The Plan or Beacon Health as the case may be, may also, where appropriate, consult applicable guidance from the Internal Revenue Service, the Department of Labor, or other governmental or private publications or authorities that may assist in interpreting language or administrative procedures of the Plan.

5.2 Adverse Benefit Determination

A decision on a Claim is "adverse" if it is (a) a denial, reduction, or termination of; or (b) a failure to provide or make payment (in whole or in part) for a Plan benefit. A rescission of coverage is treated as an adverse benefit determination (whether or not the rescission has an adverse effect on any particular benefit at that time). A rescission is a retroactive cancellation of coverage, other than for failure to pay premiums.

5.3 Standard Timeframes for Deciding Initial Benefit Claims

5.3.1 Pre-Service Claims

The Plan shall decide an initial pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the Claim.

5.3.2 Urgent Care Claims

The Plan shall decide an initial urgent care claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the Claim.

5.3.3 Concurrent Care Extension Request

If a Claim is a request to extend a concurrent care decision (defined above) involving urgent care and if the Claim is made at least 24 hours prior to the end of the initially approved period of time or number of treatments, the Claim shall be decided within no more than 24 hours after receipt of the Claim. Any other request to extend a concurrent care decision shall be decided in the otherwise applicable timeframes for pre-service, urgent care, or post-service claims.

5.3.4 Concurrent Care Early Termination

A decision by the Plan to reduce or terminate an initially approved course of treatment is an adverse benefit decision that may be appealed by the Claimant under these claims procedures. Notification to the Claimant of a decision by the Plan to reduce or terminate an initially approved course of treatment shall be provided sufficiently in advance of the reduction or termination to allow the Claimant to appeal the adverse decision and receive a decision on review under these procedures prior to the reduction or termination.

5.3.5 Post-Service Claim

The Plan shall decide an initial post-service claim within a reasonable time, but no later than 30 days after receipt of the Claim.

5.4 Extensions of Time

Despite the specified timeframes, nothing prevents the Claimant from voluntarily agreeing to extend the above timeframes. In addition, if the Plan is not able to decide a pre-service or post-service claim within the above timeframes due to matters beyond its control, one 15-day extension of the applicable timeframe is permitted, provided that the Claimant is notified in writing prior to the expiration of the initial timeframe applicable to the Claim. The extension notice shall include a description of the matters beyond the Plan's control that justify the extension and the date by which a decision is expected. No extension is permitted for urgent care claims.

6. Notification of Initial Benefit Decision by Plan

6.1 Pre-Service and Urgent Care

Written notification of the Plan's decision on a pre-service or urgent care claim shall be provided to the Claimant whether or not the decision is adverse.

6.2 Notification of Adverse Benefit Decision

Written notification shall be provided to the Claimant of the Plan's adverse decision on a Claim (for any type of Claim). The information set forth in the notice will be provided in a manner calculated to be understood by the Claimant (including, if necessary, in a culturally and linguistically appropriate manner according to applicable requirements), and will include the following:

- information sufficient to identify the Claim involved, including the date of service, health care provider, and claim amount (if applicable);
- a statement of the specific reason(s) for the adverse benefit determination, including any denial code and its corresponding meaning and any Plan standard used in denying the claim;
- reference(s) to the specific Plan provision(s) on which the decision is based;
- a statement advising the Claimant of the right to request diagnosis and treatment codes and their corresponding meanings;
- a description of any additional material or information necessary to perfect the Claim and why such information is necessary;
- a description of the Plan procedures and time limits for appeal of the decision, external review rights, the right to obtain information about the claims procedures, and the right to sue in federal court after exhausting the Plan's claims procedures;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- if the decision involves scientific or clinical judgment, either an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's medical circumstances or a statement that such explanation will be provided at no charge upon request;
- if the decision is based on a Plan standard (such as a medical necessity standard), a description of that standard;
- in the case of an urgent care claim, an explanation of the expedited review methods available for such Claims; and
- contact information for the DOL's Employee Benefits Security Administration and any applicable state consumer assistance program.

Notification of an adverse decision by the Plan on an urgent care claim may be provided orally, but written notification shall be furnished not later than three days after the oral notice.

7. Appeal of an Adverse Benefit Determination

7.1 How to File an Appeal

For a description of the appeals process for pharmacy claims, please see Plan's Appeals Process – Pharmacy attached to the SPD Exhibit H.

A Claimant has a right to appeal an adverse benefit determination related to medical claims under these claims procedures. Except for urgent care claims, discussed below, an appeal of an adverse benefit determination is filed when a Claimant submits a written Request for Review form (available from the Plan) to:

Northern Light Employee Health Plan
C/O Beacon Health
Attn: Appeals Department
9601 Amberglen Blvd, Ste. 225
Austin, TX 78729

A Request for Review form will be treated as received by the Plan on the date that it is deposited in the U.S. Mail for first-class delivery in a properly stamped envelope containing the indicated name and address. The postmark on any such envelope will be proof of the date of mailing.

7.2 Submission of Comments and Other Information

A Claimant has the right to submit documents, written comments, or other information in support of an appeal. A Claimant also has the right to review the Claim file, and is permitted to present evidence and testimony as part of the appeals process. If the Plan has considered, relied upon, or generated any new or additional evidence in deciding the Claim, the Claimant will be provided with such evidence sufficiently in advance of the due date for filing the appeal to afford the Claimant an opportunity to respond to such additional evidence.

7.3 Appeal Deadline

The appeal of an adverse benefit determination must be filed within 180 days following the Claimant's receipt of the notification of adverse benefit decision. In the case of an appeal of a decision by the Plan to reduce or terminate an initially approved course of treatment (see the description above of concurrent care claims) if the Claimant does not file the appeal within 30 days of the Claimant's receipt of the notification of the Plan's decision to reduce or terminate, the Plan may reduce or terminate the approved course of treatment. Failure to comply with this important deadline may cause the Claimant to forfeit any right to any further review of an adverse decision under these

procedures or in a court of law.

7.4 Urgent Care Appeals

In light of the expedited timeframes for decision of urgent care claims, an urgent care appeal may be submitted to the Plan by telephone at 1-855-429-1024 or by fax at 1-877-403-7162. The appeal should include at least the following information:

- the identity of the Claimant;
- a specific medical condition or symptom;
- a specific treatment, service, or product for which approval or payment is requested; and
- any reasons why the appeal should be processed on a more expedited basis.

8. How Appeals Will Be Decided

8.1 Review of Decision

The appeal of an adverse benefit determination will be reviewed and decided by the Plan as Named Fiduciary under the Plan. The person who reviews and decides an appeal will be a different individual than the person who made the initial benefit decision and will not be a subordinate of the person who made the initial benefit decision. The review by the Plan will take into account all information submitted by the Claimant, whether or not presented or available at the initial benefit decision. The Plan will give no deference to the initial benefit decision.

8.2 Consultation With Expert

In the case of a Claim denied on the grounds of a medical judgment, the Plan will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the same individual who was consulted, if any, regarding the initial benefit decision or a subordinate of that individual.

8.3 Access to Relevant Information and Rationale

A Claimant shall, on request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim for benefits. The Plan will determine which information is relevant in accordance with applicable law. If the advice of a medical or vocational expert was obtained in connection with the initial benefit decision, the names of each such expert shall be provided on request by the Claimant, regardless of whether the advice was relied on by the Plan. Before issuing a final decision on appeal that is based on a rationale that was

not included in the initial determination, the Plan will provide the Claimant, free of charge, with the rationale as soon as possible and sufficiently in advance of the final internal adverse benefit determination to give the Claimant a reasonable opportunity to respond.

8.4 Expedited Methods for Urgent Care

All necessary information in connection with an urgent care appeal shall be transmitted between the Plan and the Claimant by telephone, fax, or email.

9. Timeframes for Deciding Appeals

9.1 Pre-Service Claims

The Plan shall decide the appeal of a pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 30 days after receipt by the Plan of the Request for Review form.

9.2 Urgent Care Claims

The Plan shall decide the appeal of an urgent care claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt by the Plan of the Request for Review.

9.3 Post-Service Claims

The Plan shall decide the appeal of a post-service claim within a reasonable period, but no later than sixty (60) days after receipt by the Plan of the Request for Review form.

9.4 Concurrent Care Claims

The Plan shall decide the appeal of a decision by the Plan to reduce or terminate an initially approved course of treatment (see the definition of concurrent care decision) before the proposed reduction or termination takes place. The Plan shall decide the appeal of a denied request to extend any concurrent care decision in the appeal timeframe for pre-service, urgent care, or post-service claims described above, as appropriate to the request.

10. Notification of Decision on Appeal

10.1 Written Notification

Written notification of the decision on appeal shall be provided to the Claimant whether or not the decision is adverse.

10.2 Notification of Adverse Appeal Decision

The notification provided to the Claimant of an adverse determination on appeal shall include the following, written in a manner calculated to be understood by the Claimant (including, if necessary, in a culturally and linguistically appropriate manner according to applicable requirements):

- information sufficient to identify the Claim including the date of service, the health care provider, and the claim amount (if applicable);
- the specific reason(s) for the appeal decision including any denial code and its corresponding meaning and any Plan standard used in denying the claim, including a discussion of the decision;
- a reference to the specific Plan provision(s) on which the decision is based;
- a statement advising the Claimant of the right to request diagnosis and treatment codes and their corresponding meanings;
- a statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- a description of the available external review process;
- a statement of the right to sue in federal court;
- a statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records, or other information relevant to the determination;
- if the decision involves scientific or clinical judgment, either an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's medical circumstances or a statement that such explanation will be provided at no charge upon request; and
- contact information for the DOL's Employee Benefits Security Administration and any applicable state consumer assistance program.

Notification of an adverse determination on appeal of an urgent care claim may be provided orally, but written notification shall be furnished not later than three days after the oral notice.

11. Right to Request External Review

11.1 Requesting External Review

A Claimant may request external review of an adverse benefit determination by filing a request for external review within 4 months after the date of receipt of a notice of a final adverse benefit determination. The request for external review must be made in writing to the Plan by telephone at 1-855-429-1024, by fax at 1-877-403-7162 or mailed to:

Northern Light Employee Health Plan
C/O Beacon Health
Attn: Appeals Department
9601 Amberglen Blvd, Ste. 225
Austin, TX 78729

11.2 Standard External Review

Within 5 business days following the date of receipt of the external review request, a preliminary review of the request will be performed to determine whether the Claim is eligible for external review. Claims eligible for external review are only those that involve (a) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer; or (b) rescission of coverage (whether or not the rescission has any effect on any particular benefit at the time). Furthermore, a Claim is not eligible for external review if:

- the Claimant is (or was) not covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, the Claimant was not covered under the Plan at the time the health care item or service was provided;
- the adverse benefit determination is based on the fact that the Claimant was not eligible for coverage under the Plan (except where the Claim relates to a rescission of coverage);
- the Claimant has not exhausted the Plan's internal appeal process (unless exhaustion is not otherwise required); or
- the Claimant has not provided all the information and forms required to process an external review.

The Claimant will be notified of the results of the preliminary review within one business day after completion of the preliminary review. If the request is incomplete, the notice must describe the information, materials, etc. needed to complete the request, and set forth the time limit for the Claimant to provide the additional information needed (the longer of the initial four-month period within which to request

an external review or, if later, 48 hours (or such longer period specifically identified in the notice) after the receipt of the notice).
If the Claim is eligible for external review, an Independent Review Organization (IRO) will be assigned to conduct the external review.

11.3 Expedited External Review

Expedited external review may be requested when:

- an adverse benefit determination involves a medical condition where the timeframe for completing an expedited internal appeal under the interim final regulations would seriously jeopardize the Claimant's life, health, or ability to regain maximum function, and a request for an expedited internal appeal has been filed; or
- a final internal adverse benefit determination involves (a) a medical condition where the timeframe for completing an expedited internal appeal under the interim final regulations would seriously jeopardize the Claimant's life, health, or ability to regain maximum function; or (b) an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

The request for an expedited external review must be made by contacting the Plan by phone at 1-855-429-1024 or by fax at 1-877-403-7162. . Immediately upon receipt of the request for an expedited external review, a determination will be made as to whether the request meets the requirements described above for a standard external review, the Claimant will be notified of the determination, and, if the request meets the requirements, an IRO will be assigned as described above for a standard external review.

11.4 External Review by IRO

11.4.1 Providing Information to IRO

The Plan will timely (in the case of an expedited external review, expeditiously) provide to the IRO documents and any information considered in making the adverse benefit determination. The Claimant may submit additional information in writing to the IRO within 10 business days of the IRO's notification that it has been assigned the request for external review.

11.4.2 IRO Review

The IRO will review all of the information and documents timely received. In making its decision, the IRO is not bound by the Plan's prior determination. To the extent

additional information or documents are available and the IRO considers them appropriate, the IRO may also consider the following in reaching a decision:

- the Claimant's medical records;
- the attending health care professional's recommendation;
- reports from appropriate health care professionals and other documents submitted by the Plan, the Claimant, or the Claimant's treating health care provider;
- the terms of the Claimant's summary plan description;
- evidence-based practice guidelines;
- any applicable clinical review criteria developed and used by the Plan; and
- the opinion of the IRO's clinical reviewer or reviewers after considering information noted above, as appropriate.

11.4.3 Notification of IRO Decision

The IRO will provide written notice of the final external review decision to the Claimant and the Plan within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision. To the extent the final external review decision reverses the Plan's decision (as was reflected in the notice of adverse benefit determination), the Plan shall follow the final external review decision of the IRO (but may initiate judicial review, as described below).

In the case of an expedited external review, the IRO will provide the notice of the final external review decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the IRO's notice of decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours.

12. Judicial Review

Upon completion of the Plan's internal review procedures or the external review procedures, either the Claimant or the Plan may request judicial review of the final decision on the Claim. Any action brought by, or on behalf of, a Claimant for Plan benefits must be filed not later than 24 months after completion of the Plan's claims process (including, if applicable, external review).

Northern Light Employee Health Plan Appeals Procedures – Pharmacy Claims

1. Introduction

1.1 Introduction

Under Department of Labor (“DOL”) regulations, claimants are entitled to full and fair review of any claims made under the Northern Light Employee Health Plan (the "Plan"). The procedures described in this document are intended to comply with DOL regulations by providing reasonable procedures governing the appeal of adverse benefit determinations for pharmacy claims.

1.2 Purpose of This Document

This document, which is a separate document that accompanies the Northern Light Employee Health Plan Document and Summary Plan Description (“SPD”), describes how appeals of pharmacy claims are made and decided under the Plan. The SPD describes the benefits provided under the Plan.

2. Definitions

Certain words and phrases that are used frequently throughout this document are explained below. If you are uncertain about the meaning of a word or phrase, contact the Plan Administrator for further clarification.

2.1 Claim

A "Claim" is any request for a Plan benefit or benefits made in accordance with the claims procedures set forth in the Plan. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a Claim.

2.2 Claimant

You become a "Claimant" when you make a request for a Plan benefit or benefits in accordance with the Plan’s claims procedures.

2.3 Geisinger

“Geisinger” means Geisinger Health Options

The "Plan" is the Northern Light Employee Health Plan.

2.4 Plan Administrator and Named Fiduciary

Northern Light Health is the "Plan Administrator" and "Named Fiduciary" under the Plan with the ultimate responsibility for making claim and appeal decisions. Northern Light

Health has the discretionary authority to interpret the Plan in order to make benefit decisions as it may determine in its sole discretion. Northern Light Health also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan. Northern Light Health has contracted with Geisinger to assist in the appeals process, but has not delegated final decision making to Geisinger.

2. Appeal of an Adverse Benefit Determination - Pharmacy

A Claimant has a right to appeal an adverse benefit determination made by Geisinger under these claims procedures. Except for urgent care claims, discussed below, a request for an appeal must be submitted **in writing** and received by Geisinger within **one hundred eighty (180) days** following receipt of the notification of an adverse benefit determination. It is important to let Geisinger know whether or not the requested services have been received.

Appeals are to be sent to

Geisinger Health Options
Appeal Department
100 North Academy Avenue
Danville, PA 17822-3220
FAX: 570-271-7225

A Claimant has the right to submit documents, written comments, or other information in support of an appeal. A Claimant also has the right to review the Claim file, and is permitted to present evidence and testimony as part of the appeals process. If the Plan has considered, relied upon, or generated any new or additional evidence in deciding the Claim, the Claimant will be provided with such evidence sufficiently in advance of the due date for filing the appeal to afford the Claimant an opportunity to respond to such additional evidence.

A. Pre-Service Appeal

1). Pre-Service Appeal Review for Denials not based on Medical Judgment (Complaint): A Pre-Service Appeal of an adverse benefit determination that is not based in whole or in part on a medical judgment will be reviewed by the Member Satisfaction Review Committee. The Member Satisfaction Review Committee shall consist of a minimum of three (3) or more individuals who did not previously participate in the matter under review and shall not be subordinates of the person(s) who made the adverse benefit determination or of previous reviewers. At least one-third of the Member Satisfaction Review Committee shall not be employed by Geisinger or its related subsidiaries or affiliates.

The Member Satisfaction Review Committee will fully and fairly consider all available information relevant to the Claimant's appeal including any material submitted by the Claimant to Geisinger. Geisinger shall provide at least fifteen (15) days advance written notification of the review procedures, date and the Claimant's right to attend the Member Satisfaction Review Committee meeting.

(2). Pre-Service Appeal Review for Denial Based on Medical Judgment (Grievance): A Pre-Service Appeal of an adverse benefit determination that is based in whole or in part on a medical judgment will be reviewed by the Internal Review Committee. The Internal Review Committee is comprised of three (3) or more individuals, one of which is a licensed physician, who did not previously participate in the decision to deny coverage or payment for the service and shall not be subordinates of the person(s) who made the adverse benefit determination. The Internal Review Committee shall include the written input and/or presence of a licensed physician or approved licensed pharmacist in the same or similar specialty that typically manages or consults on the health care service, condition, performs the procedure or provides the treatment and who was not previously involved in the matter under review. The Committee will consider the full record including any aspects of clinical care involved and make an independent and fair decision regarding the appeal. Upon request from the Claimant or a health care provider with the Claimant's written consent, Geisinger shall provide the Claimant or the health care provider with access to the information relating to the matter being grieved at no cost and shall permit the member and such health care provider to provide additional verbal or written data or other material to support the appeal. The Claimant and/or the health care provider who filed the appeal have the right to appear before the Internal Review Committee. Geisinger and the Claimant have the right to be represented by an attorney or other individual before the Internal Review Committee. Geisinger shall provide the Claimant and/or health care provider at least fifteen (15) days advance notification, in writing, of the hearing procedures, date, and of their right to attend the Internal Review meeting.

(3). Pre-Service Appeal Time Frame for Decision. A Pre-Service Appeal, whether denied in whole or in part based on a medical judgment, or whether denied in whole or in part not based on a medical judgment, will be reviewed and a decision made no later than thirty (30) days after receipt of the Claimant's written request. Geisinger shall provide the Claimant with a written notification of Geisinger's decision no later than thirty (30) days from receipt. The written notification from Geisinger will include:

a) the basis for the decision in easily understandable language;

b) reference to the specific Plan provisions on which the decision is based;

c) notification of the fact that the Member is entitled to receive, upon verbal or written request and free of charge, copies of all documents, records and other information relevant to the appeal including instructions for requesting a written statement of clinical rationale

d) including clinical review criteria used, if applicable;

e) contact information for the DOL's Employee Benefits Security Administration and any applicable state consumer assistance program;

f) the Member may have the right to request an external appeal review conducted by an Independent Review Organization; and

g) A statement of the right to sue in federal court

B. Post-Service Appeal

(1). Post-Service Appeal Procedure. A Post-Service Appeal is a request to change an adverse benefit determination for care or services that have already been received by the Claimant. A Claimant may request a Post-Service Appeal in writing to Geisinger. Geisinger will provide a full and fair review of the appeal.

(2). Post-Service Appeal Review for Denials not based on Medical Judgment. A Post-Service Appeal of an Adverse Benefit Determination that is not based in whole or in part on a medical judgment will be reviewed by the Member Satisfaction Review Committee. The Member Satisfaction Review Committee shall consist of a minimum of three (3) or more individuals who did not previously participate in the matter under review and shall not be subordinates of the person(s) who made the adverse benefit determination or of previous reviewers. At least one-third of the Member Satisfaction Review Committee shall not be employed by Geisinger or its related subsidiaries or affiliates. The Member Satisfaction Review Committee will fully and fairly consider all available information relevant to the Claimant's appeal including any material submitted by the Claimant to Geisinger. Geisinger shall provide at least fifteen (15) days advance written notification of the review procedures, date and the Claimant's right to attend the Member Satisfaction Review Committee meeting.

(3). Post-Service Appeal for Denials based on Medical Judgment. A Post-Service Appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment will be reviewed by the Internal Review Committee. The Internal Review Committee is comprised of three (3) or more individuals, one of which is a licensed physician, who did not previously participate in the decision to deny coverage or payment for the service and shall not be subordinates of the person(s) who made the adverse benefit determination. The Internal Review Committee shall include the written input and/or presence of a licensed physician or approved licensed pharmacist in the same or similar specialty that typically manages or consults on the health care service, condition, performs the procedure or provides the treatment and who was not previously involved in the matter under review. The Committee will consider the full record including any aspects of clinical care involved and make an independent and fair decision regarding the appeal. Upon request from the Claimant or a health care provider with the Claimant's written consent, Geisinger shall provide the Claimant or the health care provider with access to the information relating to the matter being grieved at no

cost and shall permit the Claimant and such health care provider to provide additional verbal or written data or other material to support the appeal. The Claimant and the health care provider who filed the appeal have the right to appear before the Internal Review Committee. Geisinger and the Claimant have the right to be represented by an attorney or other individual before the Internal Review Committee. Geisinger shall provide the Claimant and/or health care provider at least fifteen (15) days advance notification, in writing, of the hearing procedures, date, and of their right to attend the Internal Review Committee meeting.

(4). Post-Service Appeal Time Frame for Decision. A Post-Service Appeal, whether denied in whole or in part based on a medical judgment, will be reviewed and a decision made no later than thirty (30) days after receipt of the written request. Geisinger shall provide the Claimant with written notification of Geisinger's decision no later than thirty (30) days from receipt. The written notification from Geisinger shall include:

a) the basis for the decision in easily understandable language;

b) reference to the specific Plan provisions on which the decision is based;

c) notification of the fact that the Claimant is entitled to receive, upon verbal or written request and free of charge, copies of all documents, records and other information relevant to the appeal including instructions for requesting a written statement of clinical rationale including clinical review criteria used, if applicable;

d) contact information for the DOL's Employee Benefits Security Administration and any applicable state consumer assistance program;

e) the Claimant may have the right to request an external appeal review conducted by an Independent Review Organization; and

f) a statement of the right to sue in federal court

C. Urgent Care Appeal

(1). Urgent Care Appeal Procedure. A claim involving Urgent Care 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 as determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; 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 request.

(2). Request of an Urgent Care Appeal. A Claimant or a Claimant's health care provider may request an Urgent Care Appeal either orally or in writing. The Claimant or the Claimant's health care provider requesting the Urgent Care Appeal may contact Geisinger by telephone, fax or other methods that will expedite receipt of the information by Geisinger. Geisinger will contact the requestor by telephone, fax or other prompt method to resolve the Claimant's appeal. Geisinger will provide a full and fair review of the appeal.

(3). Review of an Urgent Care Appeal. Geisinger shall perform an Urgent Care Appeal Review and render a decision within seventy two (72) hours of receipt of the Claimant's request. The Claimant shall be responsible to provide information to Geisinger in an expedited manner to allow Geisinger to conform to the Urgent Care Appeal requirements. The Urgent Care Internal Review Committee shall be comprised of three (3) or more individuals one of which is a licensed physician, who did not previously participate in the decision to deny coverage or payment for the service and who are not subordinates of the person(s) who made the adverse benefit determination.

The Urgent Care Appeal review shall include the written input and/or presence of a licensed physician or approved licensed pharmacist in the same or similar specialty that typically manages or consults on the health care service, condition, performs the procedure, or provides the treatment and who was not previously involved in the matter under review. Geisinger shall provide the Claimant with written notification of Geisinger's decision that shall include:

a) the basis for the decision in easily understandable language;

b) reference to the specific Geisinger provisions on which the decision is based;

c) notification of the fact that the Claimant is entitled to receive, upon verbal or written request and free of charge, copies of all documents, records and other information relevant to the appeal including instructions for requesting a written statement of clinical rationale including clinical review criteria used, if applicable; and

d) contact information for the DOL's Employee Benefits Security Administration and any applicable state consumer assistance program;

e) the Claimant may have the right to request an external appeal review conducted an Independent Review Organization; and

f) A statement of the right to sue in federal court

D. External Review

(1). External Review Procedure. If an external review request is filed with the Plan within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination, the Plan will assign an independent review organization (IRO) as required by and in accordance with all applicable State and Federal regulations. Within five (5) business days of the Plan's date of receipt of an external review request, the Plan shall (i) complete a preliminary review of the request and (ii) issue a notice to the Claimant within one (1) business day after completion of the preliminary review. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete. The IRO will notify the Claimant of acceptance for external review and will inform the Claimant that they may submit in writing, within ten (10) business days, any additional information the Claimant would like the IRO to consider in the review. The IRO will perform an independent claim review and will not be bound by decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

a) The Claimant's medical records;

b) The attending health care professional's recommendation;

c) Reports from appropriate health care professionals and other documents submitted by the Plan, Claimant, or the Claimant's treating provider;

d) The terms of the Claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

e) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

f) Any applicable clinical review criteria developed and used by the Plan unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

g) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this section to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(2). Time Frame for Decision. The IRO will provide written notice of the final external review decision to the Claimant and the Plan within forty-five (45) days after the IRO receives the request for external review. The decision will be in writing and will include the following:

a) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the reason for the previous denial);

b) The date the IRO received the assignment to conduct the external review and the date of the IRO’s decision;

c) References to the evidence or documentation including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

d) A discussion of the principal reason for its decision, including the rationale for its decision and evidence-based standards that were relied on in making its decision;

e) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the PPO or the Member;

f) A statement that judicial review may be available to the Claimant; and

g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

(3). Binding Decision. The Claimant and the Plan will be bound by the final decision of the IRO except to the extent that other remedies are available under State or Federal law. The requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require payment or benefits.

The Plan must provide any benefits (including making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan

intends to seek judicial review of the external decision and unless or until there is a judicial decision.

(4). Expedited External Grievance/Adverse Benefit Determination Review Procedure. The Claimant or the health care provider with the Claimant's written consent, who is dissatisfied with the decision of the Plan's Expedited Grievance Review, may appeal orally or in writing to the Plan within two (2) business days of receipt of the Expedited Grievance Review decision.
NOTE: Under certain circumstances, which will be outlined to the Claimant in the Plan's appeal correspondence, an expedited external review may be requested at the same time the Claimant requests an expedited appeal.

(5). Preliminary Review. If the Plan determines the expedited external review request meets the Expedited External Grievance requirements, notice will be sent to the Claimant within one (1) business day after completion of the preliminary review. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete.

(6). External Review Procedure. If an external review is warranted, the Plan will assign an IRO as required by and in accordance with all applicable State and Federal regulations. The Plan will provide all the necessary documents and information considered in making the final adverse benefit determination to the external IRO by any available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents as set forth in Section D(1). In reaching a decision, the IRO will review the claim de novo and shall not be bound by any decisions or conclusions reached during the Plan's internal appeal procedures.

(7). Notice of the Final External Review Decision. The IRO will provide notice of the final external review decision as expeditiously as the Claimant's medical condition requires, but in no event later than seventy-two (72) hours after the IRO receives a request for an expedited external review.

If the notice from the IRO to the Claimant is not in writing, within forty-eight (48) hours after the date of providing the notice, the IRO will provide written confirmation of the decision to the Claimant and the Plan.

Upon completion of the Plan's internal review procedures or the external review procedures, either the Claimant or the Plan may request judicial review of the final decision on the Claim. Any action brought by, or on behalf of, a Claimant for Plan benefits must be filed not later than 24 months after completion of the Plan's claims process (including, if applicable, external review).