Northern Light Health

Employee Health Plan Document and Summary Plan Description

Effective January 1, 2021

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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 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 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 $15.34 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)

Contraception Exemption/Accommodation (Mercy Hospital)
Mercy Hospital qualifies as an objecting entity that is exempt from providing coverage or payments for some or all contraceptive services, based on its sincerely held religious beliefs. In keeping with the Ethical and Religious Directives for Catholic Health Care Services (ERD), Mercy will invoke the optional accommodation so that 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. All other preventive services will be provided in accordance with the provisions of the ACA.

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)

➔

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).

-

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.

-

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 outthe 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.

- **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 services such as inpatient hospital stays and certain outpatient surgeries

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 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 and adolescents with zero copay.

- **Livongo Diabetes Program** - Effective October 1, 2020: No cost digital therapeutics program for Plan members living with Type 1 or Type 2 diabetes. Dependents under the age of 13 require parental/guardian consent to participate.

- **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, wheelchairs, 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. Includes physical, speech, and occupational therapy for diagnoses related to developmental delays for children up to 6 years old
- 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.

COVID-19 – The COVID -19 pandemic resulted in several coverage enhancements in 2020.

Effective March 15, 2020:

- ☐ Testing for COVID-19 covered at 100% (no member cost share)
- ☐ Items or services resulting in administration of a COVID-19 test covered at 100% (no member cost share)

Effective April 4, 2020:

- ☐ All treatment for COVID-19 covered at 100% (no member cost share)

Effective October 1, 2020 through December 31, 2020:

- ☐ All preferred network Telehealth visits covered at 100% (no member cost share)

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 program.
  - Participation in 10 out of 12 Weight Watchers classes.
  - Participating in a qualified Beacon Health engagement program such as wellness coaching or tobacco cessation.

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.

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 for plan members over 6 years of age. 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 for anyone over age 6.
        - 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.
- 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 component of the Eastern Maine Healthcare Systems Welfare Benefit Plan, number 509.

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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [enter name of employer sponsoring the Plan], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

For more information visit https://www.medicare.gov/medicare-and-you

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 July 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 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
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: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 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: 916-440-5676	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: https://www.in.gov/medicaid/ Phone 1-800-457-4584

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**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. 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/other-insurance.jsp 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 Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ 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/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA,

and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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.

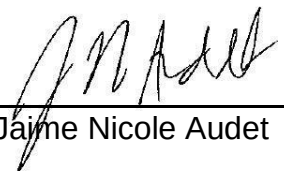
Assistance with Your Questions

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 1/1/2021
(City) (State) (Date)

BY: 
Jaime Nicole Audet

TITLE: VP, HR Operations and Total Rewards