AMOSKEAG HEALTH

EMPLOYEE BENEFIT GUIDE 2026

cgi Business Solutions

BENEFITS GUIDE

ELIGIBILITY & ENROLLMENT

At Amoskeag Health, we're proud to offer a comprehensive benefits program designed to support your health, your family, and your future. Here are the key details to help you understand your eligibility, enrollment, and important benefit guidelines.

HERE ARE SOME IMPORTANT THINGS TO KNOW.....

Eligibility

As an employee of Amoskeag Health, you are eligible to participate in a comprehensive benefits program based on your hours of employment. This summary provides a general overview of the benefit choices available to you. While every effort has been made to ensure accuracy, if there are any discrepancies between this summary and the official plan documents, the plan documents will supersede this summary. Employee benefit plans and policies may be changed at the sole discretion of the company. Please review all benefit information carefully.

Enrollment and Plan Year

Once you make your benefit elections, they will remain in effect for the entire plan year unless you experience a qualifying life event. You must enroll within 30 days of your hire date to receive coverage for the remainder of the plan year.

Qualifying Life Events

You may only make mid-year benefit changes if you experience a qualifying event, including:

- Birth or adoption of a dependent
- Death of a dependent
- Marriage or divorce
- Loss or gain of other coverage

To make changes, you must notify the Human Resources Department within 30 days of the qualifying event.

Open Enrollment

Amoskeag Health holds an Open Enrollment period once a year for all benefit options. This is your annual opportunity to review and make changes to your benefit elections. Once Open Enrollment ends, your choices remain in effect for the plan year unless you have a qualifying life event.

ONLINE BENEFITS ENROLLMENT

HOW DO I LOGIN TO KRONOS?

The KRONOS online portal allows employees to elect benefits, update personal information, make life event updates and much more. This portal is available 24/7.

Login Instructions

1. Go to Kronos App on your desktop
2. Enter your username: jdoe11 (first initial of first name followed by full last name and last two digits of social security number)
3. Enter your password that you created
4. Select Login to access KRONOS

Starting Your Enrollment

1. Click on the “hamburger” menu bar — 3 bars at the top left of the screen
2. A menu will be displayed. Click on the “person” logo, then MY BENEFITS, then Enrollment
3. Follow the instructions on the screen to make benefit changes, add dependents, and more

Enrolling is as easy as 1-2-3!

When Enrolling You Will Need the Following Information:

- Social Security Number (SSN)
- Dependents’ names and SSN
- Beneficiary information

You must go into KRONOS to make any changes and verify coverages for the plan year.

Need Help or Have Questions with Your Coverage Options? Contact:

Human Resources

- HR@amoskeaghealth.org

MEDICAL PLANS

Employees working 30 hours or more are eligible for Medical benefits the first day of the month following date of hire. Eligible employees and their eligible dependents may choose to enroll in either one of the HPI Plans.

Benefits	HMO LP LOW PLAN	HMO LP HIGH PLAN	HDHP H.S.A PLAN
Network	New England	New England	New England
Annual Deductible	$1,000 Per Person	$3,000 Per Person	$3,500 Per Person
	$3,000 Per Family	$9,000 Per Family	$7,000 Per Family
Annual Out-Of-Pocket Max	$6,500 Per Person	$6,500 Per Person	$6,500 Per Person
	$13,000 Per Family	$13,000 Per Family	$13,000 Per Family
Routine Exam for preventive care and immunizations	No charge	No charge	No charge
Office Visits	Tier 1: $25 per visit	Tier 1: $25 per visit	Subject to Deductible
	Tier 2: $50 per visit	Tier 2: $50 per visit	Subject to Deductible
Emergency Room & Urgent Care Services	ER: Subject to Deductible; then $250 per visit once deductible met	ER: Subject to Deductible; then $250 per visit once deductible met	Subject to Deductible
	Convenience Care: $25 copayment per visit **Urgent Care Clinic:** $50 copayment per visit **Hospital Urgent Care:** Subject to Deductible; then $75 per visit once deductible met	**Convenience Care:** $25 copayment per visit **Urgent Care Clinic**: $50 copayment per visit **Hospital Urgent Care:** Subject to Deductible; then $75 per visit once deductible met	Subject to Deductible
Inpatient Services	Subject to Deductible	Subject to Deductible	Subject to Deductible
Outpatient Services	Free Standing Ambulatory Surgical Center: $100 copay per visit	Free Standing Ambulatory Surgical Center: $100 copay per visit	Subject to Deductible
Labs	**Labs at Low Cost Provider:** Covered in Full, **Other providers:** subject to deductible	**Labs at Low Cost Provider:** Covered in Full, **Other providers:** subject to deductible	Subject to Deductible
X-Rays	Subject to Deductible	Subject to Deductible	Subject to Deductible
Prescription Drugs (Value Formulary)	**30 Day Supply:** $5/$15/$35/$50/30% Tier 5 up to $300 per Rx	**30 Day Supply:** $5/$15/$35/$50/30% Tier 5 up to $300 per Rx	**Subject to Deductible** **30 Day Supply:** $5/$15/$35/$50/30% Tier 5 up to $300 per Rx
	90 Day Supply Mail Order: $10/$30/$70/$150/30% Tier 5 up to $600 per Rx	**90 Day Supply Mail Order:** $10/$30/$70/$150/30% Tier 5 up to $600 per Rx	**90 Day Supply Mail Order:** $10/$30/$70/$150/30% Tier 5 up to $600 per Rx

Your medical plan is self insured with: Health Plans Inc (HPI) For more detailed information on benefits, limitations and exclusions, refer to the Summary of Benefits and Subscriber Certificate provided by the carrier. Please contact HPI's Customer Service at 1-800-532-7575 with questions regarding coverage or claims. For an online provider directory — www.hpitpa.com.

LOW COST PROVIDERS (LP)

Employees on either LP plan may utilize HPI's LP benefit option saves you money on lab tests and outpatient surgery. Here's how it works:

Labs: Your doctor wants you to get a lab test. If you use one of the labs located on HPI's Provider Finder, you pay $0 for services. Whether you need a blood, urine or strep test, nothing comes out of your pocket. No deductible. Popular labs are Quest Diagnostics, LabCorp and NorDx.

Surgery: You require a routine outpatient procedure, like knee arthroscopy. If you use a surgical center for outpatient services, you will pay a $100 copay.

Sample LP (Low Cost Providers) Lab Locations with 20 miles of Amoskeag Health	
Quest Diagnostics-Amherst, NH	282 State Route 101
Quest Diagnostics-Nashua, NH	300 Main Street, Suite 301B
Quest Diagnostics-Bedford, NH	160 South River Road
Quest Diagnostics-Goffstown, NH	558 Mast Road
Quest Diagnostics-Manchester, NH	195 Mcgregor Street
Labcorp-Bedford, NH	101 Riverway Place

Sample LP (Low Cost Providers) Outpatient Surgical Centers within 20 miles of Amoskeag Health	
Bedford Ambulatory Surgical Center (BASC)	11 Washington St, Bedford, NH
Dartmouth Hitchcock Surgery Center	100 Hitchcock Way, Manchester, NH
Elliot One Day Surgery Center	185 Queen City Ave, Manchester, NH
Nashua Ambulatory Surgical Center	15 Riverside Street, Nashua, NH
The Surgery Center of Greater Nashua	10 Prospect Street, Nashua, NH
Dartmouth Hitchcock Surgery Center	2300 Southwood Drive, Nashua, NH
Orthopedic Surgery Center Derry	14 Tsienneto Road, Derry, NH

For a full listing of providers and how to search for specialties please visit: www.hpitpa.com

Find a **Harvard Pilgrim or UnitedHealthcare** Provider Online

Already an HPI member? For quick access to your provider network search tool, use your member ID number to register for **My Plan**.

1. Go to **hpiTPA.com** and visit the Members Section.

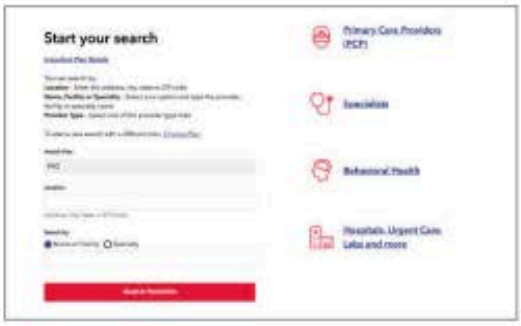
2. Click **Find a Provider**, and then choose **HPHC and UnitedHealthcare Options PPO Network** from the Harvard Pilgrim and UnitedHealthcare network list.

3. To find a provider, you can search by:

Location: Enter an address, city, state or ZIP Code.

Name, Facility or Specialty: Select your option and type in the provider, facility or specialty name.

Provider Type: Select one of the provider type links.



4. View your results. You can refine your results by choosing from the Filter Your Results list.

Have questions? Contact HPI Customer Service at 800-532-7575 or visit us online at hpiTPA.com

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Save Money with Low-Cost Providers

Why pay more when you don't have to?

Saving money doesn't mean sacrificing quality. When your plan has LP (low-cost provider) benefits, you can pay lower out-of-pocket costs for lab and outpatient surgery services when you receive them at select LP facilities.

When you use LP facilities:*

- The deductible will not apply.
- Lab tests are covered at no charge to you (excluding genetic testing).
- You'll pay a copayment for outpatient surgery.

**If you are enrolled in a Qualified High Deductible Health Plan, benefits are subject to the deductible. Specific coverage may vary by plan. Please refer to your Summary Plan Description for details.*

For the most up-to-date information on LP facilities, visit **harvardpilgrim.org**.

- Click **Find a Provider** and choose **SELECT A PLAN**.
- Under Filter Your Results, select **PPO** for Plan Type and **LP** for Plan Category. Then, click the **PPO-LP** link that appears under LP (Low-Cost Provider) Plans.
- Enter your zip code. You can opt to search by name/facility or specialty.
- On the next screen, click **Low Cost Provider** on the left in the Filter Your Results column, then select **Show only Low-Cost Providers**.
- LP facilities will be shown with an LP (Low-Cost Provider) label.

This list may change at any time without prior notice. Refer to the online provider directory at harvardpilgrim.org for the latest information.

Have other questions? Contact HPI Customer Service at the phone number or website listed on the back of your member ID card.

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Discounts & Savings

Present your HPI member ID card and save!

Receive exclusive discounts on health-related products and services through HPI's affiliation with Harvard Pilgrim Health Care.

Fitness

Fitness Programs & Equipment

- Appalachian Mountain Club
- Boston Ski+Sports Club *(MA)*
- Marathon® Sports *(MA)*
- ProSourceFit
- Runner's Alley *(NH)*
- SplitFit *(MA)*
- Workout Fitness Store *(ME)*

Quit Smoking

- Craving to Quit®
- QuitSmart®

Healthy Eating

- DASH for Health™
- Eat Right Now®
- InsideTracker
- Jenny Craig®
- Savor Health™
- Savory Living®
- The Dinner Daily
- Weight Watchers of Maine

Vision

Eyewear Program

- Free eyewear with exam at Visionworks® in MA, NH, RI & NY*
- Discounts on prescription sunglasses and frames at Harvard Vanguard Medical Associates *(MA)*
- Discounts on frames, contacts and accessories through EyeMed-affiliated providers, including:**
  - IN Style OPTICAL℠ *(MA)*
  - LensCrafters®
  - Pearle Vision®
  - Target Optical®

Laser Vision Correction

- Davis Vision™
- QualSight® LASIK
- U.S. Laser Vision Network

Family & Senior Care

- CareScout® Elder Advocacy Program
- GreatCall®
- Home Instead Senior Care®
- SeniorAssist, from the Senior Resource Center, Inc. *(MA)*
- Vigorous Mind™

Hearing Aids

- Amplifon Hearing Health Care
- Flynn Associates *(MA)*
- Speech-Language & Hearing Assoc. of Greater Boston, PC *(MA)*
- TruHearing™

Holistic Wellness

- Ava Fertility Tracker
- Center for Mindfulness and Compassion at the Cambridge Health Alliance *(MA)*
- Complementary & Alternative Medicine (CAM)†
- DharmaCrafts
- FertilityIQ
- Ivy Child
- Magic Weighted Blanket
- Mighty Well®
- *Mindful* Magazine
- Ompractice
- Sana Health
- Ten Percent Happier
- The Original Healing Threads™ by Spirited Sisters
- Unwinding Anxiety®

Important Notes

* You must have an eye exam and choose eyeglasses during the same visit. Additional restrictions apply.

** Valid at participating locations only. Restrictions apply.

† The CAM program is administered through Healthways WholeHealth Living Choices, and is not related to your medical benefits. Some benefit plans include coverage for services included in the CAM program, in which case the provider networks and office visits costs may differ. Please refer to your Summary of Benefits and Coverages for more information.

Vendor participation in the Discounts & Savings program is subject to change. For the most current information, visit us online at the website listed on the back of your member ID card. Please note that some discounts are available only at the vendor's retail location(s).

Have questions?

Contact HPI Customer Service at the phone number or website listed on the back of your member ID card.

See a doctor now, wherever you are.

dr. on demand

Access to a licensed professional at your fingertips

It's fast and easy

- Connect virtually with a physician in minutes[1]
- Video visits held online or through the mobile app
- Pay only your office visit/PCP-level cost share
- Referrals are not required
- Paperless prescriptions are sent directly to your pharmacy[2]

Medical Urgent Care Visits

Doctors can diagnose, treat and write prescriptions for many conditions, including:

- Coughs/colds/flu
- Sore/strep throat
- Pediatric issues
- Sinus and allergies
- Nausea/diarrhea
- Rashes and skin issues
- Women's health
- Sports injuries

Behavioral Health Visits[3]

Psychologists support you using talk therapy, while psychiatrists will also look for biological imbalances and can prescribe medicine as part of a treatment plan.[4]

How it works

1. Download the app on your mobile device or access doctorondemand.com/health-plans-inc
2. Create your account and enter insurance (choose Health Plans, Inc.) and pre-consult information.
3. Complete a questionnaire of current symptoms and medical history.
4. Pay cost-share via app or website.
5. Consult with a Doctor On Demand board certified provider.
6. Receive email follow up after the visit to share with your PCP, or request that it be sent directly to your PCP.

The details of your consultation will not be forwarded to your PCP without your consent.

Download on the App Store GET IT ON Google Play

or web video visits at doctorondemand.com/health-plans-inc

[1] *Availability more limited during overnight hours.*

[2] *Doctor On Demand physicians do not prescribe Schedule I-IV DEA controlled substances, and may elect not to treat or prescribe other medications based on what is clinically appropriate.*

[3] *Doctor On Demand is not meant for crisis or emergency mental health situations. If you are experiencing a crisis or emergency, call 911 or go to your nearest emergency room. Psychology visits are typically available within 48 hours to one week and psychiatry visits are typically available within 2–3 weeks.*

[4] *Doctor on Demand psychiatrists can prescribe medications when necessary for treatment; however, Doctor On Demand does not prescribe any controlled substances. In these cases, alternatives with less potential for abuse and dependence may be offered.*

Have questions about Doctor On Demand? Contact Member Support at 800-997-6196 or support@doctorondemand.com.

For questions about your plan benefits or eligibility, contact HPI Customer Service at the phone number or website on the back of your member ID card.

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Manage your plan online With **My Plan**

24/7 access to your plan and account details

Register in Minutes!

1. Go to the website listed on the back of your member ID card (it will be at the top)
2. Visit the **Members** section and click the link to **Get Registered**
3. Enter your information to create your username and password

If you are a dependent, be sure to have the five-digit home ZIP Code and the last four digits of the employee's (plan subscriber's) social security number.

Access all of your account details* in one secure location anytime, anywhere!

- Review your claims
- Check your benefits
- Access your prescription drug plan
- Search your provider network
- Download a report of your claims
- Request claim reimbursements
- View, print or order your member ID card
- View or print applicable tax forms
- Find a Primary Care Provider (PCP)
- View your health spending account details

On your mobile device!

** You will have access to details applicable to your plan. Please note, not all of the items listed above apply for all plans.*

Have questions? Contact HPI Customer Service at the phone number or website listed on the back of your member ID card.

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Connecting you to the lowest cost prescription solutions

SmithRx Connect 360

SmithRx can help lower your drug costs.

SmithRx's Connect 360 programs help you access cost-saving options, often reducing medication costs to little or nothing. Continuously evolving, Connect 360 ensures members get the best prices on their medications.

Here is the growing list of Connect 360 Programs:

Connect Access (CA-T & CA-S)	Capture manufacturer coupon savings on traditional and specialty medications. Members have a low or $0 copay on prescriptions while also helping employers save on pharmacy benefit costs.
Access Plus	Leverages advocacy foundations and grant programs to reduce cost when a high-cost specialty medication is not covered under the pharmacy benefit. We assist members in navigating and applying to these different programs.
Cost Plus Drugs	Cost Plus Drugs is building an innovative pharmacy model that delivers medications at cost, plus a straightforward 15% markup, along with a $5 dispensing fee and shipping. Cost Plus Drugs carries over 1,000 medications and is continuing to expand their drug list weekly.
Autoimmune	Through this program, SmithRx members can now access low cost, FDA-approved biosimilars such as Yusimry, a biosimilar for Humira, and Otulfi, a biosimilar for Stelara, through Cost Plus Drugs and Costco Specialty Pharmacy. FDA-approved biosimilars have no clinically meaningful differences in terms of safety and effectiveness from their brand-name counterparts, while offering a more affordable option for members with autoimmune conditions.
Multiple Sclerosis (MS)	Through the MS Program, members will transition to the lowest- cost Multiple Sclerosis treatment options on the market through Cost Plus Drugs.
Low-Cost Insulin (LCI)	This program helps reduce insulin costs at the pharmacy by transitioning to generic and biosimilar insulin products.
Diabetes Non-Insulin (DNI)	Through our partnership with Cost Plus Drugs, we are offering Brenzavvy, an SGLT2 inhibitor, as the lowest cost option for members with type 2 diabetes.
Referral Partner Program (340 B)	Provides members with lower net costs for eligible program medications. By providing access to discounted medications, the 340B program helps eligible healthcare organizations stretch their resources further, enhance patient care, and improve health outcomes.

Who is eligible for Connect 360 Programs?

Anyone on your prescription benefit plan is eligible for SmithRx Connect 360. There are no costs to participate, as long as you are enrolled with SmithRx's pharmacy benefits plan. A dedicated team of Connect 360 specialists proactively identifies medications that qualify for the program and reaches out to you to offer enrollment support in the option that provides the **lowest net cost** for your medication.

Maximize your Savings

The SmithRx Connect 360 Team works behind the scenes to find any medications you take that qualify for a Connect 360 program. They identify the program that results in the lowest net cost and contact you to help with enrollment. To ensure you don't miss out on savings, make sure your contact information is up to date.

Enrollment Process

If eligible for a Connect 360 program, you will be assigned a dedicated agent to assist you throughout the entire enrollment process.

1. The Connect 360 team will reach out via phone call, SMS text and/or a notification in the SmithRx Member portal to notify you if any of your medications are eligible cost savings.
2. The Connect 360 Team will help you complete enrollment over the phone or online.
3. The Connect 360 Team will inform you once the program enrollment was successful.

We're here to help!

If you have any questions or need assistance, the Connect 360 Team is here to help! You can reach out to us at **(844) 385-7612** or **connect@smithrx.com.**

SmithRx Pharmacy Partners

Accessing your prescriptions is easy with our **broad pharmacy network**, which gives you access to **retail**, **mail order**, and **specialty** pharmacies. You can always find the pharmacy with the best price by using the **Find My Meds** search tool in the Member Portal at mysmithrx.com.

Retail Partners

We partner with over 65,000 pharmacies, including national and regional chains, grocery stores and local pharmacies. Here are just a few of the retail pharmacies in our network.

CVS pharmacy · Walgreens · Walmart · Costco Wholesale

Specialty Partners

Costco Wholesale

To enroll, create an account on the Costco Pharmacy Member Portal or call 855-213-0070. Providers can send prescriptions via e-scribe.

Ordering: The Costco Pharmacy Team helps you manage your refills. You can order refills through the Costco Member Portal or by phone.
Shipping: Shipping is free. Refrigerated medications are shipped the next day. Other medications are be shipped within 2 days.

SENDERRA

To enroll, call 888-777-5547. Providers can send prescriptions via e-scribe.

Ordering: The Senderra Refill Specialists will call you when it's time to refill your medication. Orders need to be placed by phone.
Shipping: Standard shipping is free. Refrigerated medications are shipped overnight, except on Fridays. Other medications are sent with 2 day shipping.

Mail Order Partners

Register at www.amazon.com/smithrx. Doctors can send prescriptions via electronic prescribing, fax or phone:

- **Name/E-scribe**: Amazon Pharmacy Home Delivery
- **Amazon Pharmacy fax:** 512-884-5981
- **Amazon prescriber and pharmacy line:** 855-206-3605

Doctors can send prescriptions via electronic prescribing, fax or phone:

- **Walmart Pharmacy fax:** 1 (800) 406-8976
- **Walmart prescriber and pharmacy line:** 1 (800) 273-3455
- **Website:** www.walmart.com/cp/1042239

See whether your medications are available: costplusdrugs.com/medications. Doctors can send prescriptions via electronic prescribing to:

- **Name/E-scribe:** Mark Cuban Cost Plus Drug Company (MCCPD)

We are here to help!

Have questions or need assistance? Contact our Member Services Team. Live support is available **Monday through Friday, 8 am - 9 pm ET** and **Saturdays 11 am - 4 pm ET**.

Chat
Chat live with a member service representative on our website or in the member portal

Portal
Find plan info, ID cards and documents at smithrx.com/portal

Email
Email our team at help@smithrx.com

Phone
Call us at 844-454-5201

SCAN ME

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- Save Money on Low- Cost providers
- Manage your plan Online
- Dr.On Demand
- Find a Provider
- Discounts & Savings

LINK HERE

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SmithRx

- Pharmacy Benefit Open Enrollment
- SmithRx Pharmacy Partners
- SmithRx Connect 360

LINK HERE

DENTAL PLAN

DELTA DENTAL®

Amoskeag Health offers dental insurance through NE Delta Dental. Employees working 30 hours or more are eligible for dental benefits the first day of the month following date of hire.

PPO Network		
Diagnostic / Preventive (Coverage A)	**Basic Restorative** (Coverage B)	**Major Restorative** (Coverage C)
DIAGNOSTIC: • Evaluations twice in a 12-month period; problem-focused exams as needed • X-rays (complete series or panoramic film) once in a 5- year period • Bitewing x-rays once in a 12- month period • X-rays of individual teeth as necessary • Brush biopsy once in a 12- month period **PREVENTIVE:** • Two cleanings in a 12-month period • Fluoride once in a 12-month period to age 19 • Space maintainers to age 16 • Sealant application to permanent molars, once in a 3- year period per tooth, for children to age 19 **Note:** Expenses incurred for covered Diagnostic and Preventive services do accrue to your annual maximum.	**RESTORATIVE:** • Amalgam (silver) fillings; • Composite (white) fillings (on anterior teeth only) **ORAL SURGERY:** • Surgical and routine extractions **ENDODONTICS:** • Root canal therapy **PERIODONTICS:** • Treatment of gum disease • Periodontal Cleaning (Maintenance procedures) • Clinical crown lengthening once per tooth per lifetime **DENTURE REPAIR:** • Repair of a removable denture to its original condition **Note:** Cleanings are limited to two in a 12- month period; these may be routine (Coverage A) or periodontal (**EMERGENCY PALLIATIVE TREATMENT**	PROSTHODONTICS: • Removable and fixed partial dentures (bridge); complete dentures • Rebase and reline (dentures) • Crowns • Onlays • Implants
Dental Dental Pays 100% No Waiting Period	Delta Dental Pays 80% No Waiting Period	Delta Dental Pays: 50% No Waiting Period
Calendar Year Maximum: $1000 up to $2000 per Person with Double-Up MaxSM Health through Oral Wellness® program included		

Your Dental Plan is fully insured with: ***NE Delta Dental***

Employees and their family are free to choose a dentist of their choice. For an updated list of participating dentists, visit NE Delta Dental's website at www.nedelta.com.

Note: For more detailed information on benefits, limitations and exclusions refer to the Summary of Benefits and Subscriber Certificate provided by the carrier. Please contact NE Delta Dental's Customer Service at 1-800-832-5700 with questions regarding coverage, claims, or to change your Dentist.

DELTA DENTAL

Access Your Member Benefits 24/7

Enjoy 24/7 access to your benefit and claim information, print additional identification cards, read your benefit booklet and Explanation of Benefits (EOB), download our mobile app, search for a dentist, register for the Health *through* Oral Wellness® (HOW®) program, and so much more—*all when it's convenient for you!*

At Northeast Delta Dental we strive to give you the best experience possible. That includes technology with access to the information and tools you need, all while supporting our efforts to ***go green*** by reducing paper waste and our carbon footprint.

HOW® HEALTH *through* ORAL WELLNESS®

Register for HOW®

View your benefits/ Find a dentist

Print ID cards

Download our mobile app

View claims and print EOBs

Read your dental plan booklet

Registration is simple:

1. Go to **www.nedelta.com** and click on **PATIENTS**
2. Click **Log In** or **Register Here** to get started!
3. Complete the registration process

Note: You will need your Subscriber ID number (found on your ID card or by calling Customer Service at 1-800-832-5700).

Find a Dentist

Finding a dentist in your area is easy!

Find a Dentist is located in the top right corner of every page. Enter some general information about your location and network type, click **Search**, and a list of dentists serving your area will be displayed. **Note:** If you are enrolled in a PPO plus Premier Program, please be sure to search both networks.

Stretch your annual maximum dollars!

If your Northeast Delta Dental plan includes our PPO network, and if you are looking for ways to save money on your dental care and lower your out-of-pocket dental expenses, consider looking for a Northeast Delta Dental PPO dentist for your care.

Health *through* Oral Wellness® (HOW®)

HOW® HEALTH *through* ORAL WELLNESS®

Health *through* Oral Wellness® is a program designed to promote better oral health and overall health for Northeast Delta Dental Members. HOW® is all about YOU because it's based on your own specific oral health risks and needs. Best of all, it's secure, confidential, and absolutely FREE.

REGISTER - Go to **HealthThroughOralWellness.com** and click on "Register Now"

KNOW YOUR SCORE - After you register, please take the free oral health risk assessment!

SHARE YOUR SCORE WITH YOUR DENTIST: Share your results with your dentist at your next dental visit. Your dentist can discuss your results with you and perform a clinical version of the assessment. Based on your risk, as shown on your clinical assessment, you may be eligible for additional preventive benefits at no cost if your employer participates in the HOW program.*

**Additional preventive benefits are subject to the provisions of your Northeast Delta Dental policy. Only the clinical risk assessment performed by your dentist can determine your eligibility for additional preventive benefits.*

EyeMed Vision and Hearing Discount Program

- Save up to 35% off eyewear and 40% off hearing exams.
- With **Vision Wellness**, choose from any available frame, including quality name-brand products at provider locations, including:

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION TARGET OPTICAL

- **Hearing Wellness** includes discounted, set pricing on thousands of hearing aids and is offered through Amplifon, the nation's largest independent hearing care network.

eyeMed℠

Learn more at www.nedelta.com or from our Customer Service Representatives at 1-800-832-5700.

VISION PLANS

Employees may enroll in the Eye Med Vision plan. Employees working 30 hours or more are eligible for dental benefits the first day of the month following date of hire.

Vision Care Services	In-Network	Non-Network Reimbursement
Eye Exam with Dilation Once every 12 months	Member pays $10 copay; plan pays balance	$30 Reimbursement
Exam Options Standard contact lens fit & follow up Premium contact lens fit & follow up	Member pays up to $40 10% off the retail price	N/A N/A
Frames Once every 24 months	Plan pays $120 frame allowance amount, then 20% off balance	$60
Lenses or Contacts Once every 12 months		
Standard Plastic Lenses Single Vision Bifocal Trifocal	Member pays $10; plan pays balance	$25 Reimbursement $40 Reimbursement $55 Reimbursement
Lens Options UV treatment Tint (solid and gradient) Standard Plastic Scratch Coating Standard Polycarbonate Standard Anti-reflective Other	Member pays: $15 copay $15 copay $0 copay $40 copay $45 copay 20% off Retail Price	None None $5 None None None
Contact Lenses (materials only) Conventional Disposable Medically Necessary	Plan pays $135 contact lens allowance amount, then 15% off balance Plan pays contact lens allowance, member pays balance Covered in full	$108 $108 $200
Laser Vision correction average 15% off the regular price or 5% off the promotional price from contracted facilities		N/A

To locate a provider near you visit: www.eyemed.com. Search the SELECT network of providers.

You will receive the best value when you choose a participating Eye Med doctor. If you see a non-Eye Med provider, you will typically pay more out of pocket. For more information please visit the website: eyemed.com or call 1-866-723-0513.

EXPERIENCE MORE: ONLINE ACCESS

HOW TO: enjoy your own eye site

MEMBER WEB ON EYEMED.COM

Your vision plan is like a friendly smile – it doesn't do any good if it's hidden away. Member Web at eyemed.com is here, there and everywhere. It's your vision plan control center. A place to manage the details of every visit and every claim. Instantly. Easily. Smile-ly.

START MANAGING YOUR BENEFITS IN A FEW EASY STEPS:

1. Visit eyemed.com and click on Member Login.
2. If you're a new user, click on Create an Account.
3. Register using your member ID or the last four digits of your social security number (You'll get an email asking to confirm your account.).*
4. Finish setting up your new account with your email address and a password (To keep it secure, we list some password "musts.").
5. Come back anytime to change your password, email address and billing preferences (It's all under Manage Profiles.).

LOG IN 24/7 TO:

- View your benefit details
- Confirm eligibility
- Check claim status
- Print replacement ID cards
- Locate a provider
- Schedule an appointment online**
- View health and wellness information
- Get special offers

SEE THE GOOD STUFF

Register on eyemed.com or grab the member app (App Store or Google Play) now

* Depends on how your benefit administrator entered you into the system.

** Most, but not all, network providers offer this.

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION TARGET OPTICAL

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- Know-how and Show-how
- HOW TO

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DELTA DENTAL®

- Access Member Benefits
- Delta Dental Mobile
- HOW
- 24/7 Care

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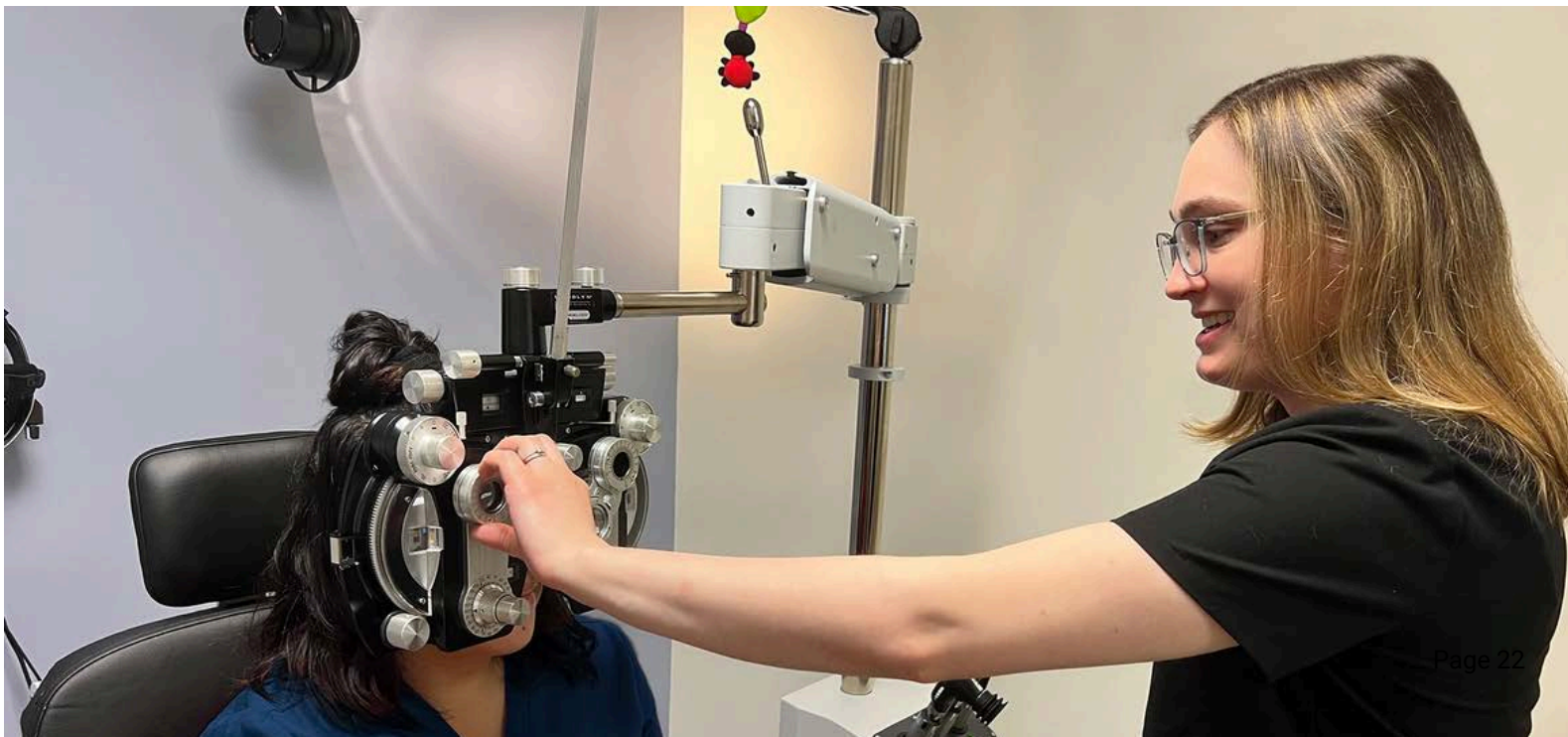

MEDICAL RATES

Plan Type	Employee Bi-Weekly (40+ hours weekly)	Employee Bi-Weekly (30 to less than 40 hours weekly)
HMO LOW LP – Employee Deductible: $1,000		
Single	$94.79	$106.63
****Employee + Spouse/Partner ****	$394.56	$460.32
Employee + Child(ren)	$299.18	$359.01
****Employee + Family ****	$630.35	$720.40

Plan Type	Employee Bi-Weekly (40+ hours weekly)	Employee Bi-Weekly (30 to less than 40 hours weekly)
HMO HIGH LP – Employee Deductible: $3,000		
Single	$66.69	$77.81
****Employee + Spouse/Partner ****	$320.78	$382.47
Employee + Child(ren)	$235.75	$291.88
****Employee + Family ****	$523.74	$608.22

Plan Type	Employee Bi-Weekly (40+ hours weekly)	Employee Bi-Weekly (30 to less than 40 hours weekly)
HDHP H.S.A. – Employee Deductible: $3,500		
Single	$58.50	$65.52
****Employee + Spouse/Partner ****	$290.88	$332.44
Employee + Child(ren)	$236.32	$264.67
****Employee + Family ****	$426.78	$512.13

Plan Type	Employee Bi-Weekly
Dental – Plan Year Rates	
Single	$5.90
****Employee + 1 Dependent ****	$19.57
****Employee + Family ****	$43.97

Plan Type	Employee Bi-Weekly
EyeMed Vision – Employee Contribution Rates	
Single	$3.57
****Employee + Family ****	$7.16

LIFE INSURANCE

Employees working 30 hours or more are eligible the first of the month following the 30 day waiting period. Your Life and AD&D insurance plans are paid for in full by Amoskeag Health

Life Insurance	100% Employer Paid	$50,000
AD&D (Accidental Death & Dismemberment)	100% Employer Paid	$50,000

Your Life and AD&D insurance is fully insured through Standard Life Insurance Co. Please be advised this is a brief overview. Please refer to your Summary Plan Description for complete benefit information.

Voluntary Term Life and AD&D

Employees are able to purchase Supplemental Life and/or AD&D Insurance in increments of $10,000 to a maximum benefit of the lesser of 5x base annual salary or $500,000. You may purchase AD&D coverage for yourself regardless of purchasing Life coverage. Guarantee Issue amount for new hires is: $100,000.

Spousal coverage of either Supplemental Life and/or AD&D Insurance may be purchased in increments of $5,000, to a maximum amount of $250,000. Guarantee Issue amount for new hires is: $25,000. Supplemental Life and/or AD&D Insurance coverage for dependent children 15 days old or older may be purchased in increments of $2,000 not to exceed $10,000. Guarantee Issue amount for new hires is: $10,000.

In order to purchase either Life or AD&D coverage for your spouse and/or child, you must purchase either Life or AD&D coverage for yourself. Employees and dependents currently enrolled in Voluntary Life Insurance or late entrants who wish to purchase additional coverage must complete an evidence of insurability (EOI) form which can be found in Kronos under single person icon > My Company > Documents > in Document name type: Standard Evidence of Insurability (EOI) form.
Your Voluntary Life and AD&D insurance is fully insured through Standard Life Insurance Co. Please be advised this is a brief overview. Please refer to your Summary Plan Description for complete benefit information.

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- **Group Basic Life and Accidental Death and Dismemberment**
- **Group Additional Life and AD&D Insurance**
- **Group Short Term Disability Insurance**
- **Group Long Term Disability Insurance**
- **Employee Assistance Program**
- **Travel Assistance**
- **Life Service Toolkit**

LINK HERE

DISABILITY INSURANCE

Employees working 30 hours or more are eligible the first of the month following the 30-day waiting period. The Short Term Disability plan is paid for in full by Amoskeag Health. The Voluntary Long Term Disability plan is paid for through payroll deductions.

Short Term Disability Income Protection (STD)

The benefit payable is **60% to a maximum of $1,000 per week** for a non-occupational injury or illness. Benefits begin on the **1st day of an injury and the 8th day of an illness** and are payable for a maximum duration of **13 weeks**.

Voluntary Long Term Disability Income Protection (LTD)

The benefit payable is **60% of your monthly salary to a maximum of $5,000 per month** for a non-occupational injury or illness. Benefits **begin after a 90-day elimination period**. All late entrants must fill out an Evidence of Insurability.

Your STD and VLTD insurance is fully insured through Standard Life Insurance Co. Please be advised this is a brief overview. Please refer to your Summary Plan Description for complete benefit information.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Employee Assistance Program (EAP) service is provided at no additional cost to you by your employer, in connection with your Group Long Term Disability coverage from Standard Insurance Co. This program can help with solutions to a wide variety of everyday challenges:

- Depression, grief, loss and emotional well-being
- Family, marital and other relationship issues
- Life improvement and goal-setting
- Addictions such as alcohol and drug abuse
- Stress or anxiety with work or family
- Financial and legal concerns
- Identity theft and fraud resolution
- Online will preparation

Through Standard Insurance Co. Employee Assistance Program (EAP), you have unlimited access to master's-degree clinicians by telephone, online, live chat, text and email, as well as resources and tools online, and up to three face-to-face visits with counselors for help with a short-term problem.
Your calls and all counseling services are completely confidential.

Call toll-free 24 hours a day, 365 days a year: 888-293-6948
For additional assistance, please visit the website at: www.healthadvocate.com/standard3

403(B) PLAN

Amoskeag employees who work a minimum of 20 hours per week may enroll immediately in this tax-favored savings program, which offers the advantage of saving money while deferring the payment of federal taxes until you begin receiving retirement benefits.

Employees may elect to defer 1% to 100%, not to exceed $24,500 of their gross annual compensation in 2026. Employees 50 years or older may defer an additional $8,000 per year in 2026. Once you have completed at least 1 year and 1,000 hours of service, you will be eligible for the company match, up to 4%. If you wish to change or cancel your current elections, simply log in to the portal to update your elections. The portal will transmit updates to both HR and Payroll.

For questions about the vesting schedule, transfers/allocation changes, investment options, rollovers, or managing your account, please visit empowermyretirement.com or call 1-800-701-8255.

FLEXIBLE SPENDING ACCOUNT (FSA)

Full-time employees are eligible to participate in the Flexible Spending Accounts. Flexible Spending Accounts provide employees with an important tax advantage that can help you pay health care and dependent care costs on a pre-tax basis.

By anticipating your family's health and dependent care expenses for the upcoming year, you can lower your taxable income.

The Medical Flexible Spending Account plan allows you to set aside up to a maximum of $3,400 per plan year from your salary on a pre-tax basis to reimburse yourself for medical or dental expenses that are not paid by the insurance plan(s) and includes the grace period provision.

The Dependent Care Reimbursement Account plan allows employees to set aside up to $7,500 per participant (or $3,750 if married filing separately) over the course of the Plan Year, pre-tax, to reimburse them for out-of-pocket dependent care expenses.

Grace Period:
The grace period extension allows for a 2 ½ month time frame following the end of the plan year. During this period, you can use any remaining funds in your account to cover eligible expenses through **3/15/2027**. You can continue to access the remaining balance using your CGI FSA debit card throughout the grace period to spend down the funds.

Health FSA	Dependent Care FSA
$3,400.00	$7,500.00

Effective in 2021 under The Cares Act, participants are able to use their CGI Benefit Card to purchase eligible over-the-counter (OTC) drugs and menstrual care products. The IRS announcement under 2021-7, Personal Protection Equipment (PPE) such as masks, hand sanitizer and sanitizing wipes are health FSA eligible items, effective April 5, 2021.

CGI'S ONLINE PORTAL

CGI's Online Portal is available 24/7 for you to access your FSA account information for health care and dependent care funds. Employees are able to use the CGI Benefit Card for health care and dependent care transactions. These features allow for more simplified claims processing.

Download the free app "CGI Business Solutions Mobile" from the Apple Store or Android Marketplace. Gain instant access by entering the same username and password you created by registering at: cgi.wealthcareportal.com

• View account balances and transactions
• Attach receipts by taking a picture with your smartphone
• Add or edit text message alerts
• Contact CGI Business Solutions' Benefits Administration Department for assistance

Please direct inquiries to either Human Resources or the CGI Benefits Administration team at 1-888-383-0088. Please be advised this is a brief overview. Please refer to your Summary Plan Description for complete benefit information.

How to Register and Create your User Account in CGI's Online Portal

Go to cgi.wealthcareportal.com or scan the QR code to get started.

Follow the steps below:

1. Enter 'first name', last name', 'zip code'
   - 'Benefit card' is optional to enter

Employer ID: CGIMCHC

2. Choose a method to receive the verification code either by email or text. Enter the code received.
3. Create a unique Username and designate an email and password to use with the account.
4. Select four (4) security questions to answer
5. Confirm your email address
6. Confirm your security questions and answers
7. Submit to complete the registration process

Account Access as Mobile as you are!

Search 'CGI Business Solutions Mobile' and download the APP.

Business Solutions

Scan the QR code to review the CARES Act Eligible Flexible Spending Account and Health Savings Account Expenses and Over-the-Counter Products, as well as the FSA Plan provided by CGI, and how to register for the CGI Online Portal.

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- **CARES Act Eligible Flexible Spending Account and Health Savings Account Expenses and Over-the-Counter Products**
- **FSA Plan**
- **CGI Online Portal Registration**

LINK HERE

HEALTH SAVINGS ACCOUNT (HSA)

If you enroll in the High Deductible Health Plan (HDHP), you may be eligible to open and contribute to a Health Savings Account (HSA).

An HSA is a special bank account you use to save money for medical expenses- things like doctor visits, prescriptions, dental care, or vision services. You don't pay taxes on the money you put into the account, and you don't pay taxes when you spend it on qualified healthcare expenses.

Employees who already have an existing HSA can keep using it. If you don't have one yet, you can open an HSA with any financial institution of your choice (for example, your own bank or credit union).

Please note: Employees enrolled in the HDHP may not participate in the Medical Flexible Spending Account (FSA) at the same time.

HSA Benefits (Why it's a good idea)

1. Triple tax advantage
   - Money you put in your HSA is not taxed.
   - The money grows tax-free while it's in the account.
   - When you use it for qualified medical expenses, you don't pay taxes on it either.
2. Your money stays with you
   - The money in your HSA is yours forever- it doesn't expire, and it stays with you even if you change jobs or retire.
3. Great for saving for the future
   - You can use your HSA now for small things (like a doctor visit), or save it long-term for medical costs in retirement.
4. Flexibility and control
   - You choose how much to contribute, which bank to use, and when to spend or save.

IRS HSA Contribution Limits for 2026	
Individual	$4,400
Family	$8,750
Catch-up Contribution (age 55 or older) **	$1,000

** Individuals aged 55 or older can make an additional **$1,000** "catch-up" contribution annually, which remains unchanged from previous years because it is fixed by law. Spouses who are both age 55 or older can each make a separate catch-up contribution to their own HSA accounts.

Who Can Contribute to an HSA

You can contribute to an HSA only if all of the following are true:

- You are enrolled in a qualified High Deductible Health Plan (HDHP).
- You are not covered by any other non-HDHP medical plan, such as a spouse's traditional PPO or HMO.
- You are not enrolled in Medicare (Part A or Part B).
- You are not claimed as a dependent on someone else's tax return.

When You Can't Contribute

You cannot make new HSA contributions if:

- You are covered by any non-HDHP plan, including a spouse's plan, FSA, or HRA that pays first-dollar benefits before the deductible.
- You are enrolled in Medicare (even Part A alone). Once you have Medicare, you can still spend your existing HSA funds but cannot contribute new money.
- You are covered by TRICARE or any Veterans Affairs (VA) benefits that pay for non-service-related care before the HDHP deductible.
- You are listed as a dependent on someone else's tax return.

HSA and Medicare

If you are approaching age 65 or planning to enroll in Medicare soon:

- You must stop contributing to your HSA the month before your Medicare coverage begins.
- If you delay Medicare enrollment, you can keep contributing until your Medicare coverage starts.
- Once enrolled in Medicare, you can still use existing HSA funds for qualified expenses (including Medicare premiums, deductibles, and copays), but you can't add new money to the account.

Important: Medicare Part A coverage is often retroactive up to 6 months. To avoid excess contributions, you may need to stop contributing up to 6 months before your Medicare effective date.

NOTICES

COBRA Information COBRA continuation coverage is a temporary extension of coverage under the group health plan. 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

Health Insurance Marketplace You may have other options available to you when you lose group health coverage. You may be eligible to buy an individual plan through the Health Insurance Marketplace (www.healthcare.gov). 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 does not accept late enrollees.

HIPAA Information Special Enrollment Right Mandated by the Health Insurance Portability and Accountability Act of 1996 Group health plans and health insurance insurers are required to provide special enrollment periods during which individuals who previously declined coverage for themselves and their dependents may be allowed to enroll without having to wait for the plan's next open enrollment period. A special enrollment period can occur if a person with other health coverage loses that coverage or if a person becomes a new dependent through marriage, birth, adoption, or placement for adoption. If you refuse enrollment for yourself or your dependents for medical coverage, you may later enroll within 30 days of a change in family status or loss of health coverage. Individuals may not be denied eligibility or continued eligibility to enroll for benefits under the terms of the plan based on specified health factors. In addition, an individual may not be charged more for coverage than similarly situated individuals based on these specific health factors. Effective April 1, 2009, the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA) created a new 60 day special enrollment period for eligible employees and dependents to immediately enroll in the plan if they become ineligible for Medicaid or any state's Children's Health Insurance Program (CHIP) and lose coverage or become eligible for that state's premium assistance program. The employee must request coverage within 60 days after the termination of coverage or the determination of subsidy eligibility.

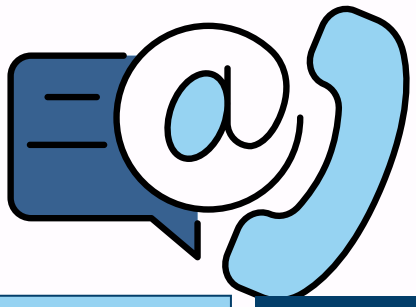
Women's Health and Cancer Rights Act of 1998 (WHCRA) WHCRA requires a group health plan to notify you, as a participant or a beneficiary, of your potential rights related to coverage in connection with a mastectomy. Your plan may provide medical and surgical benefits in connection with a mastectomy and reconstructive surgery. If it does, coverage will be provided in a manner determined in consultation with your attending physician and the patient for a) all stages of reconstruction on the breast on which the mastectomy was performed; b) surgery and reconstruction of the other breast to produce a symmetrical appearance; c) prostheses; and d) treatment of physical complications of the mastectomy, including lymphedema. The coverage, if available under your group health plan, is subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under the plan. For specific information, please refer to your summary plan description or benefits booklet, or contact Human Resources.

Newborns' and Mothers' Health Protection Act Group health plans and health insurance issuers generally may not, under Federal law, restrict 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 attending provider, 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, under Federal law, require 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).

This benefits guidebook describes the highlights of Community Partner's benefits program in non-technical language. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official plan documents, and not the information in this guidebook.

If there is any discrepancy between the descriptions of the program's elements as contained in this benefits guidebook and the official plan documents, the language in the official plan documents shall prevail as accurate. Please refer to the plan-specific documents published by each of the respective carriers for detailed plan information. You should be aware that any and all elements of Community Partner's benefits program may be modified in the future, at any time, to meet Internal Revenue Service rules, or otherwise as decided by Community Partners

CONTACTS + VENDORS



SERVICE	NUMBER	EMAIL/WEBSITE
MEDICAL BENEFITS HPI	800.532.7575	healthplansinc.com
PHARMACY SMITH RX	844.454.5201	smithrx.com
DENTAL BENEFITS NE DELTA DENTAL	800.832.5700	nedelta.com
VISION BENEFITS EYEMED	866.723.0513	eyemedvisioncare.com
LIFE AND DISABILITY EMPLOYEE ASSISTANCE PROGRAM (EAP) THE STANDARD	800.628.8600 888.293.6948	standard.com healthadvocate.com/standard
FLEXIBLE SPENDING ACCOUNT (FSA) CGI BUSINESS SOLUTIONS	888.383.0088	claims@cgibenefitsgroup.com
403(B) EMPOWER	800.701.8255	empowermyretirement.com
ACCOUNT EXECUTIVE JESS BLAIS	603.232.9375	jblais@cgibenefitsgroup.com

REQUIRED NOTICES

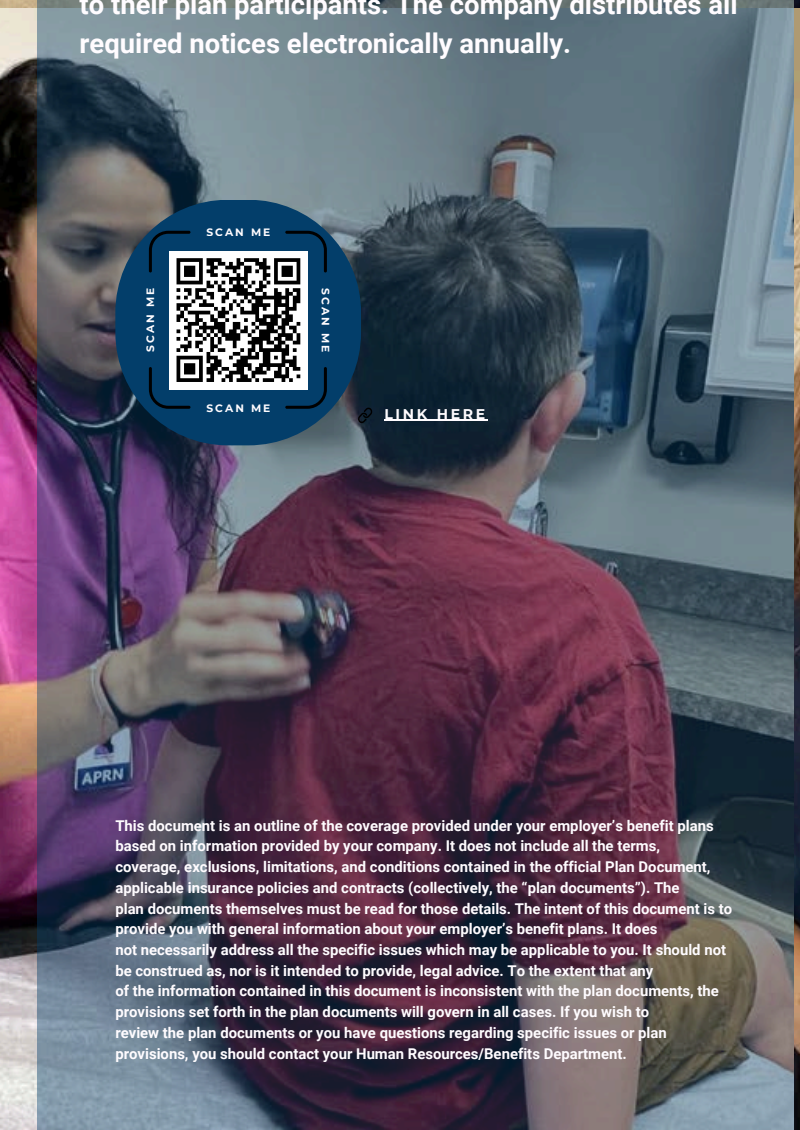
Information regarding required notices may be found at Community Partners or by contacting Human Resources at HR@amoskeaghealth.org.

Important Note:

The material enclosed is for informational purposes only and is neither an offer of coverage or medical or legal advice. It contains only a partial description of the plan or program and does not constitute a contract. Please refer to the Summary Plan Description (SPD) for complete plan details. In case of a conflict between your plan documents and this information, the plan documents will always govern.

Annual Notices:

ERISA and various other state and Federal law requires that employers provide disclosures and annual notices to their plan participants. The company distributes all required notices electronically annually.



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This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.