NOTICE OF SUMMARY MATERIAL MODIFICATION

Dear Participant and Beneficiaries,

This summary of material modification ("**SMM**") describes changes to Northwestern Medical Center Prescription Plan ("**Plan**") and supplements the Summary Plan Description ("**SPD**") for the Plan. The effective date of each of these changes is indicated below. You should read this SMM very carefully and retain this document with your copy of the SPD for future reference.

If this summary has been delivered to you by electronic means, you have the right to receive a written summary and may request a copy of this on a written paper document at no charge by contacting the plan administrator.

Benefit Plan Impacted: Prescription Plan

Reason for SMM

- Provisions that establish new conditions or requirements
- Modifications that narrow or expand the circumstances under which benefits are paid

Effective Date of Material Modification: 05/01/2020

Summary of Changes:
Please see the attached document for a description of changes impacting your benefits or participation.

Additional Information:
Refer to your Summary Plan Description (SPD) for details of your benefit plans. If you have questions regarding this modification, contact the Plan Administrator at:
Northwestern Medical Center.
Louise Roucheleau
133 Fairfield St, St Albans, VT 05478
lrocheleau@nmcinc.org
(802) 524-8438

General Plan Information:
Plan Name: Northwestern Medical Center's Health & Welfare Benefit Plan
Plan Number: 508
Plan Sponsor/Plan Administrator: Northwestern Medical Center

Northwestern Medical Center
Effective May 1, 2020

Gold

Deductible: $50 per person
The calendar year deductible applies to all drugs at retail pharmacies or Accredo Specialty Pharmacy. The deductible does not apply at NMC, affiliated pharmacies, or mail order. Once met, your covered prescriptions are subject to the copays below. The deductible does apply to the Maximum Out Of Pocket (MOOP).

	30 Day Supply NMC & Affiliated Pharmacies	90 Day Supply NMC & Affiliated Pharmacies	30 Day Supply All Other Retail Pharmacies	90 Day Supply All Other Retail*/Mail Pharmacies
Tier 1 - Generic Drugs	$5	$15	$10	$30
Tier 2 - Preferred Brand Name Drugs	$20	$60	$40	$120
Tier 3 - Non-Preferred Brand Name Drugs	$20	$60	$50	$150
****Specialty**	N/A	N/A	30%	N/A

Maximum Out of Pocket (MOOP): $2,250 Individual/$4,500 Family
The calendar year Maximum Out of Pocket (MOOP) applies to pharmacy and medical claims. Each individual family member must meet the individual MOOP unless the family MOOP has been met by any two or more covered family members. Once met, your covered prescriptions are paid at 100%.

Affiliated Pharmacies: Rite Aid – St. Albans, Rite Aid – Milton, Rite Aid – Enosburg, Walmart – St. Albans, Kinney Drugs – St. Albans, and Kinney Drugs – Milton, Walgreens-Essex Junction, Walgreens-Colchester, Walgreens-Winooski, NOTCH-Swanton, NOTCH-Richford

***Limited pharmacy network:** Over 58,000 retail pharmacies. Contact RxBenefits Member Services if you would like to inquire about a specific pharmacy.

****Specialty Medications:** Specialty medications are limited to 30 day supply and are subject to the coinsurance above. Specialty medications must be ordered from Accredo Specialty Pharmacy at 1-800-803-2523. Specialty medications may be subject to prior authorization, step therapy, and quantity limits.

High Dollar Claim Review: Medication costs exceeding $1,000 per 30 day supply and $3,000 per 90 day supply require prior authorization.

Low Clinical Value: Certain formulary exclusions including medications which have low clinical value may apply. Contact Member Services at 1-800-334-8134 for additional information.

Step Therapy Program: Your plan has certain medications that are subject to step therapy. You could be asked to try one of the first or second level options before a Brand medication is covered by the plan.

Dispense as Written (DAW) Policy: If your doctor writes a prescription stating that a Generic may be dispensed, we will only pay for the Generic drug. If you choose to buy the Brand name drug in this situation, you will be required to pay the Brand copay plus the difference in cost between the Generic and Brand name drug. The DAW Policy does not apply if your doctor requires a brand name medication.

DRUGS COVERED***

Drugs covered may be subject to Utilization Management which may include prior authorization and/or quantity limits. Please contact Member Services if you have specific drug questions or register at express-scripts.com to check coverage.

- ADD/ADHD Medications
- Androgens
- Compound medications of which at least one ingredient is a legend drug at a participating pharmacy. Compounded medications equal to or exceeding $300 per script may require prior authorization.
- Contraceptives: Oral, transdermal, intravaginal, implantable devices, injectable, diaphragms, IUD's and extended cycle products
- Diabetic Care: Insulin/Insulin pre-filled syringes, Agents/Strips for testing, Disposable insulin needles/syringes and lancets
- Growth Hormones
- Gastrointestinal-Antiemetics
- Hypnotics
- Impotency Medications
- Legend Drugs (drugs that require a prescription) Exceptions: See Exclusion list below
- Migraine medications
- Narcolepsy Medications
- Nutritional Supplements (Rx Only)
- Pain/Narcotics
- Prescription Vitamins
- Prescription and OTC smoking cessation (two 12 week programs per plan year); OTC requires prescription
- Topical Acne Medications

EXCLUSIONS***

- Anti-obesity/Appetite Suppression medications
- Biologicals, Immunization Agents
- Blood Products and Serums
- Cosmetic agents: Anti-wrinkle agents, Pigmenting & De-Pigmenting, Hair growth stimulants and hair removal products
- Compounded prescriptions that use ingredients such as bulk chemicals and powders
- Formulary Exclusion List
- Infertility Medications
- OTC Products unless noted above
- Topical Analgesic Pain Patches
- Therapeutic devices or appliances unless listed as a covered product
- Patient assistance programs may not apply to deductible and out of pocket accumulations.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a physician's office, licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

***This is not an inclusive list but is a representation of the most commonly used medications. Contact member services for specific drug coverage information**.

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

Northwestern Medical Center
Effective May 1, 2020

Silver

Deductible: $50 per person
The calendar year deductible applies to all drugs at retail pharmacies or Accredo Specialty Pharmacy. The deductible does not apply at NMC, affiliated pharmacies, or mail order. Once met, your covered prescriptions are subject to the copays below. The deductible does apply to the Maximum Out Of Pocket (MOOP).

	30 Day Supply NMC & Affiliated Pharmacies	90 Day Supply NMC & Affiliated Pharmacies	30 Day Supply All Other Retail Pharmacies	90 Day Supply All Other Retail*/Mail Pharmacies
Tier 1 - Generic Drugs	$5	$15	$10	$30
Tier 2 - Preferred Brand Name Drugs	$20	$60	$40	$120
Tier 3 - Non-Preferred Brand Name Drugs	$20	$60	$50	$150
****Specialty**	N/A	N/A	30%	N/A

Maximum Out of Pocket (MOOP): $3,250 Individual/$6,500 Family
The calendar year Maximum Out Of Pocket (MOOP) applies to pharmacy and medical claims. Each individual family member must meet the individual MOOP unless the family MOOP has been met by any two or more covered family members. Once met, your covered prescriptions are paid at 100%.

Affiliated Pharmacies: Rite Aid – St. Albans, Rite Aid – Milton, Rite Aid – Enosburg, Walmart – St. Albans, Kinney Drugs – St. Albans, and Kinney Drugs – Milton, Walgreens-Essex Junction, Walgreens-Colchester, Walgreens-Winooski, NOTCH-Swanton, NOTCH-Richford

***Limited pharmacy network:** Over 58,000 retail pharmacies. Contact RxBenefits Member Services if you would like to inquire about a specific pharmacy.

****Specialty Medications:** Specialty medications are limited to 30 day supply and are subject to the coinsurance above. Specialty medications must be ordered from Accredo Specialty Pharmacy at 1-800-803-2523. Specialty medications may be subject to prior authorization, step therapy, and quantity limits.

High Dollar Claim Review: Medication costs exceeding $1,000 per 30 day supply and $3,000 per 90 day supply require prior authorization.

Low Clinical Value: Certain formulary exclusions including medications which have low clinical value may apply. Contact Member Services at 1-800-334-8134 for additional information.

Step Therapy Program: Your plan has certain medications that are subject to step therapy. You could be asked to try one of the first or second level options before a Brand medication is covered by the plan.

Dispense as Written (DAW) Policy: If your doctor writes a prescription stating that a Generic may be dispensed, we will only pay for the Generic drug. If you choose to buy the Brand name drug in this situation, you will be required to pay the Brand copay plus the difference in cost between the Generic and Brand name drug. The DAW Policy does not apply if your doctor requires a brand name medication.

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Drugs covered may be subject to Utilization Management which may include prior authorization and/or quantity limits. Please contact Member Services if you have specific drug questions or register at express-scripts.com to check coverage.

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- Diabetic Care: Insulin/Insulin pre-filled syringes, Agents/Strips for testing, Disposable insulin needles/syringes and lancets
- Growth Hormones
- Gastrointestinal-Antiemetics
- Hypnotics
- Impotency Medications
- Legend Drugs (drugs that require a prescription) Exceptions: See Exclusion list below
- Migraine medications
- Narcolepsy Medications
- Nutritional Supplements (Rx Only)
- Pain/Narcotics
- Prescription Vitamins
- Prescription and OTC smoking cessation (two 12 week programs per plan year); OTC requires prescription
- Topical Acne Medications

EXCLUSIONS***

- Anti-obesity/Appetite Suppression medications
- Biologicals, Immunization Agents
- Blood Products and Serums
- Cosmetic agents: Anti-wrinkle agents, Pigmenting & De-Pigmenting, Hair growth stimulants and hair removal products
- Compounded prescriptions that use ingredients such as bulk chemicals and powders
- Formulary Exclusion List
- Infertility Medications
- OTC Products unless noted above
- Topical Analgesic Pain Patches
- Therapeutic devices or appliances unless listed as a covered product
- Patient assistance programs may not apply to deductible and out of pocket accumulations.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a physician's office, licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

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Northwestern Medical Center
Effective May 1, 2020

HSA

Deductible: $4,050 Individual/$8,100 Family
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Tier 3 - Non-Preferred Brand Name Drugs	$20	$60	$50	$150
****Specialty**	N/A	N/A	30%	N/A

Maximum Out of Pocket (MOOP): $5,150 Individual/$10,300 Family
The calendar year Maximum Out of Pocket (MOOP) applies to pharmacy and medical claims. One member or any combination of family members can meet the family MOOP. Once met, your covered prescriptions are paid at 100%.

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