Lehigh Valley Health Network

Summary of Benefits and Coverage: What This Plan Covers and What You Pay For Covered Services

Health Plan – LVHN PPO Plan

Coverage Period: 01/01/2022 – 12/31/2022

Coverage for: Employee + Dependents | Plan Type: PPO Plan

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call **844-GO-ASKHR** or access **the Colleague Resource Center (CRC)**. HNL employees call **484-425-5520** or access **HNL's intranet (My HNL) on the HR page**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms see the Glossary. You can view the Glossary on the CRC or call 844-GO-ASKHR (Option 4) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$250** person /**$500** family Tier 1 **$400** person/**$800** family Tier 2 **$1,000** person/**$2,000** family Tier 3	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and Tier 1 pharmacy services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$250** person/**$500** family for out-of-network prescription drug coverage.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out–of–pocket limit?	**$2,500** person/**$5,000** family Tier 1 **$3,500** person/**$7,000** family Tier 2 Out-of-Area **$8,150** person/**$16,300** family Tier 2 In-Area **$30,000** person/**$60,000** family Tier 3	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, out-of-network co-payments, penalties, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of preferred providers, see MyPopulytics.com **or call 484-862-3505.**	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, and Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider (You will pay slightly more)		Tier 3 Provider (You will pay the most)	
			In-Area	Out-Of-Area		
If you visit a health care provider's office or clinic	Primary care visit for injury or illness	$15 co-pay/visit	50%	$20 co-pay	50% coinsurance	––––none–––––
	Specialist visit	$30 co-pay/visit	50%	$40 co-pay	50% coinsurance	––––none–––––
	Preventive care/ screening/ immunization	No charge	No charge	No charge	Not covered	Routine Mammography – 1 per year (age 40+), Routine Gyn exam/physical – 1 per year, Routine Colonoscopy – 1 every 10 years (age 45+) Routine PSA exam – 1 per year (age 50+)
If you have a test	Diagnostic test (X-ray, blood work)	No charge	50%	20%	50% coinsurance	Nuclear Stress tests and EGD require preauthorization or payment will be reduced by 25%.
	Imaging (CT/PET scans, MRIs)	No charge	50%	20%	50% coinsurance	MRIs and PET scans require preauthorization or payment will be reduced by 25%.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available on the Colleague Resource Center intranet or by calling 844-GO-ASKHR (Option 4). HNL employees call 484-425-5520 or access HNL's intranet (My HNL) on the HR page.	Zero co-pay	No charge	Not covered		Not covered	Co-pays indicated are for a 30-day supply (maximum is 90-day supply) Some prescriptions require preauthorization or payment will be reduced by 25%. Exclusions: Nonprescription, cosmetic or experimental medications, dietary supplements. Additional drug exclusions are listed on MyPopulytics.com and LVHN.org/pharmacy.
	Generic drugs	At Lehigh Valley Pharmacy Services (LVPS): $5 co-pay/ prescription (some generics available for $4/prescription)	Retail Pharmacy – $10 co-pay		Retail Pharmacy – 10% coinsurance	
	Preferred brand drugs	At LVPS: $20 co-pay/ prescription	Retail Pharmacy – 30% coinsurance with minimum of $30		Retail Pharmacy – 30% coinsurance with minimum of $30	
	Brand drugs	At LVPS: $40 co-pay/ prescription	Retail Pharmacy – 30% coinsurance with minimum of $50		Retail Pharmacy – 30% coinsurance with minimum of $50)	
	Non-preferred brand drugs	At LVPS: $60 co-pay/ prescription	Retail Pharmacy – 30% coinsurance with minimum of $70		Retail Pharmacy – 30% coinsurance with minimum of $70	Retail/Physician's office $40 co-pay and 20% coinsurance (after Rx deductible)
	Specialty drugs	At LVPS: 20% coinsurance up to $150 max/prescription/ month	Not covered: unless a Certificate of Nonavail-ability (CNA) is obtained		Not covered: unless a CNA is obtained	The list of specialty drugs is available at MyPopulytics.com and LVHN.org/pharmacy
	Non-preferred Specialty drugs	At LVPS: 20% coinsurance up to $750 max/prescription/ month	Not covered: unless a CNA is obtained		Not covered: unless a CNA is obtained	
If you have outpatient surgery	Facility (e.g., ambula-tory surgery center)	No charge	50%	20%	50% coinsurance	––––none–––––
	Physician/surgeon	No charge	50%	20%	50% coinsurance	If a participating provider utilizes a Tier 3 facility, benefit reduced to 50%.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, and Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider (You will pay slightly more)		Tier 3 Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	Accident/Emergency: $100 co-pay/visit (unless admitted); Non-Emergency: $300 co-pay/visit; (unless admitted)	In-Area: Accident/Emergency: $100 co-pay/visit (unless admitted); Non-Emergency: 50%	Out-Of-Area: Non-Emergency: 20%	Accident/Emergency: $100 co-pay (unless admitted); Non-Emergency: 50% of charges	––––none–––––
	Emergency medical transport	No charge	No charge		No charge	––––none–––––
	Urgent care (non-hospital)	$15 co-pay/visit	50%	$20 co-pay/visit	50% coinsurance	––––none–––––
If you have a hospital stay	Facility (e.g., hospital room)	No charge	50%	20%	50% coinsurance	If no preauthorization, payment will be reduced by 25%.
	Physician/surgeon	No charge	50%	20%	50% coinsurance	––––none–––––
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 co-pay/office visit; $15 co-pay/medication check	50%	$20 co-pay/visit	50% coinsurance	––––none–––––
	Inpatient services	No charge	50%	20%	50% coinsurance	If no preauthorization, payment will be reduced by 25%.
If you are pregnant	Office visits	$30 co-pay	50%	$20 co-pay/visit	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound)
	Childbirth/delivery professional services	No charge	50%	20%	50% coinsurance	
	Childbirth/delivery facility services	No charge	50%	20%	50% coinsurance	If admission is longer than mandated by the Newborns' and Mothers' Health Protection Act, and not preauthorized, payment will be reduced by 25%
If you need help recovering or have other special health needs	Home health care	No charge for first 100 visits per benefit plan year; 10% coinsurance thereafter	50%	20%	50% coinsurance	If no preauthorization, payment will be reduced by 25%.
	Rehabilitation services	Physical Therapy visits $10 co-pay/visit All others – no charge	50%	20%	50% coinsurance	If you seek outpatient physical, speech or occupational therapy, preauthorization is required or payment will be reduced by 25%.
	Habilitation services	Physical Therapy visits $10 co-pay/visit All others – no charge	50%	20%	50% coinsurance	Developmental Delay – 30 visit lifetime maximum If you seek outpatient physical, speech or occupational therapy, preauthorization is required or payment will be reduced by 25%

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, and Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider (You will pay slightly more)		Tier 3 Provider (You will pay the most)	
			In-Area	Out-Of-Area		
If you need help recovering or have other special health needs *continued from page 3*	Skilled nursing care	No charge	50%	20%	50% coinsurance	If no preauthorization, payment will be reduced by 25%.
	Durable medical equipment	10% coinsurance	50%	20%	50% coinsurance	Preauthorization is required for DME or medical supplies/aids costing more than $500 or payment will be reduced by 25%. There are maximums for specific DME, refer to the SPD for details.
	Hospice services	No charge	50%	20%	Not covered unless a CNA is obtained	If no preauthorization, payment will be reduced by 25%.
If your child needs dental or eye care	Children's Eye Exam	Covered under the vision plan, if elected				
	Children's Glasses	Covered under the vision plan, if elected				
	Children's Dental checkup	Covered under the dental plan, if elected				

Excluded Services and Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Hearing aids
- Long-term care
- Weight-loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Dental care (Adult) – under dental plan, if elected
- Infertility treatment
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing
- Routine eye care (Adult) – under vision plan, if elected
- Routine foot care (for diabetes only)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Populytics, P.O. Box 1830, Allentown, PA 18105-1830, 484-862-3505.

Does this plan provide Minimum Essential Coverage? Yes. Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standard? Yes. If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

——————————To see examples of how this plan might cover costs for a sample medical situation, see the next page.——————————

About These Coverage Examples

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$530**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$250
Primary Care Physician copayment	$15
Hospital (facility) coinsurance	0%
Other coinsurance	10%

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$300
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$560**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$250
Emergency Room copayment	$100
Hospital (facility) coinsurance	0%
Other coinsurance	10%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$150
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$420**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.