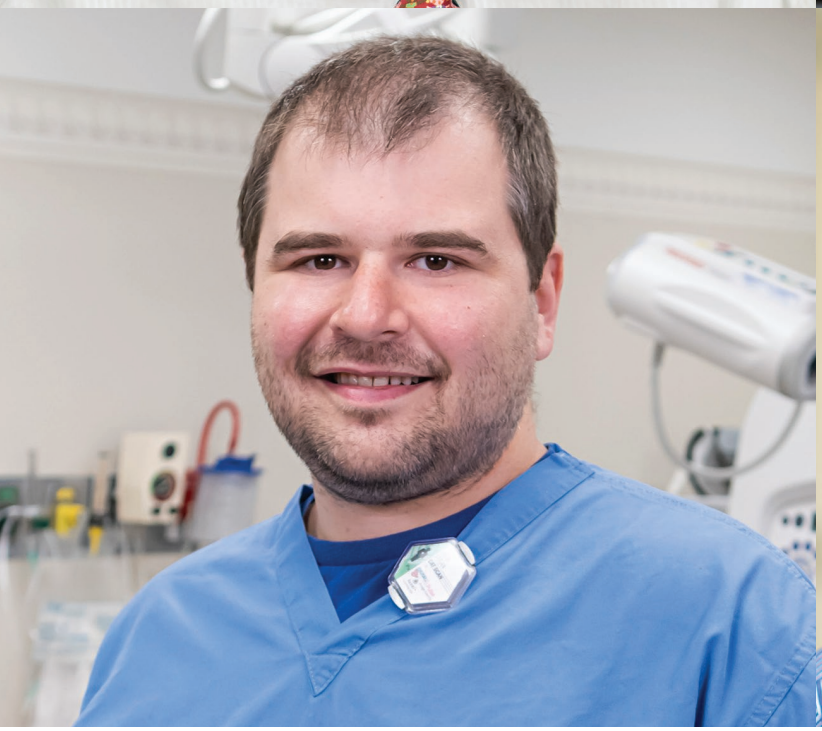
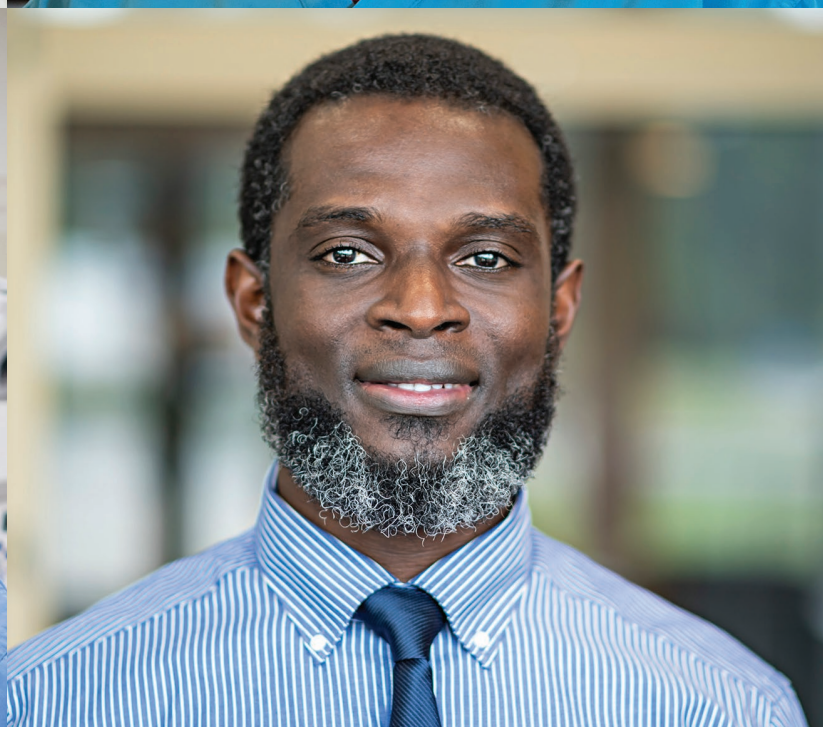
Benefit Information Guide
January 1, 2021



LVHN.org 888-402-LVHN

Lehigh Valley Health Network

January 2021

Dear Colleague,

Lehigh Valley Health Network (LVHN) is strong because our 19,000 colleagues move forward together to heal, comfort and care for the people of our community.

At LVHN, we value and appreciate your contributions and understand the importance of your health and well-being. That is why we offer benefits through the LVHN Health Plan, which provides comprehensive and cost-effective coverage. You have a choice of two medical options, two dental options, two vision plans, supplemental and dependent life insurance, and flexible spending accounts (FSAs), which can help you and your family achieve optimal health.

This enrollment guide provides information about the coverage available to you. Please review the enclosed information to learn about your benefits, and then select the coverage that will work best for you and your family.

Please access the Colleague Resource Center (CRC) or call 844-GO-ASK-HR if you have any questions. If you are a HNL Lab Medicine (HNL) colleague, please call HNL's human resources department at 484-425-5520.

Thank you for your commitment and dedication to our health network and community. We look forward to partnering with you to further our mission and make LVHN the best place to work and grow in the region.

In good health,

Lynn Turner
Senior Vice President and
Chief Human Resources Officer

Deborah Dobrina
Director, HR Colleague Rewards/Benefits

Table of Contents

This booklet has been developed to help you learn about and understand your benefits under the plans sponsored by Lehigh Valley Health Network (LVHN). Although the plans have been summarized in everyday language, this booklet does not replace the legal documents governing the plans. If there are any differences between this information and the official plan documents, the plan documents will govern.

Benefits Designed Just for You

You choose the benefit package that's best for you and your family.

We encourage you to read this information carefully, and use it as a reference should you have any questions about your benefits during 2021. LVHN is committed to keeping you and your family healthy by providing this competitive benefits package.

Benefit Eligibility

LVHN requires verification of health, dental and vision plan eligibility for all dependents covered under the plan. This practice ensures that all covered members of the health, dental and vision plans are eligible under the rules of the plan(s). The Lehigh Valley Health Network (LVHN) Health Plan is a self-insured plan; therefore, claims paid for ineligible dependents are money paid by LVHN inappropriately. Also, this action, if purposeful, may be considered a fraudulent act. Additional information is available on the Colleague Resource Center (CRC).

You may enroll yourself and your eligible dependents as of the first of the month following 30 days of employment or annually at open enrollment.

Eligible employees include:

- Employees scheduled to work 15 hours or more per week
- Non-benefit-eligible (per diem) employees working on average 30 hours per week during the 12-month measurement period, as defined under Health Care Reform legislation.

Eligible dependents shall mean an employee's:

- Spouse under a legally valid existing marriage between persons of the same or opposite sex; or
- Natural child, stepchild, foster child, legally adopted child, child whom the employee is legally obligated to support in anticipation of adopting the child (regardless of whether the adoption is final), child for whom the employee is legal guardian as designated by the court order, custodian, or child to whom the employee is required to provide medical coverage pursuant to a Qualified Medical Child Support Order (QMCSO) and:
  - Under age 26; or
  - Over age 26 but has a physical or mental disability and is the employee's tax dependent. Such child remains eligible for coverage even after the child turns 26, for as long as the disability exists – provided the employee submits satisfactory proof of the child's disability within 31 days after his/her coverage would normally end, and as required by LVHN.

If you elect coverage for yourself and your eligible dependents, you must provide the required documentation to human resources to certify that your eligible dependents meet all plan eligibility requirements. LVHN maintains the right to request documentation from you at any time to ensure that your dependents meet the eligibility criteria.

Irrevocable Election Unless Qualifying Life Event

Benefit elections are irrevocable for the duration of the year with the exception of certain qualifying life events such as marriage, divorce, death of a spouse or child, birth or adoption of a child, commencement or termination of a spouse's employment, change from PT to FT employment or vice versa by the employee or the employee's spouse, taking an unpaid leave of absence by the employee or the employee's spouse, or a significant change in the employee's or spouse's health coverage that is attributable to the spouse's employment, just to name a few. Human Resources (HR) must be apprised of any such qualifying events within 31 days of occurrence. Elections must be made prior to any taxable benefits under the plan becoming available.

FSAs do not continue from year to year; you must enroll each year during open enrollment to continue this benefit option.

Tobacco User Surcharge

According to the American Cancer Society, smoking causes one in five deaths and millions of illnesses every year in the U.S. Other uses of tobacco can be similarly harmful. The health risks of tobacco use increase health care costs not only for tobacco users, but also for everyone else covered under our medical plan. At LVHN, we take tobacco use and its harmful effects seriously, and we have a responsibility to our colleagues to create a healthy and productive work environment and manage our health care costs.

When you enroll in medical coverage, you will be required to complete a certification regarding your tobacco usage. If you certify that you have used any tobacco product(s) in the last three months, you will be assessed a $25 per pay period surcharge on medical premiums in 2021. Tobacco use includes cigarettes, pipes, cigars, chewing tobacco, snuff or any other type of smoking or smokeless tobacco (including e-cigarettes). Random tobacco testing will occur. Any colleague who falsifies information will be subject to disciplinary action up to and including termination of employment.

If you complete the BeneQUIT Tobacco Cessation Program in 2021, you will have the surcharge removed and all 2021 surcharge payments refunded. This is a five-session

telephonic program that offers a comprehensive approach to nicotine (tobacco) dependence by combining behavioral modification, psycho-social support and pharmacologic therapy. An individualized plan of care is developed that incorporates nicotine dependence assessment, education, cessation/relapse prevention strategies and ongoing support. To enroll in the program, call 610-969-0487.

If your physician determines that it is not medically appropriate for you to achieve tobacco-free status, you can obtain a reasonable alternative as recommended by your physician. You must submit a Physician Tobacco Alternative form prior to your benefit eligibility date to receive the lower tobacco free medical plan premiums for 2021. The form is available on the Colleague Resource Center (CRC).

Working Spouse Surcharge

If you enroll a spouse on your medical coverage who is eligible for benefits through his or her employer [other than LVHN or Coordinated Health or HNL], you will pay an additional $50 per pay period in medical plan premiums. This surcharge will not apply if you certify that your spouse is not eligible for coverage elsewhere.

At enrollment, you will be asked to certify whether your enrolled spouse is eligible for medical coverage through his or her employer and to identify the name of the employer. **If your spouse works at LVHN, Coordinated Health or HNL, answer "no" to the working spouse question.** Any colleague who falsifies information will be subject to disciplinary action.

LVHN Health Plan

LVHN offers two medical options — the LVHN PPO Plan and the LVHN HSA Plan. Both plan options use the same LVHN Health Plan provider network and cover the same services. The differences are your premiums, annual deductible, out-of-pocket maximum, and how you pay for doctor visits and prescription drugs. In addition, the LVHN HSA Plan features a health savings account (HSA), a tax-advantaged account that you can use for eligible health care expenses not covered by the medical plan.

Three-Tier Network

The LVHN PPO Plan and the LVHN HSA Plan both feature a network that is designed to promote use of LVHN providers and facilities. The amount you pay for medical care depends on the provider you use. Here are the tiers:

TIER 1: You will **receive the highest level of coverage**.

- LVHN and Coordinated Health Hospitals/Facilities
- LVPG and Coordinated Health Physicians
- Select LVHN Medical Staff and select Highmark Participating Physicians (see the provider directory for specific physicians), excluding those outlined in Tier 3.
- Highmark participating Home Health, Hospice, Skilled Nursing Facility, Durable Medical Equipment, Behavioral Health, Substance Abuse, Outpatient Dialysis, Chiropractors, Audiologists and Dermatologists.
- HNL Lab Medicine (HNL)
- LVHN ExpressCARE
- Medical Imaging of the Lehigh Valley/LVHN Imaging Services

TIER 2: You will **pay more out-of-pocket**.

- Highmark participating Hospitals/Facilities and BlueCard Physicians/Facilities not included in Tier 1, including Blue Card Global Coverage.

TIER 3: You will **pay the most out-of-pocket.**

- Non-participating (Out-of Network) Physicians and Facilities

IMPORTANT NOTE: Although a facility may be Tier 1 or Tier 2, there may be providers you utilize within these facilities who may not participate with the LVHN Health Plan network. Those services may be reimbursed at the Tier 3 benefit level.

When you use an LVHN hospital/facility or an LVHN Health Plan physician, you are controlling costs for you and LVHN. You will pay lower co-pays and deductibles when you visit a Tier 1 hospital, facility or physician. You will pay the most out-of-pocket when you visit Tier 3 out-of-network providers.

You are not required to use an LVHN provider. Although we encourage you to use our hospitals, facilities and physicians when appropriate, you may always choose the physicians and hospitals that best meet your needs. For a complete list of LVHN Health Plan network hospitals, facilities and physicians, refer to the LVHN Health Plan Provider Directory available at **MyPopulytics.com** or on the Colleague Resource Center (CRC). The provider directory will identify Tier 1 and Tier 2 providers.

If a service is not available at a Tier 1 hospital/facility or physician, you must obtain a Certificate of Nonavailability (CNA) through Care Management before services are rendered in order to receive benefits at the highest level. Refer to page 14 for additional information regarding a CNA.

You and your covered dependents may not have any other non-high deductible health coverage (i.e., from a parent or spouse) while enrolled in the LVHN HSA Plan. Examples of other non-qualifying high-deductible health coverage include:

- **Medicare**
- **Another plan with an annual deductible lower than $1,400 for individual coverage and $2,800 for family coverage.**
- **Another plan, even with a high deductible, not including an HSA component (i.e., PPO or HMO).**

Services at Cancer Treatment Centers of America are excluded from coverage under all LVHN Health Plan tiers.

LVHN PPO Plan

The LVHN PPO Plan has higher premiums and a lower deductible than the LVHN HSA Plan. You pay a small co-pay when you visit the doctor and for prescription drugs. Preventive care is covered at 100% with no co-pays or deductible when you use a Tier 1 or Tier 2 provider. See the benefit grid beginning on page 6 for additional services covered under the LVHN PPO Plan.

The plan has an out-of-pocket maximum. After the out-of-pocket maximum is met, the plan pays 100% for covered expenses. If you use a Tier 3 provider, you may be responsible for any expenses above the allowable charge.

LVHN HSA Plan

The LVHN HSA Plan has lower premiums than the LVHN PPO Plan but does have a higher deductible. When visiting a participating doctor, you pay 10% of the allowable charge, after you meet the deductible, instead of a co-pay. Preventive care is still covered at 100% with no deductible when you use a Tier 1 or Tier 2 provider. See the benefit grid beginning on page 6 for additional services covered under the LVHN HSA Plan.

The LVHN HSA Plan has an additional feature – a health savings account (HSA). An HSA is a tax-advantaged account that lets you save money on a pre-tax basis that you can use for eligible expenses now and in the future, such as health care expenses not covered by the plan and retiree medical coverage. Any funds in the account at the end of the year roll over to the following year, so you can build an account balance for future use. To help your account grow, LVHN will make an automatic contribution to your account each pay period.

The annual deductible applies to all non-preventive care services. If you cover any dependents, the family deductible must be met before the plan begins to pay benefits for any person. One person, or a combination of family members, can meet the family deductible. The deductible is $1,400 for Employee Only coverage and $2,800 for Family coverage.

The plan has an out-of-pocket maximum. After the out-of-pocket maximum is met, the plan pays 100% for covered expenses if you use a Tier 1 or Tier 2 provider. If you use a Tier 3 provider, you may be responsible for any expenses above the allowable charge. If one person meets the individual out-of-pocket maximum, the plan begins to pay 100% of eligible expenses. The other covered individuals must meet the family out-of-pocket maximum.

The HSA

When you enroll in the LVHN HSA Plan, LVHN contributes to an HSA for you, whether you make any contributions or not. LVHN's contribution is $25 per pay period ($650 per year) for Employee Only coverage and $50 per pay period ($1,300 per year) if you cover any dependents. This contribution will be deposited in your HSA throughout the year.

Your HSA can grow faster, and you can save on taxes, when you make pre-tax contributions. The maximum annual amount that LVHN and you can contribute in total to your HSA is set by the IRS.

- For Employee Only coverage, the maximum amount for 2021 is $3,600, so you may contribute up to $2,950.
- For Family coverage, the maximum amount for 2021 is $7,200, so you may contribute up to $5,900.
- The pre-tax contributions are prorated monthly if you are eligible only part of the year.

If you are age 55 or older in 2021, you may contribute an additional $1,000 to your HSA. This is known as a catch-up contribution.

You don't pay taxes on any money you and LVHN put into your HSA – when it goes into your account or when you use it for eligible expenses. And, if you invest your HSA dollars and earn interest, those earnings are tax-free too.

You can use your HSA on an ongoing basis to pay for incurred eligible expenses, up to the amount in your account at any given time. Eligible expenses include the deductible, co-insurance, allowable expenses not covered by the plan and charges above the allowable charge for Tier 3 providers. You can spend from it with a debit card. It earns interest, like a savings account, and you can invest it in mutual funds when your balance is more than $1,000.

You also can save the funds in your account to use later. You own the money in your account. It rolls over from year to year – even if you change medical plans or drop LVHN coverage. The account stays with you. Because your funds roll over and you own the account, you can use the HSA as your retirement health care savings account. After you retire or leave employment, you can continue to spend the funds on eligible medical and prescription drug expenses without paying taxes; you can even cover COBRA, Long-Term Care or Medicare premiums with your tax-free savings.

If you elect the LVHN HSA Plan, you will receive a welcome packet from UMB Bank, the HSA banking institution. The packet will include steps to set up your account, as well as additional detailed information. Any banking fees will be outlined in the welcome packet.

Geographic Area

If you live in a ZIP code that is not listed in this table and you utilize a provider outside the LVHN Health Plan network, these claims will be paid at the Tier 2 out-of-area benefit level. If you use an out-of-network provider, that provider may balance bill you for charges in excess of the option's reimbursement. You have the option to utilize a Tier 1 provider.

If a Tier 1 provider performs services at an out-of-network facility, the provider's claims will be considered at the Tier 3 benefit level.

Note: The Tier 2 benefit option does not entitle members to go to nonparticipating facilities or physicians in the ZIP codes listed below; doing this will be considered Tier 2 in-area or Tier 3 out-of-network reimbursement.

In-Area ZIP Codes

Employees who live in these ZIP codes will be subject to Tier 1, Tier 2 in-area and Tier 3 benefit levels.

17832	17834	17840	17851	17888	17901	17920
17921	17922	17923	17925	17929	17930	17931
17932	17933	17934	17935	17936	17943	17944
17945	17946	17948	17949	17951	17952	17953
17954	17957	17959	17960	17961	17963	17965
17966	17967	17970	17972	17974	17976	17979
17981	17982	17985	18001	18002	18003	18010
18011	18012	18013	18014	18015	18016	18017
18018	18020	18025	18030	18031	18032	18034
18035	18036	18037	18038	18039	18040	18041
18042	18043	18044	18045	18046	18049	18050
18051	18052	18053	18054	18055	18056	18059
18060	18062	18063	18064	18065	18066	18067
18068	18069	18070	18071	18072	18073	18076
18077	18078	18079	18080	18081	18083	18085
18086	18087	18088	18091	18092	18098	18099
18101	18102	18103	18104	18105	18106	18109
18195	18201	18202	18211	18212	18214	18216
18218	18219	18220	18221	18222	18223	18224
18225	18229	18230	18231	18232	18234	18235
18237	18239	18240	18241	18242	18244	18245
18246	18247	18248	18249	18250	18251	18252
18254	18255	18256	18301	18302	18320	18321
18322	18323	18326	18327	18330	18331	18332
18335	18341	18342	18343	18344	18346	18349
18351	18352	18353	18354	18355	18356	18357
18360	18370	18371	18372	18601	18660	18707
18921	18930	18935	18951	18953	18955	18960
18962	18968	18970	18981	19503	19504	19505
19507	19511	19512	19519	19522	19529	19530
19534	19535	19536	19538	19539	19545	19547
19549	19554	19559	19562	19564		

Summaries of Benefits and Coverage

The Summaries of Benefits and Coverage (SBCs), which are required under Health Care Reform, are available on the Colleague Resource Center (CRC). Please be sure to review these before enrolling to learn valuable information about your LVHN Health Plan.

Summary of Benefits In-Area Plan

If your ZIP code is listed in the chart as In-Area, below is your Summary of Benefits.

The following chart gives a quick overview of how the LVHN medical options compare for the In-Area Plan. For more information and a complete health plan grid and Summary Plan Description (SPD), go to the Colleague Resource Center (CRC).

	LVHN PPO Plan			LVHN HSA Plan		
	Tier 1	**Tier 2***	**Tier 3****	**Tier 1**	**Tier 2***	**Tier 3****
Annual Deductible	$250 individual $500 family	$400 individual $800 family	$1,000 individual $2,000 family	$1,400 single $2,800 family	$1,400 single $2,800 family	$1,400 single $2,800 family
Annual Out-of-Pocket Maximum *(includes co-pays, co-insurance and amounts applied to the deductible)*	$2,500 individual $5,000 family	$8,150 individual $16,300 family	$30,000 individual $60,000 family	$5,000 individual $10,000 family	$8,150 individual $16,300 family	$45,000 individual $90,000 family
Hospital Services (see pre-certification section, page 14)						
Inpatient	Plan pays 100% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 100% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Outpatient	Plan pays 100% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Ambulatory Surgical Facility	Plan pays 100% after deductible	Plan pays 50% after deductible	Plan pays 50% of Medicare's fee schedule after deductible	Plan pays 90% after deductible	Plan pays 50% after deductible	Plan pays 50% of Medicare's fee schedule after deductible
Emergency Care (hospital emergency room and emergency room physician)						
Accident	You pay a $100 co-pay (waived if admitted)	You pay a $100 co-pay (waived if admitted)	You pay a $100 co-pay (waived if admitted)	Plan pays 90% after deductible	Plan pays 90% after deductible	Plan pays 90% after deductible
Medical Emergency	You pay a $100 co-pay (waived if admitted)	You pay a $100 co-pay (waived if admitted)	You pay a $100 co-pay (waived if admitted)	Plan pays 90% after deductible	Plan pays 90% after deductible	Plan pays 90% after deductible
Non-Accident/ Nonmedical Emergency	You pay a $300 co-pay (waived if admitted)	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Physician Office and Facility Outpatient Services (see pre-certification section, page 14)						
Office Visits *(normal hours)*	You pay a $15 co-pay/visit	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible

Summary of Benefits In-Area Plan

	LVHN PPO Plan			LVHN HSA Plan		
	Tier 1	**Tier 2***	**Tier 3****	**Tier 1**	**Tier 2***	**Tier 3****
Office Visits *(after hours)*	You pay a $30 co-pay/visit	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Clinic Visits *(normal hours)*	You pay a $15 co-pay/visit	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Clinic Visits *(after hours)*	You pay a $30 co-pay/visit	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Routine Physical Exams and Well-Baby Care	Plan pays 100%	Plan pays 100%	Not covered	Plan pays 100%	Plan pays 100%	Not covered
Immunizations	Plan pays 100%	Plan pays 100%	Not covered	Plan pays 100%	Plan pays 100%	Not covered
Routine Gyn Exams *(1 per year)*	Plan pays 100%	Plan pays 100%	Not covered	Plan pays 100%	Plan pays 100%	Not covered
Routine Mammography *(1 per year for women 40+)*	Plan pays 100%	Plan pays 100%	Not covered	Plan pays 100%	Plan pays 100%	Not covered
Specialist Office Visit	You pay a $30 co-pay/visit	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Surgical Services	Plan pays 100% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible	Inpatient 100%; outpatient 90% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Initial Infertility Screening and Treatment *(after diagnosis) Lifetime max: $20,000*	Artificial insemination: Plan pays 100% after deductible IVF: Plan pays 60% after deductible CNA not available***	Artificial insemination: Plan pays 50% after deductible IVF: Not covered CNA not available***	Artificial insemination: Plan pays 50% after deductible IVF: Not covered CNA not available***	Artificial insemination: Plan pays 90% after deductible IVF: Plan pays 60% after deductible CNA not available***	Artificial insemination: Plan pays 50% after deductible IVF: Not covered CNA not available***	Artificial insemination: Plan pays 50% after deductible IVF: Not covered CNA not available***
Hospital Visits and Consultations	Plan pays 100% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 100% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
X-ray and Laboratory	Plan pays 100% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 100% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Additional Services (see pre-certification section, page 14)						
Ambulance – Medical Emergency	Plan pays 100% after deductible	Plan pays 100% after deductible	Plan pays 100% after deductible	Plan pays 100% after deductible	Plan pays 100% after deductible	Plan pays 100% after deductible
Chemotherapy, Dialysis, Radiation and Respiratory	Plan pays 100% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 100% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible

Summary of Benefits In-Area Plan

	LVHN PPO Plan			LVHN HSA Plan		
	Tier 1	**Tier 2***	**Tier 3****	**Tier 1**	**Tier 2***	**Tier 3****
Chiropractic *(12 visits maximum; beyond 12 requires pre-certification) Includes 2 E&Ms per plan year Participating chiropractors only*	You pay a $15 co-pay/visit	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Durable Medical Equipment and Durable Medical Supplies	Plan pays 90% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Home Health Care	Plan pays 100% after deductible for the first 100 visits, then 90%	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 100% after deductible for the first 100 visits, then 90%	Plan pays 50% after deductible	Plan pays 50% after deductible
Hospice Care	Plan pays 100% after deductible	Plan pays 50% after deductible	Not covered	Plan pays 100% after deductible	Plan pays 50% after deductible	Not covered
Outpatient Physical Therapy Visits	You pay a $10 co-pay/visit	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Outpatient Therapy, OT and ST	Plan pays 100% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 100% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Skilled Nursing Facility	Plan pays 100% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 100% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Behavioral Health Services (see Behavioral Health Services pre-certification section, page 14)						
Hospital Inpatient and Intensive Outpatient	Plan pays 100% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 100% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Physician Inpatient	Plan pays 100% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 100% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Physician Outpatient	You pay a $15 co-pay/ visit and a $15 co-pay for all medication checks	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible

* Reimbursement for Tier 1 and Tier 2 LVHN Hospitals, Facilities, Physicians/Providers is based on the LVHN Health Plan Fee Schedule. Selected Tier 1 Highmark providers are based on the Highmark Fee Schedule.

** Reimbursement for out-of-network services is based on the LVHN Health Plan/Highmark fees schedules.

*** Please see "Certificates of Nonavailability" on page 14 for more information.

For services requiring a co-pay outlined above, please note the deductible applies for the remaining balance after the co-pay.

Summary of Benefits Out-of-Area Plan

If your ZIP code is <u>not</u> listed in the chart as In-Area, below is your Summary of Benefits.

The following chart gives a quick overview of how the LVHN medical options compare for the Out-of-Area Plan. For more information and a complete health plan grid and Summary Plan Description (SPD), go to the Colleague Resource Center (CRC).

	LVHN PPO Plan			LVHN HSA Plan		
	Tier 1	**Tier 2***	**Tier 3****	**Tier 1**	**Tier 2***	**Tier 3****
Annual Deductible	$250 individual $500 family	$400 individual $800 family	$1,000 individual $2,000 family	$1,400 single $2,800 family	$1,400 single $2,800 family	$1,400 single $2,800 family
Annual Out-of-Pocket Maximum *(includes co-pays, co-insurance and amounts applied to the deductible)*	$2,500 individual $5,000 family	$3,500 individual $7,000 family	$30,000 individual $60,000 family	$5,000 individual $10,000 family	$5,000 individual $10,000 family	$45,000 individual $90,000 family
Hospital Services (see pre-certification section, page 14)						
Inpatient	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible
Outpatient	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible
Ambulatory Surgical Facility	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 50% of Medicare's fee schedule after deductible	Plan pays 90% after deductible	Plan pays 80% after deductible	Plan pays 50% of Medicare's fee schedule after deductible
Emergency Care (hospital emergency room and emergency room physician)						
Accident	You pay a $100 co-pay (waived if admitted)	You pay a $100 co-pay (waived if admitted)	You pay a $100 co-pay (waived if admitted)	Plan pays 90% after deductible	Plan pays 90% after deductible	Plan pays 90% after deductible
Medical Emergency	You pay a $100 co-pay (waived if admitted)	You pay a $100 co-pay (waived if admitted)	You pay a $100 co-pay (waived if admitted)	Plan pays 90% after deductible	Plan pays 90% after deductible	Plan pays 90% after deductible
Non-Accident/ Nonmedical Emergency	You pay a $300 co-pay (waived if admitted)	You pay a $300 co-pay (waived if admitted)	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 90% after deductible	Plan pays 50% after deductible
Physician Office and Facility Outpatient Services (see pre-certification section, page 14)						
Office Visits *(normal hours)*	You pay a $15 co-pay/visit	You pay a $20 co-pay/visit	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 90% after deductible	Plan pays 50% after deductible
Office Visits *(after hours)*	You pay a $30 co-pay/visit	You pay a $40 co-pay/visit	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 90% after deductible	Plan pays 50% after deductible
Clinic Visits *(normal hours)*	You pay a $15 co-pay/visit	You pay a $20 co-pay/visit	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 90% after deductible	Plan pays 50% after deductible

Summary of Benefits Out-of-Area Plan

	LVHN PPO Plan			LVHN HSA Plan		
	Tier 1	**Tier 2***	**Tier 3****	**Tier 1**	**Tier 2***	**Tier 3****
Clinic Visits *(after hours)*	You pay a $30 co-pay/visit	You pay a $40 co-pay/visit	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 90% after deductible	Plan pays 50% after deductible
Routine Physical Exams and Well-Baby Care	Plan pays 100%	Plan pays 100%	Not covered	Plan pays 100%	Plan pays 100%	Not covered
Immunizations	Plan pays 100%	Plan pays 100%	Not covered	Plan pays 100%	Plan pays 100%	Not covered
Routine Gyn Exams *(1 per year)*	Plan pays 100%	Plan pays 100%	Not covered	Plan pays 100%	Plan pays 100%	Not covered
Routine Mammography *(1 per year for women 40+)*	Plan pays 100%	Plan pays 100%	Not covered	Plan pays 100%	Plan pays 100%	Not covered
Specialist Office Visit	You pay a $30 co-pay/visit	You pay a $40 co-pay/visit	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 90% after deductible	Plan pays 50% after deductible
Surgical Services	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible	Inpatient 100%; outpatient 90% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible
Initial Infertility Screening and Treatment *(after diagnosis) Lifetime max: $20,000*	Artificial insemination: Plan pays 100% after deductible IVF: Plan pays 60% after deductible CNA not available***	Artificial insemination: Plan pays 80% after deductible IVF: Not covered CNA not available***	Artificial insemination: Plan pays 50% after deductible IVF: Not covered CNA not available***	Artificial insemination: Plan pays 90% after deductible IVF: Plan pays 60% after deductible CNA not available***	Artificial insemination: Plan pays 80% after deductible IVF: Not covered CNA not available***	Artificial insemination: Plan pays 50% after deductible IVF: Not covered CNA not available***
Hospital Visits and Consultations	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible
X-ray and Laboratory	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible
Additional Services (see pre-certification section, page 14)						
Ambulance – Medical Emergency	Plan pays 100% after deductible	Plan pays 100% after deductible	Plan pays 100% after deductible	Plan pays 100% after deductible	Plan pays 100% after deductible	Plan pays 100% after deductible
Chemotherapy, Dialysis, Radiation and Respiratory	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible

Summary of Benefits Out-of-Area Plan

	LVHN PPO Plan			LVHN HSA Plan		
	Tier 1	**Tier 2***	**Tier 3****	**Tier 1**	**Tier 2***	**Tier 3****
Chiropractic *(12 visits maximum; beyond 12 requires pre-certification) Includes 2 E&Ms per plan year Participating chiropractors only*	You pay a $15 co-pay/visit	You pay a $20 co-pay/visit	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 90% after deductible	Plan pays 50% after deductible
Durable Medical Equipment and Durable Medical Supplies	Plan pays 90% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible
Home Health Care	Plan pays 100% after deductible for the first 100 visits, then 90%	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 100% after deductible for the first 100 visits, then 90%	Plan pays 80% after deductible	Plan pays 50% after deductible
Hospice Care	Plan pays 100% after deductible	Plan pays 80% after deductible	Not covered	Plan pays 100% after deductible	Plan pays 80% after deductible	Not covered
Outpatient Physical Therapy Visits	You pay a $10 co-pay/visit	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible
Outpatient Therapy, OT and ST	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible
Skilled Nursing Facility	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible
Behavioral Health Services (see Behavioral Health Services pre-certification section, page 14)						
Hospital Inpatient and Intensive Outpatient	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible
Physician Inpatient	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible
Physician Outpatient	You pay a $15 co-pay/visit and a $15 co-pay for all medication checks	You pay a $20 co-pay/visit and a $20 co-pay for all medication checks	Plan pays 50% after deductible	Plan pays 90% after deductible	Plan pays 90% after deductible	Plan pays 50% after deductible

* Reimbursement for Tier 1 and Tier 2 LVHN Hospitals, Facilities, Physicians/Providers is based on the LVHN Health Plan Fee Schedule. Selected Tier 1 Highmark providers are based on the Highmark Fee Schedule.

** Reimbursement for out-of-network services is based on the LVHN Health Plan/Highmark fees schedules.

*** Please see “Certificates of Nonavailability” on page 14 for more information.

For services requiring a co-pay outlined above, please note the deductible applies for the remaining balance after the co-pay.

Comparing LVHN PPO Plan and LVHN HSA Plan

At a glance, here's how the two options compare:

Features	LVHN PPO Plan	LVHN HSA Plan
Covered services	**Same**	
Provider network	**Same** LVHN Health Plan network	
Tier 1 network care **Tier 2 network care**	There is a "discounted cost" of care (the allowable charge) when you use an LVHN Plan Tier 1 or Tier 2 Provider Health Plan hospital/facility or physician.	
Tier 3 out-of-network care	Both options cover most out-of-network care, but you'll pay the most out-of-pocket. **Reminder:** All LVHN Health Plan tiers exclude coverage from Cancer Treatment Centers of America	
Your premiums	**Higher**	**Lower**
Plan deductible	**Lower**	**Higher** *Important if you cover any dependents:* The family deductible must be met before the plan begins to pay benefits for any person. One person or a combination of family members can meet the family deductible.
What you pay for care	Co-pay when you visit the doctor, fill a prescription, or visit the emergency room or an urgent care facility Co-insurance for most other services	Co-insurance after you meet the deductible (single or family)
What you pay for prescription drugs	Generally co-pays	Co-insurance after you meet the deductible (single or family)
What you pay for preventive care	Nothing when you use a Tier 1 or Tier 2 up to the plan maximums	
Out-of-pocket maximums (most you pay in one year for covered services)	**Lower**	**Higher**
Health care account	Health Care Flexible Spending Account (FSA) – optional	Health Savings Account (HSA)

My Total Health

At Lehigh Valley Health Network (LVHN), we believe living a healthy life is about more than just your physical health. That's why we offer My Total Health, our comprehensive health and wellness offerings for colleagues and their eligible dependents designed to support your physical, emotional, financial and social wellness.

Read the My Total Health booklet on the Colleague Resource Center to learn more about our wellness culture and the many programs, services and classes available. Many are free of charge to all colleagues regardless of health plan coverage.

Some of the highlights:

- **LVHN Fitness membership for all colleagues (free)**
- **Health coaching** with a certified health coaching professional (free)
- **Retirement planning** advice, seminars, planning tools (free)

Condition Support Program

Managing a health condition can be overwhelming, but it doesn't have to be. As an adult member of the LVHN Health Plan with a diagnosis of asthma, diabetes and/or hypertension, you are eligible for the At Your Best condition support program. At Your Best provides you with free confidential and individualized support in a way that works best for you, because we respect your time and priorities.

The goal of At Your Best is to empower you to take charge of your health. Achieve your goals with clinical health coaching, designed to support you and keep you on track every step of the way, or utilize other program resources, online tools and educational opportunities to help you be at your best.

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).

Women's Health and Cancer Rights Act

Federal law requires health plans that provide mastectomy benefits also to provide certain related reconstructive benefits and to tell participants that they are available. In the case of a participant or beneficiary receiving benefits in connection with a mastectomy and who elects breast reconstruction, the coverage under the plan will be provided in a manner determined in the consultation with the attending physician and the patient for:

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

The reconstructive benefits are subject to annual plan deductibles and co-insurance provisions like other medical and surgical benefits under the plan.

Children's Health Insurance Program Reauthorization Act (CHIPRA)

If you are eligible for health coverage from your employer but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums.

This notice can be found on the LVHN Colleague Resource Center – Required Legal Posting and Safety tile – Legal Plan Notices – CHIP Notice.

Employee Assistance Program (EAP)

When you need to talk, we'll listen. The Preferred Employee Assistance Program (EAP) is a confidential assessment, brief counseling and referral service sponsored by LVHN. Whenever you or your family needs professional help with personal or work-related problems, Preferred EAP's specially educated staff is here to help, free of charge for up to five counseling sessions. At LVHN we care about colleagues and recognize that your well-being can affect your health. That's why we encourage you to schedule an appointment with a Preferred EAP counselor if you're experiencing marital difficulties, depression, anxiety, conflicts with family members or colleagues, stress, or drug and alcohol abuse.

Behavioral Health Services

Both options provide coverage for mental health and drug and alcohol rehabilitation. When you or a family member needs care, contact care management.

Pre-certification Required

- Behavioral health and substance abuse inpatient admissions

Certificates of Nonavailability

When a service is not available at a Tier 1 participating facility/provider, in order to secure entitlement to benefits at the highest Tier 1 level, you must obtain a Certificate of Nonavailability (CNA). All CNAs must be approved by care management prior to services being rendered.

There may be balance billing because the Tier 2 or Tier 3 provider may not have agreed to accept the fee schedule as payment in full. Without a CNA, benefits may be paid at the Tier 2 or Tier 3 level.

Pre-certification

Contact Care Management for pre-certification requirements under both plans. Non-emergent admissions require pre-certification prior to admission. In emergency situations, you must contact Care Management within 48 hours or the next business day. Receiving services without pre-certification may result in a reduction in the reimbursement for the covered expenses, whether or not a participating or nonparticipating provider provided the services. If you do not obtain pre-certification when required, your benefits will be reduced by 25 percent.

Pre-certification is required for:

- All medical, surgical and behavioral health-related inpatient admissions, including acute, subacute, rehabilitation and hospice, excluding 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
- Home health care and home infusion therapy
- Durable medical equipment – purchases more than $500
- Outpatient physical therapy by all providers
- Outpatient speech and occupational therapy by all providers
- Skilled nursing facility
- The list of prescriptions requiring pre-certification is available at **MyPopulytics.com** and **LVHN.org/pharmacy**.
- Genetic testing and counseling
- Private-duty nursing
- Home monitoring equipment
- MRIs and PET scans
- Chiropractic visits beyond 12 per plan year
- Nuclear stress tests
- EGD (Upper GI endoscopy)
- Medical Nutritional Therapy (more than 4 visits)
- Behavioral Health intensive outpatient (IOP)
- Behavioral Health partial hospital program (PHP)
- Botox®
- Screening Colonoscopy under the age of 50 years
- Electroconvulsive Therapy (ECT)
- Neuropsychiatric testing (including IMPACT testing)
- Transcranial magnetic stimulation (TMS)
- Psoralen and ultraviolet A (PUVA) therapy over 40 treatments
- Bronchial Thermoplasty
- TX 360 Nasal Applicator treatment

Explanation of Benefits (EOB)

EOBs for all LVHN HSA Plan and LVHN PPO Plan members will be uploaded automatically to your **MyPopulytics.com** account electronically – and not mailed to your home – unless you choose otherwise. You also can switch back to paperless at any time. When claims are processed for you or your dependent, you will receive an email notice (sent to the address you entered into **MyPopulytics.com**) that an EOB is posted in your account. You then can view or download your EOB by using the "Claims" link in the title bar on the **MyPopulytics.com** home page. It is important to maintain a current email in MyPopulytics.com.

Prescription Drug Plan

Both the LVHN HSA Plan and LVHN PPO Plan offer you the convenience of purchasing your prescriptions from any Lehigh Valley Pharmacy Services pharmacy (formerly Health Spectrum Pharmacy Services) locations listed here.

- LVH–Cedar Crest – 610-402-8444
- LVH–Muhlenberg – 484-884-7004
- LVH–Schuylkill – 570-621-4110
- LVH–17th Street – 610-969-2780
- LVH–Pocono – 272-762-6337

The amount you pay for your prescriptions is based on the type of medications and the medical plan option in which you enroll.

For Convenience Shipping, access the Lehigh Valley Pharmacy Services website at LVHN.org/pharmacy to enroll and for more details.

The following chart reflects prescription costs at Lehigh Valley Pharmacy Services and any retail pharmacy.

	Lehigh Valley Pharmacy Services					Retail Pharmacy (30-day supply)			
	Zero Copay	Generic	Preferred Brand-Name	Brand-Name	Non-Preferred Brand-Name	Generic	Preferred Brand-Name	Brand-Name	Non-Preferred Brand-Name
PPO Plan	**$0**	$5	$20	$40	$60	$10	30% with $30 minimum	30% with $50 minimum	30% with $70 minimum
HSA Plan	**$0**	10% after deductible with $24 maximum per prescription	10% after deductible with $60 maximum per prescription	10% after deductible with$120 maximum per prescription	10% after deductible with$180 maximum per prescription	50% after deductible	50% after deductible	50% after deductible	50% after deductible

If the retail price of the medication is lower than the co-pay, you pay the lower price. Supplies for 30, 60 or 90 days are allowed if ordered by your physician for the co-pay total per month.

In an effort to continue to contain costs associated with escalating drug prices, there will be some brand-name drugs that have less expensive brand-name or generic equivalents excluded from prescription coverage under the LVHN Health Plan. The list of excluded brand-name drugs is available at **MyPopulytics.com** and **LVHN.org/pharmacy**.

At a retail pharmacy, you can have:

- Unlimited fills of antibiotics and oral steroids
- One 30 day fill of each newly prescribed medication each calendar year
- There is a separate out-of-network prescription deductible. An annual prescription deductible of $250 per person, not to exceed $500 per family, will be applicable for prescription drug expenses incurred outside of Lehigh Valley Pharmacy Services. This deductible is separate from the health plan deductible.

Specialty Drugs

Specialty drugs are prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic and often costly conditions, such as infertility, cancer, multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia.

- **With the LVHN PPO Plan**, at Lehigh Valley Pharmacy Services you pay:
  - 20% co-insurance with a $150 maximum for a 30-day supply for specialty drugs
  - 20% co-insurance with a $750 maximum for a 30-day supply for non-preferred specialty drugs
- **With the LVHN HSA Plan**, at Lehigh Valley Pharmacy Services you will pay:
  - 10% of the cost, after the deductible, up to a maximum payment of $450 per prescription, up to a 90-day supply
  - 10% of the cost, after the deductible, up to a maximum payment of $2,250 per prescription, up to a 90-day supply for non-preferred specialty drugs

Please note that specialty drugs are covered under the LVHN Health Plan when a prescription is filled at Lehigh Valley Pharmacy Services. If Lehigh Valley Pharmacy Services cannot obtain a prescription, you will need to get a Certificate of Nonavailability (CNA) through Care Management to fill your prescription. Your claim will be processed as if you received it at Lehigh Valley Pharmacy Services. If you do not get a CNA, the prescription will not be covered under the plan.

The drugs in the Non-Preferred Specialty Drug tier have stable copay reduction programs through the drug manufacturer, lowering your out of pocket cost for the drug substantially. If at any time should the copay program be eliminated, the health plan will move the medication to the specialty drug tier. The pharmacy will ensure that you are enrolled in one of the copay programs prior to dispensing your medication.

To see if a drug is considered a specialty drug, refer to the most current LVHN Health Plan Master Drug List available at **MyPopulytics.com**, **LVHN.org/pharmacy** and the Colleague Resource Center (CRC).

Step Therapy for Prescription Medications

New medications come on the market all the time. As a new drug is developed, it takes some time to make sure that it will work in the way it was expected. These new drugs can be costly. LVHN Health Plan is always looking for ways to keep costs down for members while still making sure you get the safest, most effective and reasonably priced drug available. One way we can do this is with a step therapy program. Step therapy is trying other medications in the same drug class first before "stepping up" to drugs that cost more. We want to know that less expensive options don't work before the plan will cover the new drug. Here's an example of step therapy:

- **Step 1**: You try a low-cost medication proven to be effective for acid reflux. You're still having symptoms.
- **Step 2:** Because you have tried a lower-cost medication, if your physician prescribes a more expensive medication for acid reflux, it will be covered.

The list of drugs requiring step therapy is available at **MyPopulytics.com** and **LVHN.org/pharmacy**. If your drug is on the step therapy list, either you or your pharmacist will need to let your doctor know. Your doctor might switch your therapy to another drug that doesn't require approval from the health plan. Or, your doctor can contact Care Management to start the approval process and tell us the needed information.

Emergent Prescription Drug Benefit

An Emergent Prescription Drug Benefit is available under the LVHN Health Plan. LVHN Health Plan members who receive a prescription from an emergency room or urgent care setting outside of the regular business hours of Lehigh Valley Pharmacy Services (LVPS), and have a need to fill the prescription immediately, will now be able to fill this at a non-LVPS pharmacy and be reimbursed at the Tier 1 prescription benefit level.

The member will be required to pay the providing pharmacy at the time of service, complete the Emergent Prescription claim form and submit to Populytics for reimbursement with the appropriate medical documentation as outlined on the form. The form is available on the Colleague Resource Center (CRC) under CRC - All Forms or at **MyPopulytics.com** under Pharmacy Forms and Benefit Guides.

Additional Information About Prescription Drug Coverage

Both the LVHN PPO and LVHN HSA plans cover generic prescription contraceptives at 100% with no co-pay or deductible. Brand-name prescription contraceptives will be paid without a co-pay or deductible only if the physician expressly notes the brand is medically necessary or a generic equivalent is not available. Otherwise, the plan will pay only the cost of the generic equivalent.

- 90-day maximum for maintenance medications, see below for restrictions on narcotics and controlled substances

Generic medications typically save you the most money. If you are taking a brand-name medication, ask your doctor if there is a generic medication available.

Brand-name drug prescriptions will be paid at brand-name level only if your doctor expressly notes that the brand is medically necessary or a generic equivalent is not available. Otherwise, both plans will pay only the cost of the generic equivalent. The member is required to pay the difference, and this difference will not be applied to the out-of-pocket maximum.

If you currently take a non-preferred brand-name medication, talk with your doctor to see if you can switch to a preferred brand-name medication and pay less.

The **Preferred Brand-Name Medication List** is available at **MyPopulytics.com** and **LVHN.org/pharmacy**. The list is subject to change based on clinical information.

Narcotics and controlled medications are subject to the following limits under both options:

- 30-day maximum unless the patient is being treated for attention deficit disorder
- A 90-day supply is allowed if the controlled medication has an FDA-labeled use for attention deficit disorder and the physician writes the prescription for an appropriate quantity.

Migraine medications are limited to 15 doses per month under both options.

Sexual dysfunction medication is covered for up to six doses a month under both options if the cause of the condition is deemed to be organic in nature.

LVHN Prescription Drug Plan and Medicare Comparison

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug plan with LVHN and prescription drug coverage for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

1. **Effective Jan. 1, 2006, new Medicare prescription drug coverage was made available to everyone with Medicare.**
2. **LVHN has determined that the prescription drug coverage offered by the LVHN Comprehensive Health Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.**
3. **Read this notice carefully – it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.**

You may have heard about Medicare's prescription drug coverage, and wondered how it would affect you. LVHN has determined that your prescription drug coverage with LVHN is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

Effective Jan. 1, 2006, prescription drug coverage was available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also might offer more coverage for a higher monthly premium. **Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.**

The original enrollment in the Medicare prescription drug plan was from Nov. 15, 2005, through May 15, 2006. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later. Each year you will have the opportunity to enroll in a Medicare prescription drug plan between Oct. 15 and Dec. 7. **If you do decide to enroll in a Medicare prescription drug plan and drop your LVHN coverage, be aware that you may not be able to get this coverage back.** You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

In addition, your current coverage pays for other health expenses, in addition to prescription drugs.

You also should know that if you drop or lose your coverage with LVHN and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If after May 15, 2006, you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage; your monthly premium will go up at least 1% per month for every month after May 15, 2006, that you did not have that coverage. For example, if you go 19 months without coverage, your premium will be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until next November to enroll.

For more information about this notice or your current prescription drug coverage, call the Colleague Resource Center (CRC) at 844-GO-ASK-HR.

Note: You may receive this notice at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…More detailed information about Medicare plans that offer prescription drug coverage is available in the Medicare & You 2021 handbook. You'll get a copy of the handbook in the mail from Medicare. You also may be contacted directly by Medicare prescription drug plans. You can get more information about Medicare prescription drug plans from these places:

- Visit **medicare.gov** for personalized help.
- Call your state Health Insurance Assistance Program. (See your copy of the Medicare & You 2021 handbook for the telephone number.)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. For information about this extra help, visit the Social Security Administration (SSA) online at **socialsecurity.gov**, or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enrolled in one of the new plans approved by Medicare that offer prescription drug coverage after May 15, 2006, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date:	Sept. 1, 2020
Name of Entity/Sender:	Lehigh Valley Health Network
Contact–Position/Office:	Director HR Colleague Rewards/Benefits
Address:	3435 Winchester Road Allentown, PA 18104
Phone Number:	484-884-3079

Delta Dental Plan

You have a choice of two dental options. The Basic Plan covers preventive, basic, and major services. The Comprehensive Plan covers preventive, basic, major, orthodontic services and Implants.

Find a Delta Dentist

It is easy to find a Delta Dental dentist in your area. You can access their website for participating providers at **deltadentalins.com** and select Delta Dental PPO or Premier Network. You will have access to both.

Summary of Dental Plan Benefits

This summarizes the dental coverage you are eligible to purchase as an employee if you are scheduled to work at least 15 hours per week. See premium section of this guide for information on per-pay-period dental plan deductions from your paycheck.

Annual Deductible

$50 per individual; maximum not to exceed $150 per family

Basic Dental Plan

PREVENTIVE 100% of Fee Schedule, No Deductible	BASIC 80% of Fee Schedule After Annual Deductible Met	MAJOR 50% of Fee Schedule After Annual Deductible Met
Preventive and Diagnostic (2 per calendar year) • Prophylaxis • Fluoride for children • Routine examinations • Bitewing and full-mouth X-rays • Sealants	**Basic Restoration** • Other X-rays • Fillings • Extractions** • Oral surgery** • General anesthesia* • Endodontics • Periodontics* • Root canal therapy	**Major Restorative***** • Full dentures • Partial dentures • Fixed bridgework • Crowns • Inlays • Repairs and replacements of all above services
	20% co-payment by the employee	50% co-payment by the employee
Calendar year maximum $1,500 per individual		

Comprehensive Dental Plan

PREVENTIVE 100% of Fee Schedule, No Deductible	BASIC 80% of Fee Schedule After Annual Deductible Met	MAJOR 50% of Fee Schedule After Annual Deductible Met	ORTHODONTICS AND IMPLANTS 50% of Fee Schedule, No Deductible
Preventive and Diagnostic (2 per calendar year) • Prophylaxis • Fluoride for children • Routine examinations • Bitewing and full-mouth X-rays • Sealants	**Basic Restoration** • Other X-rays • Fillings • Extractions** • Oral surgery** • General anesthesia* • Endodontics • Periodontics* • Root canal therapy	**Major Restorative***** • Full dentures • Partial dentures • Fixed bridgework • Crowns • Inlays • Repairs and replacements of all above services	**Teeth Straightening** • Any service that attempts to alter occlusion or alignment of the teeth • Night guard • Treatment for bruxism
	20% co-payment by the employee	50% co-payment by the employee	50% co-payment by the employee
Calendar year maximum $1,500 per individual			Orthodontics: $1,500 individual lifetime maximum Dental Implants: limit–1 every five years

* Limited benefit

** Some services may be payable under medical plan.

*** Reimbursement level could be dependent on pre-existing condition.

Please refer to the CRC for more detailed dental plan information.

Vision Plan

The vision provider is EyeMed Vision Care (EyeMed). You are eligible to purchase vision coverage if you are scheduled to work at least 15 hours per week. You have the option of electing the Base or Buy-Up Plan.

The vision plan includes Lasik and hearing aid benefit discounts. *(See the Colleague Resource Center for more information.)*

Please see the summary of vision benefits below.

To find a participating provider, access the EyeMed website at EyeMed.com – Select "Insight network," no login needed.

EyeMed customer service: OE/Pre-enrollment: 866-804-0982; Post-enrollment: 866-800-5457

Plan Highlights	Base Plan Member Cost In-Network	Buy-Up Plan Member Cost In-Network	Out-of-Network Reimbursement
Examination	Once every 12 months	Once every 12 months	
Lenses or contact lenses	Once every 12 months	Once every 12 months	
Frame	Once every 24 months	Once every 12 months	
Examination with dilation as necessary	$0 co-pay in network	$0 co-pay in network	$40 (base and buy-up)
Fundus photography benefit	Up to $39	Up to $39	N/A (base and buy-up)
Contact Lens Fit and Follow-up* *Available once a comprehensive eye exam has been completed			
Standard	$0 co-pay, paid-in-full fit and two follow-up visits	$0 co-pay, paid-in-full fit and two follow-up visits	$40 (base and buy-up)
Premium	$0 co-pay, 10% off retail price, then apply $55 allowance	$0 co-pay, 10% off retail price, then apply $55 allowance	$40 (base and buy-up)
Frames: Any available frame at provider location	$0 co-pay; $130 allowance, 20% off balance over $130	$0 co-pay; $150 allowance, 20% off balance over $150	$60 (base), $68 (buy-up)
Standard Plastic Lenses			
Single Vision	$0 co-pay	$0 co-pay	$40 (base and buy-up)
Bifocal	$0 co-pay	$0 co-pay	$60 (base and buy-up)
Trifocal	$0 co-pay	$0 co-pay	$80 (base and buy-up)
Lenticular	$0 co-pay	$0 co-pay	$100 (base and buy-up)
Standard Progressive Lens	$50 co-pay	$50 co-pay	$60 (base and buy-up)
Lens Options			
UV Treatment	$12 co-pay	$12 co-pay	$5 (base and buy-up)
Tint (Solid and Gradient)	$10 co-pay	$10 co-pay	$5 (base and buy-up)
Standard Plastic Scratch Coating	$0 co-pay	$0 co-pay	$5 (base and buy-up)
Standard Polycarbonate - Adults	$25 co-pay	$25 co-pay	$5 (base and buy-up)
Standard Polycarbonate - Kids under 19	$0 co-pay	$0 co-pay	$5 (base and buy-up)
Standard Anti-Reflective Coating	$40 co-pay	$40 co-pay	$5 (base and buy-up)
Polarized	20% off retail price	20% off retail price	N/A
Photochromatic/Transitions Plastic	$65 co-pay	$65 co-pay	$5 (base and buy-up)
Other Add-Ons	20% off retail price	20% off retail price	N/A
Contact Lenses: Contact lens allowance includes materials only			
Conventional	$0 co-pay, $130 allowance, 15% off balance over $130	$0 co-pay, $130 allowance, 15% off balance over $130	$130 (base and buy-up)
Disposable	$0 co-pay, $130 allowance, plus balance over $130	$0 co-pay, $130 allowance, plus balance over $130	$130 (base and buy-up)

Plan Highlights	Base Plan Member Cost In-Network	Buy-Up Plan Member Cost In-Network	Out-of-Network Reimbursement
Contact Lenses Medically Necessary	$0 co-pay, paid in full	$0 co-pay, paid in full	$300 (base and buy-up)
Laser Vision Correction			
Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	15% off retail price or 5% off promotional price	N/A
Amplifon Hearing Health Care	Members receive a 40% discount off hearing exams and a low-price guarantee on discounted hearing aids.	Members receive a 40% discount off hearing exams and a low-price guarantee on discounted hearing aids.	N/A
Additional Pairs Benefit	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Progressive Price List*	**Member Pays**	**Member Pays**	
Standard Progressive	$50 co-pay	$50 co-pay	
Premium Progressives			
Tier 1	$70 co-pay	$70 co-pay	
Tier 2	$80 co-pay	$80 co-pay	
Tier 3	$95 co-pay	$95 co-pay	
Tier 4	$50 co-pay, 80% of charge less $120 allowance	$50 co-pay, 80% of charge less $120 allowance	
Anti-Reflective Coating Price List*			
Standard Anti-Reflective Coating	$40 co-pay	$40 co-pay	
Premium Anti-Reflective Coatings			
Tier 1	$52 co-pay	$52 co-pay	
Tier 2	$63 co-pay	$63 co-pay	
Tier 3	80% of charge	80% of charge	
Other Add-ons Price List			
Photochromic (Plastic)	$65	$65	
Polarized	80% of charge	80% of charge	

* Member Reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate.

Additional Discounts:

Member receives a 20% discount on items not covered by the plan at network providers. Discount does not apply to EyeMed provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered.

Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.

After initial purchase, replacement contact lenses may be obtained via the internet at substantial savings and mailed directly to the member. Details are available at eyemedvisioncare.com.

The contact lens benefit allowance is not applicable to this service.

Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency.

Certain brand-name Vision Materials in which the manufacturer imposes a no-discount practice.

Plan Exclusions:

1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; **2)** Medical and/or surgical treatment of the eye, eyes or supporting structures; **3)** Any eye or Vision Examination, or any corrective eye wear required by a Policyholder as a condition of employment; Safety eye wear; **4)** Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; **5)** Plano (non-prescription) lenses and/or contact lenses; **6)** Non-prescription sunglasses; **7)** Two pair of glasses in lieu of bifocals; **8)** Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; **9)** Services or materials provided by any other group benefit plan providing vision care; **10)** Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

EyeMed Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs.

*Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.

For a current listing of brands by tier, go to: eyemedvisioncare.com/theme/pdf/microsite-template/eyemedlenslist.pdf.

2021 LVHN Medical, Dental and Vision Premiums

Your premium will be based on your coverage tier (Employee, Employee + Spouse, Employee + Child(ren), Employee + Family) and which option you select. For employees scheduled to work 36–40 hours per week, your premium also will be based on your annual salary (see chart below).

2021 Benefit Premiums

Costs are per pay based on pre-tax payroll deductions over 26 pay periods per year unless otherwise noted.

LVHN PPO Plan – Employees scheduled 36 hours per week or more				
Base Annual Earnings	**Employee**	**Employee + Spouse**	**Employee + Child(ren)**	**Employee + Family**
$200,000 +	$82.81	$163.30	$163.30	$247.28
$100,000 - $199,999	$74.26	$149.44	$149.44	$221.22
$75,000 - $99,999	$53.98	$106.40	$106.40	$157.89
$50,000 - $74,999	$45.87	$92.99	$92.99	$136.35
$40,000 - $49,999	$39.01	$78.31	$78.31	$116.07
$30,000 - $39,999	$32.45	$64.90	$64.90	$94.53
Under $30,000	$24.34	$49.92	$49.92	$75.43
Employees scheduled to work 15–35 hours per week				
	Employee	**Employee + Spouse**	**Employee + Child(ren)**	**Employee + Family**
Part-Time Employees (for all earnings)	$88	$171	$171	$255

LVHN HSA Plan – Employees scheduled 36 hours per week or more				
Base Annual Earnings	**Employee**	**Employee + Spouse**	**Employee + Child(ren)**	**Employee + Family**
$200,000 +	$20	$65	$65	$110
$100,000 - $199,999	$15	$48	$48	$86
$75,000 - $99,999	$15	$33	$33	$56
$50,000 - $74,999	$10	$27	$27	$44
$40,000 - $49,999	$10	$22	$22	$34
$30,000 - $39,999	$10	$18	$18	$26
Under $30,000	$10	$15	$15	$20
Employees scheduled to work 15–35 hours per week				
	Employee	**Employee + Spouse**	**Employee + Child(ren)**	**Employee + Family**
Part-Time Employees (for all earnings)	$45	$85	$85	$143

If applicable, the $25 per-pay-period tobacco surcharge and/or $50 per-pay-period working spouse surcharge will apply in addition to the medical premiums listed above.

Delta Dental Plan			
	Dependents on Plan	**Basic Dental**	**Comprehensive Dental**
All Eligible Colleagues	Employee	$13	$15
	Employee + Spouse	$21	$27
	Employee + Child(ren)	$21	$31
	Employee + Family	$31	$44

LVHN Vision Plan			
	Dependents on Plan	**Base Plan**	**Buy-Up Plan**
All Eligible Colleagues	Employee	$3.04	$4.00
	Employee + Spouse	$5.60	$7.37
	Employee + Child(ren)	$5.31	$6.99
	Employee + Family	$7.56	$9.95

Supplemental "Term" Life and Dependent Life Insurance

Employees may purchase supplemental term life insurance (in addition to their group term life insurance) as well as life insurance for a spouse and/or dependent children (under age 26) through The Hartford. Premiums are paid on a post-tax basis through payroll deduction.

The imputed cost of the group life insurance plus any employee supplemental life insurance in excess of $50,000 will be included in your annual earnings and is subject to social security and Medicare taxes.

In order to elect spousal or child coverage, you also must elect coverage for yourself.

- Eligibility requirement – 15 hours or more per week. You can elect up to five times your annual salary or $500,000 (lesser) for employee coverage. Elect in increments of $25,000 (see enrollment form for rates and options)

New Hires

- Limited enrollment window – must enroll within 30 days of your date of hire. After 30-day window, you are subject to enrollment guidelines (i.e., eligible Qualifying Event, annual Open Enrollment)
- Evidence of Insurability (EOI) is required for employee life insurance applications of more than $250,000 (for new hires – EOI is not required for spousal coverage)

For a supplemental term life insurance enrollment packet, including highlight sheet and enrollment form, please see the Colleague Resource Center (CRC).

Open Enrollment

- During Open Enrollment, you can increase your existing supplemental life coverage by $25,000 or newly enroll for $25,000 without Evidence of Insurability (EOI). If you elect coverage beyond an increment of $25,000, you will have to provide EOI.
- You may elect spouse life insurance coverage of either $25,000 or $50,000, provided you elect employee supplemental life coverage. You can increase spouse coverage by a $25,000 increment without EOI.
- Dependent life coverage of $15,000 for each child, up to age 26, can be elected without EOI provided you elect employee supplemental life coverage.
- If you elected or increased Supplemental Life or Spousal Life insurance by an amount greater than $25,000, you must complete the Evidence of Insurability form (EOI). An individualized form will be presented to you on the confirmation screen at the end of online Open Enrollment, which you will need to print.

Flexible Spending Accounts

Understanding FSAs

An FSA is a plan, authorized under IRS Code Section 125, allowing employees to fund qualified benefits on a before-tax basis. Under an FSA, employees reduce their taxable income and use the income reduction to pay for expenses that otherwise would have been paid with after-tax dollars. FSAs are completely voluntary. You may choose to participate in none, one or both if you wish.

LVHN offers two types of flexible spending accounts (FSA):

- Health Care FSA – This FSA is utilized for coverage of health, dental and vision expenses not covered by insurance such as deductibles, co-pays, co-insurance and certain non-covered items like eyeglasses. You may not contribute to a Health Care FSA if you have a Health Savings Account (HSA).
- Child/Elder Care FSA – This FSA covers qualifying dependent care expenses incurred ***(i.e., child care, day care, elder care)*** in order to allow you and your spouse to be gainfully employed.

In both cases, you elect to defer into your FSA a certain dollar amount tax-free each pay period. When qualifying expenses occur, the FSA will reimburse you without taxes deducted.

Tax Savings

By definition, FSAs are funded on a pre-tax basis and payments made from them are made without tax deductions. Savings will differ for each employee depending on family income and federal and state taxes, but the general calculation works as follows:

Assuming a $1,500 annual FSA pre-tax contribution

Assume 28% Federal Tax (28% x $1,500)	$ 420.00
Assume State Tax (5% x $1,500)	75.00
Assume Social Security Tax (7.65% x $1,500)	114.75
Total taxes saved	$ 609.75

Thus, employees can increase their take-home pay by using pre-tax dollars to pay for non-reimbursed medical, vision, dental, and child or adult care expenses.

Social Security Benefit

Because both the employer and the employee do not pay Social Security (FICA) tax on the money contributed to FSAs, your contributions may reduce Social Security benefit payments in the event of your retirement, disability or death. However, the tax savings from the FSAs are likely to offset any loss in Social Security benefit payments.

Impact on Other Benefits

FSA contributions reduce your income only for tax purposes. Your benefits (such as life insurance, disability, pension, and 403(b) or 401(k) contributions) will be based on your full base pay before FSA contribution amounts.

Flexible Spending Plan Year

The FSA plan year runs from Jan. 1 through Dec. 31 for both the Health Care FSA and the Child/Elder Care FSA. Only expenses incurred during the 2021 plan year are eligible for reimbursement from contributions made during 2021. You will have until March 31, 2022, to submit all claims. Any funds not used for expenses incurred during 2021 will be forfeited. New employees enrolling in an FSA can only submit eligible expenses incurred beginning with their first date of coverage. If an employee ends employment during the year, expenses for the Health Care FSA can only be submitted for services incurred prior to the date of employment termination, unless the employee continues FSA coverage under COBRA.

"Use It or Lose It"

IRS rules do not allow unused money in your FSA(s) to be returned to you at the end of the plan year. As well, the IRS prohibits the transfer of funds between a Health Care FSA and a Child/Elder Care FSA. Remaining amounts in either or both accounts after the claim submission deadline are forfeited. The sponsoring employer may use those funds to defray administrative expenses. Estimate carefully.

Using the Health Care FSA

If you choose a Health Care FSA, you will receive a Benefits (debit) Card in the mail. This allows you to use your Health Care FSA dollars at your doctor's or dentist's office, and in the emergency room, pharmacy or other eligible locations. It's fast, simple and easy to use just like a credit card.

To be eligible for reimbursement, medical expenses must:

- Be incurred by you or an eligible dependent during the plan year;
- Not be reimbursable from another source;
- Constitute a deductible medical, dental or vision expense as described by IRS Publication 502; and
- Be properly submitted to Populytics for consideration.

Using the Child/Elder Care FSA

Eligible dependent care expenses include those related to the care of children age 12 and under and/or elderly or incapacitated dependents. This benefit is provided to enable you and your spouse to work (unless your spouse is a full-time student).

- This does not include medical expenses.
- If the expenses are incurred for services outside of your home, the dependent must spend at least eight hours per day in your home. Charges for overnight stays are not eligible.
- If expenses are incurred for services provided by a child/elder care facility, the center must comply with all state and local laws.
- Expenses related to overnight camps are not eligible.
- You must supply the taxpayer ID number for each child/elder care service provider to the IRS on your annual tax return.
- Services performed must be within the plan year and must have been incurred prior to reimbursement. The IRS defines "incurred" as "when the child/elder care is provided and not when the participant is formally billed or charged for or pays for child/elder care."
- The total amount a married couple can exclude or deduct is limited to $5,000 per tax year.
- Detailed information can be obtained in the IRS publication 503.

Annual Contribution Limits

Health Care FSA

You may elect an amount between $100 and $2,750, taken pre-tax over 26 pay periods in a full calendar year.

You and your spouse may each contribute an amount up to your respective employer's plan limit. However, you may claim reimbursement of each expense from only one plan (not the same expense under both plans).

Child/Elder Care FSA

You may elect amount between $100 and $5,000, taken pre-tax over 26 pay periods in a full calendar year, subject to any necessary nondiscrimination testing adjustments.

A Child/Elder Care FSA vs. tax credit – You may receive a tax break on your expenses, but you must choose whether to use the Child Care Credit or the FSA. The IRS will not allow you to receive two tax breaks on the same expenses. Please contact your tax adviser if you have questions about which is best for you.

Medical and FSA Claims Submission Instructions

Send claims for these benefits to Populytics.

LVHN HSA and LVHN PPO Plans

*All forms are available on the Colleague Resource Center (CRC) or at **MyPopulytics.com**.*

Tier 1

If you use a Tier 1 provider or facility, you do not have to submit a claim for services. Simply pay the physician the co-payment or co-insurance at the time of the service rendered. You may be billed for the deductible.

Tier 2

If you use a Tier 2 LVHN Health Plan hospital/facility, you do not have to submit a claim for services; however, you may be billed for the deductible.

Tier 3

If you use a Tier 3 provider or facility, you must submit a claim form unless your provider chooses to bill Populytics directly.

Claim Form Submission

Late Claim Filing – In order for claims to be considered for payment, they must be received by the plan within 12 months of the date of service. Claims received thereafter will be ineligible for health plan reimbursement. This includes resubmissions and responding with additional information.

Coordination of Benefits (COB) Form

If you are covered as "Employee only" and you do not have coverage with another employer, LVHN is your primary coverage. You do not need COB and are not required to complete a form.

If you have a dependent(s) covered, you will need to complete a COB form to get any of your dependents' health claims covered.

You are required to complete the COB form during new hire enrollment or on MyPopulytics.com.

The form may be completed online at **MyPopulytics.com** or by paper. You can either fax it to 484-862-3502 or scan and upload it to **MyPopulytics.com** through an Express Request, or mail the paper form to Populytics. If you have any questions, you can use Populytics' online customer service at **MyPopulytics.com** or call their call center at 484-862-3505.

HSA Claims

You can use the funds in your HSA to pay for eligible health care expenses up to the amount in the account.

There are two ways for you to access the funds in your HSA.

- **Benefits Card –** You will receive a debit card, which you may use to pay for eligible health care expenses. You can use the debit card to pay the provider directly.
- **Online Access –** You will have online access to your HSA through WealthCare within **MyPopulytics.com**. You also can reimburse yourself through the online bill pay options.

When you withdraw money from your HSA, you are responsible for ensuring that the funds are used to cover eligible expenses. IRS regulations require you to keep receipts for all expenses reimbursed from your HSA. If you use HSA funds to pay for ineligible expenses, you must report the ineligible withdrawals as income on your tax return, and you will pay income tax and a 20 percent penalty tax on those amounts.

Health Care FSA

- If you choose a Health Care FSA, you will receive a Benefits (debit) Card. The Benefits (debit) Card makes using your FSA dollars simple and easy. The card deducts each payment directly from your FSA, so it's as convenient as using an ordinary credit card. What's more, the card virtually eliminates the paperwork and reimbursement wait time that seemed to make FSAs complex and cumbersome. All you have to do is save receipts for all your FSA purposes in the event they are requested by Populytics or the IRS.
- In many cases you won't have to send in a receipt, because with the Benefits (debit) Card, your purchases will be auto-substantiated at thousands of retailer locations nationwide. Because they have an Inventory Information Approval System (IIAS) in place, these retailers will know instantly which items you purchase are eligible FSA purchases. With one swipe of your Benefits (debit) Card, approved purchases will be authorized and debited from your FSA. You will be asked to remit another form of payment for the non-eligible items. For optimal convenience, your Benefits (debit) Card offers 24/7/365 online access, for you to check your account balance and other vital information by accessing WealthCare on **MyPopulytics.com**.

- If you choose not to use your debit card, or for those purchases that you are unable to use the debit card, you still can submit your claims on paper with a completed claim form. Documentation must include the provider's name and address, the patient's name, date(s) of service, description of the service or supply, and amount charged. Summary bills or bills solely indicating a balance due are not acceptable forms of proof of reimbursable expense.
- Medical expenses may be reimbursed in advance of Health Care FSA contributions made, up to the total annual amount elected.
- By their very nature, Health Care FSA reimbursements are meant to repay you for expenses you have incurred. Payment will be made to you, not to your service provider.

Child/Elder Care FSA

- You must submit an itemized statement from the care provider. A canceled check is insufficient documentation. The provider must include his or her tax identification number, full name and business address.
- Populytics will reimburse you for the amount of your claim provided it does not exceed your current account balance. If there is not enough money in your account to cover your claim, it will be held until there are sufficient funds to reimburse you.
- By their very nature, Child/Elder Care FSA reimbursements are meant to repay you for expenses you have incurred. Payment will be made to you, not to your service provider, except as indicated below.
- If you are utilizing the Children's Early Care and Education Center located at Lehigh Valley Hospital–Cedar Crest, reimbursements from the Child/Elder Care FSA can be assigned directly to this provider.

Direct Deposit

Direct deposit is available for reimbursements from your FSA through the WealthCare link on **MyPopulytics.com**. Simply update your Reimbursement settings under My Accounts.

If Your Claim Is Denied

If you do not agree with a claim determination, you or an authorized representative (e.g., spouse, dependent or provider) may appeal the adverse determination. Forward a written request along with a signed authorization for review of the claim to Populytics at P.O. Box 1830, Allentown, PA 18105-1830 within 180 days of the date of the adverse determination. The written appeal should state the reasons why you feel the claim was improperly processed and include any additional information pertaining to the claim. You will receive a written decision within 30 days of the receipt of the appeal. If your situation meets the definition of urgent under the law, your review will generally be conducted within 72 hours. Upon written request you may receive, free of charge, copies of all relevant documents, information and records relevant to the claim. You also may request copies of any internal rule, guideline or protocol that was relied upon in processing your claim, including an explanation of scientific or clinical judgment that was applied to any claim that was denied based on a medical necessity, experimental treatment, or similar exclusion or limit contained in the plan.

After you have exhausted your internal appeals you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. A request for an external review must be requested in writing no later than four months after the date of your final internal adverse determination letter. After all appeal processes have been exhausted and you still feel the claim was processed incorrectly, you have the right to pursue civil action under ERISA 502(a). Please see your Summary Plan Description for any questions and a complete overview of the appeal process. You can access the Summary Plan Description through the Colleague Resource Center (CRC) or Populytics' member portal at **MyPopulytics.com**.

Notice of Privacy Practices for Lehigh Valley Health Network Health Plan

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact the corporate compliance office at 610-402-9100.

OUR PLEDGE REGARDING PROTECTED HEALTH INFORMATION

Lehigh Valley Health Network (LVHN) understands that medical information about you is personal, and we are committed to protecting your PHI. This notice describes how LVHN's sponsored Health Plan ("the Plans") use and disclose your PHI.

USE AND DISCLOSURE OF YOUR PHI

The following categories describe different ways that the Plans use and disclose your PHI. For each category of uses or disclosures, we will explain what we mean and try to provide some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

The Plans may use certain types of health information that identify you and relate to the provision of health care services or payment for your health care. This information constitutes protected health information (PHI) as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Plans may use your PHI for the purposes of making or obtaining payment for your care and conducting health care operations.

The following is a summary of the circumstances under which and purposes for which your PHI may be used and disclosed:

FOR TREATMENT – We may use and disclose your PHI to assist your health care providers (doctors, pharmacies, dentists, hospitals and others) in your diagnosis and treatment. For example, we may disclosure your PHI to providers to enable them to supply you with information about alternative treatments.

FOR PAYMENT – The Plans may use or disclose your PHI to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Plans may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

FOR HEALTH CARE OPERATIONS – The Plans may use or disclose your PHI to facilitate the administration of the Plans and as necessary to provide coverage and services to all of the Plans' participants. Health care operations include such activities as:

- Quality assessment and improvement activities
- Activities designed to improve health or reduce health care costs
- Clinical guideline and protocol development, case management and care coordination
- Contacting health care providers and participants with information about treatment alternatives and other related functions
- Health care professional competence or qualifications review and performance evaluation
- Accreditation, certification, licensing or credentialing activities
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs
- Business planning and development including cost management and planning related analyses and formulary development
- Business management and general administrative activities of the Plans, including customer service and resolution of internal grievances

For example, the Plans may use your PHI to conduct quality improvement, utilization review and provider credentialing activities, or to engage in customer service and grievance resolution activities.

SPECIAL USES – The Plans also use and disclose your PHI for purposes that involve your relationship as a plan participant. Such special uses include the following:

FOR DISTRIBUTION OF HEALTH-RELATED BENEFITS AND SERVICES – The Plans may use or disclose your PHI to provide to you information on health-related benefits and services that may be of interest to you.

FOR REMINDERS – The Plans may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

TO PERSONS INVOLVED IN YOUR CARE – The Plans may use or disclose your PHI to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, the Plans will use its best judgment to decide if the disclosure is in your best interest.

FOR RESEARCH PURPOSES – The Plans may use or disclose your PHI for research purposes related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.

TO BUSINESS ASSOCIATES – The Plans may disclose your PHI to business associates that perform functions on our behalf or provide us with service if the information is necessary for such functions or services. Business associates are required, under contract with the Plans, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

FOR DATA BREACH NOTIFICATION PURPOSES – The Plans may use your contact information to provide legally required notices of unauthorized acquisition, access or disclosure of your PHI.

The Plans may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

CERTAIN USES AND DISCLOSURES OF YOUR PHI THAT ARE PERMITTED OR REQUIRED BY LAW

FOR DISCLOSURE TO THE PLAN SPONSOR – The Plans may disclose your PHI to the plan sponsor for plan administration functions performed by the plan sponsor on behalf of the Plans. In addition, the Plans may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from health insurers or modify, amend or terminate a plan. The Plans also may disclose to the plan sponsor information on your participation (or enrollment) in the health and dental plans.

WHEN LEGALLY REQUIRED – The Plans will disclose your PHI when it is required to do so by any federal, state or local law.

TO CONDUCT HEALTH OVERSIGHT ACTIVITIES – The Plans may disclose your PHI to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Plans, however, may not disclose your PHI if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

IN CONNECTION WITH JUDICIAL AND ADMINISTRATIVE PROCEEDINGS – As permitted or required by state law, the Plans may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Plans make reasonable efforts to either notify you about the request or to obtain an order protecting your PHI.

FOR LAW ENFORCEMENT PURPOSES – As permitted or required by state law, the Plans may disclose your PHI to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Plans have a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

IN THE EVENT OF A SERIOUS THREAT TO HEALTH OR SAFETY – The Plans may, consistent with applicable law and ethical standards of conduct, disclose your PHI if the Plans, in good faith, believe that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

FOR SPECIFIED GOVERNMENT FUNCTIONS – In certain circumstances, federal regulations require the Plans to use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the President and others, and correctional institutions and inmates.

ORGAN AND TISSUE DONATION – If you are an organ donor, the Plans may disclose your PHI to organizations that handle such organ procurement or transplantation, or to an organ bank, as necessary to help with organ procurement, transplantation or donation.

PUBLIC HEALTH RISKS – PHI about you may be disclosed for public health purposes.

MILITARY AND VETERANS – If you are a member of the armed forces, PHI may be disclosed as required by military command authorities.

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS – PHI may be disclosed to coroners, medical examiners and funeral directors, as authorized or required by law as necessary for them to carry out their duties.

INMATES – The Plans may disclose PHI about you to a correctional institution as authorized or required by law if you are an inmate or under the custody of law enforcement officials.

FOR WORKERS' COMPENSATION – The Plans may release your PHI to the extent necessary to comply with laws related to workers' compensation or similar programs.

CERTAIN STRICTER REQUIREMENTS THAT WE FOLLOW

Several state laws may apply to your PHI that set a stricter standard than the protections offered under HIPAA. Stricter state law in Pennsylvania will, for example, limit us from disclosing records containing HIV-related information; records containing alcohol and drug abuse information; and records containing psychiatric and psychological treatment. State law dictates to whom and under what circumstances disclosure is appropriate. Generally, release of this information unrelated to treatment or payment purposes is contingent upon your specific authorization, or pursuant to a court order.

GENETIC INFORMATION – The Plans are not permitted to use genetic information for underwriting purposes.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, the Plans will not disclose your PHI other than with your written authorization. Most uses and disclosures for marketing purposes fall within this category and require your authorization before we may use your health information for these purposes. Additionally, with certain limited exceptions, we are not allowed to sell or receive anything of value in exchange for your health information without your written authorization. If you authorize the Plans to use or disclose your PHI, you may revoke that authorization in writing at any time. However, uses and disclosures made before your withdrawal are not affected by your action and cannot take back any disclosures we may have already made with your authorization.

YOUR RIGHTS WITH RESPECT TO YOUR PHI

You have the following rights regarding your PHI that the Plans maintain:

RIGHT TO INSPECT AND COPY YOUR PHI – With certain exceptions, you have the right to inspect and copy your PHI. You also have the right to request that we send a copy of your plan record to a third party. You are required to submit your request in writing to the attention of the Privacy Officer at Populytics, P.O. Box 1830, Allentown, PA 18105-1830. In certain limited circumstances, the Plans may deny your request to inspect and copy your health information. If the request is denied, you have the right to have the denial reviewed by a licensed health care professional. We will comply with the outcome of the review. If you request a copy of your PHI, the Plans may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

If the Plans maintain electronic health records, you will have the right to request that the Plans send a copy of your PHI in an electronic format to you or a third party that you identify. If electronic formats are requested but are not feasible, or you decline the electronic medium offered, the Plans shall provide a hard copy to you to fulfill the request. The Plans may charge a reasonable fee for sending the electronic copy of your PHI.

RIGHT TO AMEND YOUR PHI – If you believe that your PHI record is inaccurate or incomplete, you may request to amend your record. That request may be made as long as the information is maintained by the Plans. A request for an amendment of records must be made in writing to the attention of the Privacy Officer at Populytics, P.O. Box 1830, Allentown, PA 18105-1830. The Plans may deny the request if you do not include a reason to support the amendment. The request also may be denied if your PHI record was not created by the Plans, if the health information you are requesting to amend is not part of the Plans' records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Plans determine the records containing your PHI are accurate and complete.

If the Plans refuse to make your requested amendment, you have the right to submit a written statement about why you disagree. The Plans have the right to prepare a counter-statement. Your statement and the counter-statement will become part of the record.

RIGHT TO REQUEST RESTRICTIONS – You may request restrictions on certain uses and disclosures of your PHI. You have the right to request a limit on the Plans' disclosure of your PHI to someone involved in the payment of your care. However, the Plans are not required to agree to your request. If you wish to make a request for restrictions, please contact the Privacy Officer at Populytics, P.O. Box 1830, Allentown, PA 18105-1830.

You must submit your request in writing. You must indicate what information you want to limit, the particular LVHN-sponsored health plan, and to whom you want the limits to apply. If the plan agrees to your restriction, the restriction will only apply to that particular episode of care unless agreed otherwise.

RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS – You have the right to request that the Plans communicate with you in a certain way if you feel the disclosure of your PHI could endanger you. For example, you may ask that the Plans only communicate with you at a certain telephone number or an alternative address other than your home address. If you wish to receive confidential communications, please make your request in writing to the attention of the Privacy Officer at Populytics, P.O. Box 1830, Allentown, PA 18105-1830. The Plans will attempt to honor your reasonable requests for confidential communications, unless the request imposes an unreasonable administrative burden. It is your responsibility to notify the Plans of any changes in this information.

RIGHT TO AN ACCOUNTING – You have the right to request a list of certain disclosures of your PHI that the Plans are required to keep a record of under the Privacy Rule, such as disclosures for public purposes authorized by the law. The Plans do not account for all disclosures, including those involving treatment, payment or health care operations; or where you authorized the release of information.

The request must be made in writing to the attention of the Privacy Officer at Populytics, P.O. Box 1830, Allentown, PA 18105-1830. The request should specify the specific plan and the time period for which you are requesting the accounting, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. The Plans will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Plans will inform you in advance of the fee, if applicable.

RIGHT TO GET NOTICE OF A BREACH – You have the right to be notified upon a breach of any of your unsecured PHI.

RIGHT TO A PAPER COPY OF THIS NOTICE – You have a right to request and receive a paper copy of this notice at any time, even if you have received this notice previously or agreed to receive the notice electronically. To obtain a paper copy, please contact the corporate compliance officer at 610-402-9100, or in writing to Populytics, P.O. Box 1830, Allentown, PA 18105-1830.

You also may obtain a copy of the current version of this notice at our website, **LVHN.org**.

DUTIES OF THE PLANS

The Plans are required by law to maintain the privacy of your PHI as set forth in this notice and to provide to you this notice of its duties and privacy practices. The Plans are required to abide by the terms of this notice, which may be amended from time to time. The Plans reserve the right to change the terms of this notice and to make the new notice provisions effective for all health information that it currently maintains as well as any health information that it receives in the future. If the Plans change their policies and procedures, the Plans will revise the notice and will provide a copy of the revised notice to you within 60 days of the change.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with LVHN or with the Office for Civil Rights. To file a complaint with LVHN, contact the corporate compliance officer at 610-402-9100, or in writing to 2100 Mack Blvd., 6th floor, P.O. Box 4000, Allentown, PA 18105-4000, to the attention of the Privacy Officer. You also have the right to file a complaint with the Office for Civil Rights, either in writing or electronically. You must include the identity of the entity and the alleged violation, and the complaint must be filed within 180 days of knowledge of the alleged violation.

You will not be penalized for filing a complaint.

EFFECTIVE DATE

This notice is effective April 14, 2003, and amended effective Sept. 23, 2013.

WHO WILL FOLLOW THIS NOTICE?

This Notice will apply to the LVHN-sponsored Plans, including medical, dental and medical flexible spending accounts.

Benefit Contact Information

Lehigh Valley Health Network
Human Resources Department

3435 Winchester Road
Allentown, PA 18104
Colleague Resource Center (CRC): 844-GO-ASK-HR, select Option 4
Hazleton HR: 570-501-4825
Pocono HR: 570-476-3360
Schuylkill HR: 570-621-4695
Access your SSO Toolbar and click on the CRC icon, LVHN CRC-Lawson.

Populytics

P.O. Box 1830
Allentown, PA 18105-1830
484-862-3505
MyPopulytics.com

Delta Dental

deltadentalins.com
800-932-0783

EyeMed Vision Care

OE/Pre-enrollment: 866-804-0982
Post-enrollment: 866-800-5457
EyeMed.com

Lehigh Valley Pharmacy Services

(formerly Health Spectrum Pharmacy)

LVH–Cedar Crest 610-402-8444
Monday–Friday, 7 a.m.–7 p.m.
Saturday and Sunday, 9 a.m.–3 p.m.

LVH–17th Street 610-969-2780
Monday–Friday, 7 a.m.–6 p.m.

LVH–Muhlenberg 484-884-7004
Monday–Friday, 8 a.m.–6 p.m.
Saturday, 9 a.m.–3 p.m.

LVH–Pocono 272-762-6337
Monday–Friday, 8:30 a.m.–5 p.m.

LVH–Schuylkill 570-621-4110
Monday–Friday, 8:30 a.m.–5 p.m.

LVHN Health Plan Provider Directory

MyPopulytics.com
Colleague Resource Center (CRC)

HNL Lab Medicine
Human Resources Department

794 Roble Road
Allentown, PA 18109
484-425-5520

Care Management

Pre-certification, disease management
and/or certificate of nonavailability (CNA)
P.O. Box 1830
Allentown, PA 18105-1830
484-862-3506
MyPopulytics.com
Outside of United States call collect

Employee Assistance Program (EAP)

610-433-8550
preferredeap.org

My Total Health

Colleague Resource Center (CRC)
484-862-3505

Human Resources Employee Benefits
3435 Winchester Road, Allentown, PA 18104

LVHN.org **888-402-LVHN**

Lehigh Valley Health Network

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