



Open Enrollment Guide

Included in This Guide

LIU12 Employee Benefits Highlights	3
Medical, Dental and Vision Coverage for Administrators and Teachers	5
Spousal Surcharge Qualifications for Administrators and Teachers.....	13
Medical, Dental and Vision Coverage for Support Staff and Confidential Staff	16
Spousal Surcharge Qualifications for Support Staff and Confidential Staff	24
Health Insurance Per Pay Contributions	27
Flexible Spending Accounts.....	29
Disability – Short Term and Long Term	32
Life Insurance and Voluntary Life Insurance	37
Tax Sheltered Annuity Account 403(b)	46
WellSpan Employee Assistance Program	50
Highmark Medical and Prescription Resources	52
Important Regulations and Notices Regarding Your Health Coverage	68
Vendor Contact Information and Online Registration Information.....	82

LIU12 Employee Benefits

LIU12 Open Enrollment Period

The annual Open Enrollment period is your once-a-year opportunity to review your benefits and make any changes for the year ahead. During this year's Open Enrollment, you will learn about your options, evaluate your needs, and choose the benefits that will protect you (and your eligible family members) for a full year.

Lincoln Intermediate Unit 12 is committed to offering you:

- Quality benefit choices designed to meet your needs and the needs of your family.
- Tax advantages — pre-tax payroll deductions.

Health benefits remain one of the most valuable components of any employee compensation program. As in the past, we are dedicated to offering you a comprehensive medical plan, while also contributing toward the cost of your premium.

Qualified Life Events

The choices you make during Open Enrollment will be in effect for the 12-month plan year from January 1, 2024. However, you may make changes during the year if you experience a qualified life event. If you need to report a life event during the year, you will need to contact Human Resources with the necessary changes within 31 days of the event.

Some examples of life events are:

- Birth or adoption of a child
- Marriage
- Divorce and/or legal separation
- Death or loss of a dependent (including loss of dependent status)
- Change in your spouse's employment status causing loss or gain of benefits coverage
- Change in your own employment status
- Eligibility for Medicare

Dependent Eligibility

You may enroll your eligible dependents at Open Enrollment. Proof of dependent eligibility will be

requested when enrolling a spouse or child. Dependents who are eligible for benefit coverage include:

- Your legally married spouse
- Your dependent children

Included in the definition of dependent child(ren) are:

- Your naturally born child(ren), legally adopted child(ren), step-child(ren) or court-ordered dependent child(ren) for whom you are the court-appointed legal guardian.
- Your dependent child(ren) up to age 26 for medical and dental. Coverage ends at the end of the month following in which the dependent's birthday falls for each line of coverage.
- Your continuously disabled dependent child(ren) [if disabled prior to age 26] who are incapable of self-sustaining employment and dependent upon you for support, regardless of age.

Spouses of employees who have medical benefits from a local government agency, county or state governments, school districts, intermediate units, and the Federal government, are not eligible to enroll in the LIU12's health benefits.

Spousal Surcharge and Waiver Qualifications

Employees who elect medical benefits for their spouse shall pay an additional surcharge for such coverage. The surcharge applies to working spouses, or spouses who earn an annual gross income of more than \$10,000 or \$15,080, as defined in the employment agreements. The monthly surcharge for teachers and administrators is \$300. The monthly surcharge for support staff is \$200, and \$250 for confidential staff.

Employees electing coverage for their spouse, and waiver of the spousal surcharge, will be asked to verify the employment status of the spouse and will be requested to submit appropriate tax documentation to verify the spouse's annual gross income.

Opt-Out Program

Employees may elect to receive a payment in lieu of medical coverage. Employees who waive the medical option, must provide proof of their current major medical coverage in order to receive the "opt-out" payment. The annual payment is \$2,500 and is paid out at the end of the plan year. Payment is prorated based on the number of months the "opt-out" was in effect. Employees must be actively employed to receive the payment.

Flexible Spending Accounts (FSA's)

An FSA is an easy, convenient way to get more out of your paycheck. It allows you to set aside a predetermined amount of pre-tax dollars to cover certain out-of-pocket medical expenses throughout the year. There are 2 types of Spending Accounts: Health Care FSA and Dependent Care FSA. IRS Rules allow you to contribute to your FSA's through pretax payroll deductions. This means that the money is deposited to your account before any deductions for income tax, social security, or state withholding taxes are taken from your paycheck. Your spending accounts are managed by you through the Highmark website.

You may use your Health Care FSA for things not covered by your health plan benefits such as, copayments, deductibles, or certain vision, hearing and orthodontic care costs. At the start of the plan year, you choose how much you want to set aside with each paycheck (max amount is \$3,050). The total amount of funds are pre-loaded onto a debit card for you to use immediately. *Remember to save your receipts, as you may be required to provide documentation to Highmark.

A Dependent Care FSA reimburses you for non-medical day care expenses for children under the age of 13, disabled dependents of any age, or adult daycare expenses. At the start of the plan year, you choose how much you want to set aside with each paycheck (max amount is \$5,000 per household). You then withdraw funds from your account (up to the amount you have available in your account) as needed throughout the plan year to reimburse yourself for daycare expenses you have already paid.

Life and Accidental Death & Dismemberment Insurance

You are automatically enrolled in a Group Life/ADD Insurance policy. Refer to your employment agreement for the policy amount. Make sure your beneficiary information is accurate and up to date in the Employee Access Portal. Your Life Insurance policy is through Sun Life.

Supplemental Life and Accidental Death & Dismemberment Insurance

Optional Voluntary or Supplemental Life/ADD Insurance may be purchased in \$10,000 increments starting at \$50,000-\$200,000 for self only. If electing supplemental coverage during the Open Enrollment period, you will be required to complete an Evidence of insurability application (health history), and be approved by Sun Life. In addition, Life Insurance coverage over \$50,000 is considered a taxable fringe

benefit and will be subject to imputed income. Imputed income is income attributed to any taxable non-cash benefit that isn't a part of your normal taxable wages.

Optional Retirement Account

You may establish a 403(b) Tax Sheltered Annuity Account with an outside vendor as a way to save additional money for your retirement. There is no employer contribution to your 403(b) account. The contribution amount can be withheld from your wages.

How to Enroll

You will make your benefit selections for Open Enrollment electronically through the Employee Access portal. Navigate to the LIU12 Lobby website and click on the Employee Access "button".

You may also click [here](#) to begin your benefit selections for Open Enrollment. The portal will be open November 1 and will close at midnight on November 15.

How to Prepare for Open Enrollment

Review your current health coverage. Decide if you will keep your current coverage, or waive coverage. Decide if you will be adding or removing a dependent from your coverage. Decide if you want to enroll in a Flexible Spending Account. Gather the necessary documentation and information. If adding a spouse, please provide a copy of your marriage certificate. If adding children to your health insurance, please provide a copy of the birth certificate(s). Send required documentation to openenrollment@iu12.org or secure fax – 717-624-6520. You may also mail required documentation to New Oxford Central Office, Attn: Kelly Reynolds, 65 Billerbeck Street, New Oxford, PA 17350.

Benefits Questions & Help with Open Enrollment

- Email openenrollment@iu12.org
- Call 717-624-6441
- Visit the [Benefits Web Page](#)

In-Person Help with Open Enrollment

11/6/23	York Learning Center	Staff Lounge	11-4
11/7/23	Franklin Learning Center	Media Center	11-4
11/13/23	New Oxford Central Office	Jenny Wade Conf Room	12-5



Medical, Dental and Vision Coverage
For
Administrators and Teachers
(Act 93 & LIUEA Agreements)

LBT - LIU - Admin and Teachers - Actives, Cobra and Retirees under 65 – Effective 1-1-2024

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Group Numbers: 02876110, -11, -12, -20, -21 and -22

Benefit	In Network	Out of Network
General Provisions		
Effective Date	January 1, 2024	
Benefit Period (1)	Calendar Year	
Deductible (per benefit period)		
Individual	\$500	\$600
Family	\$1,000	\$1,800
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	None	\$3,000
Family	None	\$6,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period.		
Individual	\$9,450	Not Applicable
Family	\$18,900	Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after \$45 copay	80% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after \$45 copay	80% after deductible
Specialist Office Visits & Virtual Visits	100% after \$55 copay	80% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after \$55 copay copay, if any, does not apply to urgent care center visits prescribed for the treatment of mental health or substance abuse	80% after deductible
Telemedicine Services (3)	100% after \$25 copay	Not Covered
Preventive Care (4)		
Routine Adult		
Physical Exams	100% (deductible does not apply)	80% after deductible
Adult Immunizations	100% (deductible does not apply)	80% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, Medically Necessary	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Routine Pediatric		
Physical Exams	100% (deductible does not apply)	80% after deductible
Pediatric Immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Emergency Services		
Emergency Room Services (5)	100% after \$150 copay (waived if admitted)	
Ambulance - Emergency and Non-Emergency (6)	100% (deductible does not apply) for emergency services; 100% after deductible for non-emergencies	100% (deductible does not apply) for emergency services; 80% after deductible for non-emergencies
Hospital and Medical / Surgical Expenses (including maternity) (5)		
Hospital Inpatient	100% after deductible	80% after deductible
	Limit: 365 days; 2 pint deductible/benefit period	
Hospital Outpatient	100% after deductible	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations)	100% after deductible	80% after deductible
Surgical Expenses (except office visits) Includes Assistant Surgery, Anesthesia, Sterilization Excludes Neonatal Circumcision and Sterilization Reversal Procedures	100% after deductible	80% after deductible

Benefit	In Network	Out of Network
Therapy and Rehabilitation Services		
Physical Medicine	100% after \$55 copay	80% after deductible
Respiratory Therapy	100% after deductible	80% after deductible
Speech Therapy	100% after \$55 copay	80% after deductible
Occupational Therapy	100% after \$55 copay	80% after deductible
Spinal Manipulations	100% after \$55 copay	80% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100% after deductible	80% after deductible
Inpatient Detoxification / Rehabilitation	100% after deductible	80% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after \$55 copay	80% after deductible
Outpatient Substance Abuse Services	100% after \$55 copay	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	80% after deductible
Home Health Care	100% after deductible	50% after deductible
	Limit: 90 visits/benefit period aggregate with visiting nurse	
Hospice	100% after deductible	not covered
Infertility Counseling, Testing and Treatment (7)	100% after deductible	80% after deductible
Private Duty Nursing	100% after deductible	80% after deductible
	Limit: 240 hours/benefit period	
Skilled Nursing Facility Care	100% after deductible	80% after deductible
Transplant Services	100% after deductible	80% after deductible
Precertification/Authorization Requirements (8)	Yes	Yes

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.

(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.

(3) Telemedicine Services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark Designated Telemedicine Provider. Additional services provided by a Designated Telemedicine Provider are paid according to the benefit category that they fall under (e.g. PCP is eligible under the PCP Office Visit benefit, Behavioral Health is eligible under the Outpatient Mental Health Services benefit).

(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).

(5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.

(6) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.

(7) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

(8) If you receive services from an out-of-area provider or an out-of-network provider, you must contact Highmark Utilization Management prior to a planned inpatient admission, prior to receiving certain outpatient services or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.



LBT – LIU – Admin and Teachers – Actives, Cobra and Retirees under 65 Prescription Drug Card Program – Summary of Benefits - Effective 1-1-2024

Group Numbers: 02876110, -11, -12, -20, -21 and -22

PRESCRIPTION DRUG		RETAIL PHARMACY	MAIL SERVICE PHARMACY
Deductible	None		
Prescription Drug Defined by the National Pharmacy Network - Not Physician Network.	34 day supply \$15 Generic Copay \$30 Brand Copay Specialty Drug – up to 34 days supply		
Smart90 CVS	Smart90 CVS Maintenance Drugs through Mail Order (90-day Supply) \$30 Generic Copay \$60 Brand Copay		
Formulary	Comprehensive		
Formulary Benefit Design	Open		
Generic Substitution	Not Applicable		
Out-of-Pocket Maximum	Not Applicable		
Claim Submission	Pharmacy Files at Point-of-Sale		
Non-Network Pharmacy	Covered at a Participating Pharmacy Level		
PRESCRIPTION DRUG CATEGORIES			
Contraceptives (oral and injectable)	Covered		
Fertility Agents	Not Covered		
Fluoride Products	Covered		
Insulin and Diabetic Supplies	Covered		
Smoking Deterrents (prescription)	Covered		
Vitamins (prescription)	Covered		
Weight Loss Drugs	Not Covered		
Prescription Hair Growth Products	Not Covered		
CARE MANAGEMENT PROGRAMS			
Exclusive Pharmacy Provider	Applies - selected high cost prescription drugs are covered only when they are dispensed through an exclusive pharmacy provider		
Quantity Level Limits on selected prescription drugs	Applies - selected high cost prescription drugs are covered only when they are dispensed through an exclusive pharmacy provider.		
Managed Rx Coverage on selected prescription drugs	Applies – the quantity dispensed under your plan per new or refill prescription may be limited per recommended guidelines.		
Managed Prior Authorizations*	Applies – certain drug therapies may be monitored for appropriate usage and subject to case evaluation if recommended guidelines are exceeded.		

The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. This formulary covers all FDA-approved generic and brand-name drugs. With the Smart90 CVS Network, after two fills at a retail pharmacy that is not CVS you must choose between a 90-day supply through CVS retail pharmacy stores or through Express Scripts Mail Order Pharmacy. Your plan requires that you use Accredo specialty pharmacy for select specialty medications. The Copay Armor program helps members to afford high cost medications (mostly specialty) by leveraging manufacturer coupon dollars. Members will not need to change where prescriptions are filled and will be contacted by Pillar Rx for cost savings enrollment.

Highmark Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association.

Keep Smiling

Delta Dental PPO™



Save with PPO

Visit a dentist in the PPO¹ network to maximize your savings.² These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.³ Find a PPO dentist at deltadentalins.com.

Set up an online account

Get information about your plan anytime, anywhere by signing up for an online account at deltadentalins.com. This free service, available once your coverage kicks in, lets you check benefits and eligibility information, find a network dentist and more.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or social security number. If your family members are covered under your

plan, they will need your information. Prefer to take a paper or electronic ID card with you? Simply log in to your account, where you can view or print your card with the click of a button.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim, and we'll handle the rest.

Understand transition of care

Did you start on a dental treatment plan before your PPO coverage kicked in? Generally, multi-stage procedures are only covered under your current plan if treatment began after your plan's effective date of coverage.⁴ You can find this date by logging in to your online account.

Newly covered?

Visit deltadentalins.com/welcome.

Save with a PPO dentist



¹ In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

² You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

³ You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

⁴ Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

LEGAL NOTICES: Access federal and state legal notices related to your plan at deltadentalins.com/about/legal/index-enrollee.html.

Plan Benefit Highlights for: Lincoln Intermediate Unit
(Administrators and Teachers)

Group No: 05915 - 00010~00013 & 00020~00023

Eligibility	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 26			
Deductibles	None			
Maximums	\$1,000 per person each calendar year			
D & P counts toward maximum?	Yes			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO & Premier dentists**	Non-Delta dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100%	100%
Basic Services Fillings, posterior composites, simple extractions and denture repair	100%	100%
Endodontics (root canals) Covered Under Basic Services	100%	100%
Periodontics (gum treatment) Covered Under Major Services	80%	80%
Oral Surgery Covered Under Basic Services	80%	80%
Major Services Crowns, inlays, onlays and cast restorations	80%	80%
Prosthodontics Bridges, dentures and implants	80%	80%
Orthodontic Benefits Dependent children to age 19	50%	50%
Orthodontic Maximums	\$2,000 Lifetime	\$2,000 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of Pennsylvania One Delta Drive Mechanicsburg, PA 17055	Customer Service 800-932-0783 deltadentalins.com	Claims Address P.O. Box 2105 Mechanicsburg, PA 17055-6999
---	--	--

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Lincoln Benefit Trust - Lincoln Intermediate Unit #12



Welcome to Davis Vision!

We are pleased to provide you with information on your vision benefit to help you care for your vision and eye health - a key part of overall health and wellness!

If you are not currently enrolled, please visit our member site at davisvision.com or call 1.877.923.2847 and enter client code 2097 to locate providers or for additional information.

Using your benefits is easy! Just log on to our Member site at davisvision.com and click "Find a Provider," or call us at 1.800.999.5431.

Make an appointment. Tell your provider you are a Davis Vision member with coverage through Lincoln Benefit Trust - Lincoln Intermediate Unit #12. Provide your member ID number, name and date of birth, and do the same for your covered dependents seeking vision services. Your provider will take care of the rest!

Your Davis Vision Fashion Plan Benefits

100% OF YOUR CALLS & CLAIMS ARE PROUDLY ADMINISTERED IN THE USA 

Benefit	Frequency Once every -	In-network Copay	In-network Coverage
Eye Examination	24 months (over age 19) 12 months (up to age 19)	\$0	Covered in full. <i>Includes dilation when professionally indicated.</i>
Spectacle Lenses	24 months (over age 19) 12 months (up to age 19)	\$0	Clear plastic lenses in any single vision, bifocal, trifocal or lenticular prescription. Covered in full. (See below for additional lens options and coatings.)
Frame	24 months (over age 19) 12 months (up to age 19)	\$0	Covered in Full Frames: Any Fashion level frame from Davis Vision's Collection ^{1/} (retail value, up to \$100). OR, Frame Allowance: \$100 credit toward any frame from provider plus 20% off any balance. No copay required.
Contact Lens Evaluation, Fitting & Follow Up Care	24 months (over age 19) 12 months (up to age 19)	\$0	Davis Vision Collection Contacts: Covered in full Standard, Soft Contacts: Covered in full
Contact Lenses (in lieu of spectacle lenses)	24 months (over age 19) 12 months (up to age 19)	\$0	Covered in Full Contacts: From Davis Vision's Collection ^{1/} , up to: Planned Replacement Two boxes/multi-packs* Disposable Four boxes/multi-packs* OR, Contact Lens Allowance: \$100 allowance toward any contacts from provider's supply plus 15% off balance. No copay required. OR, Visually Required Contacts: Covered in full with prior approval.

*Number of contact lens boxes may vary based on manufacturer's packaging.

Significant savings on optional frames, lens types and coatings!

Member Price

Davis Vision Collection Frames: Fashion Designer Premier	\$0 \$20 \$40
Tinting of Plastic Lenses.....	\$15
Scratch-Resistant Coating.....	\$0
Premium Scratch-Resistant Coating	\$30
Ultraviolet Coating	\$15
Anti-Reflective Coating: Standard Premium Ultra Ultimate	\$40 \$55 \$69 \$85
Polycarbonate Lenses	\$0 ^{2/} -\$35
High-Index Lenses: 1.67 1.74	\$60 \$120
Progressive Lenses: Standard Premium Ultra Ultimate	\$65 \$105 \$140 \$175
Polarized Lenses	\$75
Photochromic Lenses (i.e. Transitions®, etc.) ^{3/} : Plastic Glass	\$70 \$20
Digital Single Vision Lenses	\$30
Blended Lenses.....	\$20
Scratch Protection Plan: Single Vision Multifocal Lenses	\$20 \$40
Trivex Lenses	\$50
Blue Light Filtering.....	\$15

^{1/} The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change. Collection is inclusive of select toric and multifocal contacts.

^{2/} For dependent children, monocular patients and patients with prescriptions of +/- 6.00 diopters or greater.

^{3/} Transitions® is a registered trademark of Transitions Optical Inc.

Please note: Your provider reserves the right to not dispense materials until all applicable member costs, fees and copayments have been collected. Contact lenses: Routine eye examinations do not include professional services for contact lens evaluations. Any applicable fees above the evaluation and fitting allowance are the responsibility of the member. If contact lenses are selected and fitted, they may not be exchanged for eyeglasses. Progressive lenses: If you are unable to adapt to progressive addition lenses you have purchased, conventional bifocals will be supplied at no additional cost; however, your copayment is nonrefundable. May not be combined with other discounts or offers. Please be advised these lens options and copayments apply to in-network benefits.

Frequently Asked Questions

How can I contact Member Services?

Call 1.800.999.5431 for automated help 24/7. Live help is also available seven days a week: Monday-Friday, 8 a.m.-11 p.m. | Saturday, 9 a.m.-4 p.m. | Sunday, 12 p.m.-4 p.m. (Eastern Time). (TTY services: 1.800.523.2847.)

What frames are in Davis Vision's Collection?

Our Collection offers a great selection of fashionable and designer frames, most of which are covered in full. No wonder 8 out of 10 members select a Collection frame. Log on to our member Web site at davisvision.com and take a look!

When will I receive my eyewear?

Your eyewear will be delivered to your network provider generally within five business days of order receipt. Special prescriptions, lens coatings, provider frames or out-of-stock frames may delay the standard turnaround time.

Do I need a claim form?

Claim forms are only required if you visit an out-of-network provider. Claim forms are available on our member Web site.

Can I split my benefits?

You may split your benefits by receiving your eye examination and eyeglasses or contact lenses on different dates or through different provider locations. To maximize your benefit value we recommend that all services be obtained from a network provider.

Can I use an out-of-network provider?

Yes; however, you receive the greatest value by staying in-network. If you go out-of-network, pay the provider at the time of service, then submit a claim to Davis Vision for reimbursement, up to the following amounts: eye exam - \$45 | single vision lenses - \$35 | bifocal - \$52 | trifocal - \$70 | lenticular - \$100 | frame - \$65 | elective contacts - \$75 | daily wear - \$20 | extended wear - \$30 | visually required contacts - \$225.

Are there any exclusions to the vision benefits?

Your vision plan does not cover medical treatment of eye disease or injury; vision therapy; special lens designs or coatings, other than those described herein; replacement of lost eyewear; non-prescription (plano) lenses; contact lenses and eyeglasses in the same benefit cycle; services not performed by licensed personnel; two pair of eyeglasses in lieu of bifocals.

DAVIS VISION EXTRAS!

One Year Breakage Warranty Repair or replacement of your plan covered spectacle lenses, Collection frame or frame from a network retail location where the Collection is not displayed.

Additional Savings Members will receive 50% off of additional complete pairs of eyeglasses and sunglasses at Visionworks and 30% off at other participating providers on the same transaction. Otherwise, a 20% discount off the provider's usual and customary rate is available. Contact lenses are available at a 10% discount.

Mail Order Contact Lenses Replacement contacts (after initial benefit) through www.DavisVisionContacts.com mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. Log on to our member Web site for details.

Laser Vision Correction Davis Vision provides you and your eligible dependents with the opportunity to receive discounted laser vision correction, often referred to as LASIK. For more information, visit www.davisvision.com.

Low Vision Services Comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Covers up to four follow-up visits in five years.

Eye Health & Wellness Log on and learn more about your eyes, health and wellness; common eye conditions that can impair vision; and what you can do to ensure healthy eyes and a healthier life.

For more details... about your vision benefits, patient rights and responsibilities about Davis Vision or to obtain a copy of Davis Vision's Privacy Practices Notice, please log on to our member Web site or contact us at 1.800.999.5431.

Davis Vision has made every effort to correctly summarize your vision plan features herein. In the event of a conflict between this information and your organization's contract with Davis Vision, the terms of the contract will prevail.

Fully insured product Underwritten by HM Life Insurance Company. Administered by Davis Vision, which may operate as Davis Vision Insurance Administrators in California.

Spousal Surcharge Waiver Qualifications
for Teachers and Administrators

Act 93 & LIUEA

Spousal Surcharge Waiver Qualifications

Eligibility determination for the spousal surcharge waiver (SSW) for a calendar year is based on the prior year's tax filing information. For example, a spousal surcharge waiver for the year 2024 is based on the 2023 tax information.

There are various scenarios that may qualify an employee for a SSW. Employee must re-verify every year that their spouse is eligible for the surcharge waiver by providing supporting documentation. Employee is responsible for advising HR as soon as a change occurs. It is the responsibility of the employee to notify HR if a spouse who had previously been granted the spousal waiver surcharge is re-employed or starts earning income from employment related operations. The spousal surcharge begins as soon as a spouse becomes employed and earns greater than \$10,000 in that calendar year.

All omissions, submission of incomplete information or falsification of information will be considered insurance fraud and the employee will be subject to discipline, which may include termination of employment.

1. Spouse retiring at the end of the year:

Spouses who retire at the end of the calendar year who provide a letter from their employer stating that they are no longer employed and will not be receiving any form of earned income from that employer in excess of \$10,000, will be granted the waiver. If they earned more than \$10,000, and provide a letter stating they are retired, the waiver will commence January 1st of the following year. The letter should include the spouse's name, their employer and the detail related to their retirement.

2. Spouse retiring mid-year:

Spouses who retire mid-year and can provide W-2's or paystubs to prove their current year wage earnings are less than \$10,000 will be granted the waiver. If the retiree earned more than \$10,000, the waiver will commence January 1st of the following year if they provide documentation as outlined in step #1.

3. Spouse already retired:

Employees must annually provide copies of either their spouse's year-end tax filing or their joint filing indicating the spouse earned over \$10,000 from wages in the preceding year. Employees must submit the applicable W-2's as back up if the filing does not distinguish the employment wages per spouse.

4. Spouse lost job:

Spouses who lose their jobs mid-year and can provide W-2's or paystubs to prove that their current year earnings due to wages are less than \$10,000 will be granted the waiver. They must also provide a letter from their employer stating they will not be eligible for severance benefits. If a spouse is re-employed, it is the responsibility of the employee to notify HR to commence paying the spousal surcharge.

5. Spouse permanently disabled (Long term disability (LTD)):

Spouses who qualify for LTD and provide proof from their insurance carrier will be granted the waiver of the spousal surcharge for the period of time approved by the insurance carrier.

6. Spouse permanently disabled (SSDI):

Waiver may commence first of the month following receipt of the SSDI AWARD (Not Benefits Payable) Letter to HR.

7. Non-working spouse:

Spouses will be granted the waiver based on the prior year's tax filing. Employees must submit the applicable W-2's as back up if the filing does not distinguish the employment wages per spouse.

Verification:

Employees are required to re-verify every year that their spouse is eligible for the waiver of the spousal surcharge. The only exception to the re-verification is spouses who have received Permanent Disability status from Social Security.

Timing:

For current employees: Evidence must be provided by the tax filing deadline of the impacted year. If evidence is not provided, the employee will be responsible for the Spousal Surcharge for the calendar year retroactive back to the original date of the waiver for the year.

It is imperative that if you know your spouse will earn over \$10,000 in a calendar year that the spousal surcharge is appropriately updated as soon as possible.



Medical, Dental and Vision Coverage
For
Support Staff and Confidential Employees
(ESPA & Confidential Agreements)

LBT - LIU - Support Office and Confidential - Actives, Cobra and Retirees – Effective 1-1-2024

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Group Numbers: 02876130, -31, -32, -70, 71 and -72

Benefit	In Network	Out of Network
General Provisions		
Effective Date	January 1, 2024	
Benefit Period (1)	Calendar Year	
Deductible (per benefit period)		
Individual	\$300	\$750
Family	\$900	\$1,500
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	None	\$3,000
Family	None	\$6,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period.		
Individual	\$9,450	Not Applicable
Family	\$18,900	Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after \$45 copay	80% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after \$45 copay	80% after deductible
Specialist Office Visits & Virtual Visits	100% after \$55 copay	80% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after \$55 copay	80% after deductible
	copay, if any, does not apply to urgent care center visits prescribed for the treatment of mental health or substance abuse	
Telemedicine Services (3)	100% after \$25 copay	Not Covered
Preventive Care (4)		
Routine Adult		
Physical Exams	100% (deductible does not apply)	80% after deductible
Adult Immunizations	100% (deductible does not apply)	80% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, Medically Necessary	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Routine Pediatric		
Physical Exams	100% (deductible does not apply)	80% after deductible
Pediatric Immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Emergency Services		
Emergency Room Services (5)	100% after \$150 copay (waived if admitted)	
Ambulance - Emergency and Non-Emergency (6)	100% (deductible does not apply) for emergency services; 100% after deductible for non-emergencies	100% (deductible does not apply) for emergency services; 80% after deductible for non-emergencies
Hospital and Medical / Surgical Expenses (including maternity) (5)		
Hospital Inpatient	100% after deductible	80% after deductible
	Limit: 365 days; 2 pint deductible/benefit period	
Hospital Outpatient	100% after deductible	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations)	100% after deductible	80% after deductible
Surgical Expenses (except office visits) Includes Assistant Surgery, Anesthesia, Sterilization Excludes Neonatal Circumcision and Sterilization Reversal Procedures	100% after deductible	80% after deductible

Benefit	In Network	Out of Network
Therapy and Rehabilitation Services		
Physical Medicine	100% after \$55 copay	80% after deductible
Respiratory Therapy	100% after deductible	80% after deductible
Speech Therapy	100% after \$55 copay	80% after deductible
Occupational Therapy	100% after \$55 copay	80% after deductible
Spinal Manipulations	100% after \$55 copay	80% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100% after deductible	80% after deductible
Inpatient Detoxification / Rehabilitation	100% after deductible	80% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after \$55 copay	80% after deductible
Outpatient Substance Abuse Services	100% after \$55 copay	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	80% after deductible
Home Health Care	100% after deductible	50% after deductible
	Limit: 90 visits/benefit period aggregate with visiting nurse	
Hospice	100% after deductible	not covered
Infertility Counseling, Testing and Treatment (7)	100% after deductible	80% after deductible
Private Duty Nursing	100% after deductible	80% after deductible
	Limit: 240 hours/benefit period	
Skilled Nursing Facility Care	100% after deductible	80% after deductible
Transplant Services	100% after deductible	80% after deductible
Precertification/Authorization Requirements (8)	Yes	Yes

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.

(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.

(3) Telemedicine Services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark Designated Telemedicine Provider. Additional services provided by a Designated Telemedicine Provider are paid according to the benefit category that they fall under (e.g. PCP is eligible under the PCP Office Visit benefit, Behavioral Health is eligible under the Outpatient Mental Health Services benefit).

(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).

(5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.

(6) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.

(7) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

(8) If you receive services from an out-of-area provider or an out-of-network provider, you must contact Highmark Utilization Management prior to a planned inpatient admission, prior to receiving certain outpatient services or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.

LBT – LIU – Support and Confidential – Actives, Cobra and Retirees under 65 Prescription Drug Card Program – Summary of Benefits - Effective 1-1-2024

Group Numbers: 02876130, -31, -32, -70, -71 and -72

PRESCRIPTION DRUG		RETAIL PHARMACY	MAIL SERVICE PHARMACY
Deductible		None	
Prescription Drug Defined by the National Pharmacy Network - Not Physician Network.		34 day supply \$15 Generic Copay \$30 Brand Copay Specialty Drug – up to 34 days supply	
Smart90 CVS		Smart90 CVS Maintenance Drugs through Mail Order (90 day supply) \$30 Generic Copay \$60 Brand Copay	
Formulary		Comprehensive	
Formulary Benefit Design		Open	
Generic Substitution		Not Applicable	
Out-of-Pocket Maximum		Not Applicable	
Claim Submission		Pharmacy Files at Point-of-Sale	
Non-Network Pharmacy		Covered at a Participating Pharmacy Level	
PRESCRIPTION DRUG CATEGORIES			
Contraceptives (oral and injectable)		Covered	
Fertility Agents		Not Covered	
Fluoride Products		Covered	
Insulin and Diabetic Supplies		Covered	
Smoking Deterrents (prescription)		Covered	
Vitamins (prescription)		Covered	
Weight Loss Drugs		Not Covered	
Prescription Hair Growth Products		Not Covered	
CARE MANAGEMENT PROGRAMS			
Exclusive Pharmacy Provider		Applies - selected high cost prescription drugs are covered only when they are dispensed through an exclusive pharmacy provider	
Quantity Level Limits on selected prescription drugs		Applies - selected high cost prescription drugs are covered only when they are dispensed through an exclusive pharmacy provider.	
Managed Rx Coverage on selected prescription drugs		Applies – the quantity dispensed under your plan per new or refill prescription may be limited per recommended guidelines.	
Managed Prior Authorizations*		Applies – certain drug therapies may be monitored for appropriate usage and subject to case evaluation if recommended guidelines are exceeded.	

The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. This formulary covers all FDA-approved generic and brand-name drugs. With the Smart90 CVS Network, after two fills at a retail pharmacy that is not CVS you must choose between a 90-day supply through CVS retail pharmacy stores or through Express Scripts Mail Order Pharmacy. Your plan requires that you use Accredo specialty pharmacy for select specialty medications. The Copay Armor program helps members to afford high cost medications (mostly specialty) by leveraging manufacturer coupon dollars. Members will not need to change where prescriptions are filled and will be contacted by Pillar Rx for cost savings enrollment.

Highmark Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association.

Keep Smiling

Delta Dental PPO™



Save with PPO

Visit a dentist in the PPO¹ network to maximize your savings.² These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.³ Find a PPO dentist at deltadentalins.com.

Set up an online account

Get information about your plan anytime, anywhere by signing up for an online account at deltadentalins.com. This free service, available once your coverage kicks in, lets you check benefits and eligibility information, find a network dentist and more.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or social security number. If your family members are covered under your

plan, they will need your information. Prefer to take a paper or electronic ID card with you? Simply log in to your account, where you can view or print your card with the click of a button.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim, and we'll handle the rest.

Understand transition of care

Did you start on a dental treatment plan before your PPO coverage kicked in? Generally, multi-stage procedures are only covered under your current plan if treatment began after your plan's effective date of coverage.⁴ You can find this date by logging in to your online account.

Newly covered?

Visit deltadentalins.com/welcome.

Save with a PPO dentist



¹ In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

² You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

³ You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

⁴ Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

LEGAL NOTICES: Access federal and state legal notices related to your plan at deltadentalins.com/about/legal/index-enrollee.html.

Plan Benefit Highlights for: Lincoln Intermediate Unit
(Support Staff)

Group No: 05915 - 00030~00033

Eligibility	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 26			
Deductibles	None			
Maximums	\$1,000 per person each calendar year			
D & P counts toward maximum?	Yes			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO & Premier dentists**	Non-Delta dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100%	100%
Basic Services Fillings, posterior composites, simple extractions and denture repair	100%	100%
Endodontics (root canals) Covered Under Basic Services	100%	100%
Periodontics (gum treatment) Covered Under Major Services	80%	80%
Oral Surgery Covered Under Basic Services	80%	80%
Major Services Crowns, inlays, onlays and cast restorations	80%	80%
Prosthodontics Bridges and dentures	80%	80%
Orthodontic Benefits Dependent children to age 19	50%	50%
Orthodontic Maximums	\$1,000 Lifetime	\$1,000 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of Pennsylvania One Delta Drive Mechanicsburg, PA 17055	Customer Service 800-932-0783	Claims Address P.O. Box 2105 Mechanicsburg, PA 17055-6999
---	---	--

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Lincoln Benefit Trust - Lincoln Intermediate Unit #12



Welcome to Davis Vision!

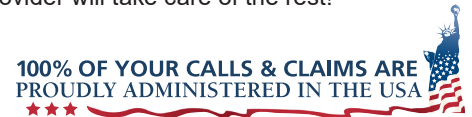
We are pleased to provide you with information on your vision benefit to help you care for your vision and eye health - a key part of overall health and wellness!

If you are not currently enrolled, please visit our member site at davisvision.com or call 1.877.923.2847 and enter client code 2097 to locate providers or for additional information.

Using your benefits is easy! Just log on to our Member site at davisvision.com and click "Find a Provider," or call us at 1.800.999.5431.

Make an appointment. Tell your provider you are a Davis Vision member with coverage through Lincoln Benefit Trust - Lincoln Intermediate Unit #12. Provide your member ID number, name and date of birth, and do the same for your covered dependents seeking vision services. Your provider will take care of the rest!

Your Davis Vision Fashion Plan Benefits



Benefit	Frequency Once every -	In-network Copay	In-network Coverage
Eye Examination	24 months (over age 19) 12 months (up to age 19)	\$0	Covered in full. <i>Includes dilation when professionally indicated.</i>
Spectacle Lenses	24 months (over age 19) 12 months (up to age 19)	\$0	Clear plastic lenses in any single vision, bifocal, trifocal or lenticular prescription. Covered in full. (See below for additional lens options and coatings.)
Frame	24 months (over age 19) 12 months (up to age 19)	\$0	Covered in Full Frames: Any Fashion level frame from Davis Vision's Collection ^{1/} (retail value, up to \$100). OR, Frame Allowance: \$100 credit toward any frame from provider plus 20% off any balance. No copay required.
Contact Lens Evaluation, Fitting & Follow Up Care	24 months (over age 19) 12 months (up to age 19)	\$0	Davis Vision Collection Contacts: Covered in full Standard, Soft Contacts: Covered in full
Contact Lenses (in lieu of spectacle lenses)	24 months (over age 19) 12 months (up to age 19)	\$0	Covered in Full Contacts: From Davis Vision's Collection ^{1/} , up to: Planned Replacement Two boxes/multi-packs* Disposable Four boxes/multi-packs* OR, Contact Lens Allowance: \$100 allowance toward any contacts from provider's supply plus 15% off balance. No copay required. OR, Visually Required Contacts: Covered in full with prior approval.

*Number of contact lens boxes may vary based on manufacturer's packaging.

Significant savings on optional frames, lens types and coatings!

Member Price

Davis Vision Collection Frames: Fashion Designer Premier	\$0 \$20 \$40
Tinting of Plastic Lenses.....	\$15
Scratch-Resistant Coating.....	\$0
Premium Scratch-Resistant Coating	\$30
Ultraviolet Coating	\$15
Anti-Reflective Coating: Standard Premium Ultra Ultimate	\$40 \$55 \$69 \$85
Polycarbonate Lenses	\$0 ^{2/} -\$35
High-Index Lenses: 1.67 1.74	\$60 \$120
Progressive Lenses: Standard Premium Ultra Ultimate	\$65 \$105 \$140 \$175
Polarized Lenses	\$75
Photochromic Lenses (i.e. Transitions®, etc.) ^{3/} : Plastic Glass	\$70 \$20
Digital Single Vision Lenses	\$30
Blended Lenses.....	\$20
Scratch Protection Plan: Single Vision Multifocal Lenses	\$20 \$40
Trivex Lenses	\$50
Blue Light Filtering.....	\$15

^{1/} The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change. Collection is inclusive of select toric and multifocal contacts.

^{2/} For dependent children, monocular patients and patients with prescriptions of +/- 6.00 diopters or greater.

^{3/} Transitions® is a registered trademark of Transitions Optical Inc.

Please note: Your provider reserves the right to not dispense materials until all applicable member costs, fees and copayments have been collected. Contact lenses: Routine eye examinations do not include professional services for contact lens evaluations. Any applicable fees above the evaluation and fitting allowance are the responsibility of the member. If contact lenses are selected and fitted, they may not be exchanged for eyeglasses. Progressive lenses: If you are unable to adapt to progressive addition lenses you have purchased, conventional bifocals will be supplied at no additional cost; however, your copayment is nonrefundable. May not be combined with other discounts or offers. Please be advised these lens options and copayments apply to in-network benefits.

Frequently Asked Questions

How can I contact Member Services?

Call 1.800.999.5431 for automated help 24/7. Live help is also available seven days a week: Monday-Friday, 8 a.m.-11 p.m. | Saturday, 9 a.m.-4 p.m. | Sunday, 12 p.m.-4 p.m. (Eastern Time). (TTY services: 1.800.523.2847.)

What frames are in Davis Vision's Collection?

Our Collection offers a great selection of fashionable and designer frames, most of which are covered in full. No wonder 8 out of 10 members select a Collection frame. Log on to our member Web site at davisvision.com and take a look!

When will I receive my eyewear?

Your eyewear will be delivered to your network provider generally within five business days of order receipt. Special prescriptions, lens coatings, provider frames or out-of-stock frames may delay the standard turnaround time.

Do I need a claim form?

Claim forms are only required if you visit an out-of-network provider. Claim forms are available on our member Web site.

Can I split my benefits?

You may split your benefits by receiving your eye examination and eyeglasses or contact lenses on different dates or through different provider locations. To maximize your benefit value we recommend that all services be obtained from a network provider.

Can I use an out-of-network provider?

Yes; however, you receive the greatest value by staying in-network. If you go out-of-network, pay the provider at the time of service, then submit a claim to Davis Vision for reimbursement, up to the following amounts: eye exam - \$45 | single vision lenses - \$35 | bifocal - \$52 | trifocal - \$70 | lenticular - \$100 | frame - \$65 | elective contacts - \$75 | daily wear - \$20 | extended wear - \$30 | visually required contacts - \$225.

Are there any exclusions to the vision benefits?

Your vision plan does not cover medical treatment of eye disease or injury; vision therapy; special lens designs or coatings, other than those described herein; replacement of lost eyewear; non-prescription (plano) lenses; contact lenses and eyeglasses in the same benefit cycle; services not performed by licensed personnel; two pair of eyeglasses in lieu of bifocals.

DAVIS VISION EXTRAS!

One Year Breakage Warranty Repair or replacement of your plan covered spectacle lenses, Collection frame or frame from a network retail location where the Collection is not displayed.

Additional Savings Members will receive 50% off of additional complete pairs of eyeglasses and sunglasses at Visionworks and 30% off at other participating providers on the same transaction. Otherwise, a 20% discount off the provider's usual and customary rate is available. Contact lenses are available at a 10% discount.

Mail Order Contact Lenses Replacement contacts (after initial benefit) through www.DavisVisionContacts.com mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. Log on to our member Web site for details.

Laser Vision Correction Davis Vision provides you and your eligible dependents with the opportunity to receive discounted laser vision correction, often referred to as LASIK. For more information, visit www.davisvision.com.

Low Vision Services Comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Covers up to four follow-up visits in five years.

Eye Health & Wellness Log on and learn more about your eyes, health and wellness; common eye conditions that can impair vision; and what you can do to ensure healthy eyes and a healthier life.

For more details... about your vision benefits, patient rights and responsibilities about Davis Vision or to obtain a copy of Davis Vision's Privacy Practices Notice, please log on to our member Web site or contact us at 1.800.999.5431.

Davis Vision has made every effort to correctly summarize your vision plan features herein. In the event of a conflict between this information and your organization's contract with Davis Vision, the terms of the contract will prevail.

Fully insured product Underwritten by HM Life Insurance Company. Administered by Davis Vision, which may operate as Davis Vision Insurance Administrators in California.

Spousal Surcharge Waiver Qualifications
for Support & Confidential Staff

ESPA & Confidential Employees

Spousal Surcharge Waiver Qualifications

Eligibility determination for the spousal surcharge waiver (SSW) for a calendar year is based on the prior year's tax filing information. For example, a spousal surcharge waiver for the year 2024 is based on the 2023 tax information.

There are various scenarios that may qualify an employee for a SSW. Employee must re-verify every year that their spouse is eligible for the surcharge waiver by providing supporting documentation. Employee is responsible for advising HR as soon as a change occurs. It is the responsibility of the employee to notify HR if a spouse who had previously been granted the spousal waiver surcharge is re-employed or starts earning income from employment related operations. The spousal surcharge begins as soon as a spouse becomes employed and earns greater than \$15,080 in that calendar year.

All omissions, submission of incomplete information or falsification of information will be considered insurance fraud and the employee will be subject to discipline, which may include termination of employment.

1. Spouse retiring at the end of the year:

Spouses who retire at the end of the calendar year who provide a letter from their employer stating that they are no longer employed and will not be receiving any form of earned income from that employer in excess of \$15,080, will be granted the waiver. If they earned more than \$15,080, and provide a letter stating they are retired, the waiver will commence January 1st of the following year. The letter should include the spouse's name, their employer and the detail related to their retirement.

2. Spouse retiring mid-year:

Spouses who retire mid-year and can provide W-2's or paystubs to prove their current year wage earnings are less than \$15,080 will be granted the waiver. If the retiree earned more than \$15,080, the waiver will commence January 1st of the following year if they provide documentation as outlined in step #1.

3. Spouse already retired (providing proof for re-verification):

Employees must annually provide copies of either their spouse's year-end tax filing or their joint filing indicating the spouse did not earn over \$15,080 from wages in the preceding year. Employees must submit the applicable W-2's as back up if the filing does not distinguish the employment wages per spouse.

4. Spouse lost job:

Spouses who lose their jobs mid-year and can provide W-2's or paystubs to prove that their current year earnings due to wages are less than \$15,080 will be granted the waiver. They must also provide a letter from their employer stating they will not be eligible for severance benefits. If a spouse is re-employed, it is the responsibility of the employee to notify HR to commence paying the spousal surcharge.

5. Spouse permanently disabled (Long term disability (LTD)):

Spouses who qualify for LTD and provide proof from their insurance carrier will be granted the waiver of the spousal surcharge for the period of time approved by the insurance carrier.

6. Spouse permanently disabled (SSDI):

Waiver may commence first of the month following receipt of the SSDI AWARD (Not Benefits Payable) Letter to HR.

7. Non-working spouse:

Spouses will be granted the waiver based on the prior year's tax filing. Employees must submit the applicable W-2's as back up if the filing does not distinguish the employment wages per spouse.

Verification:

Employees are required to re-verify every year that their spouse is eligible for the waiver of the spousal surcharge. The only exception to the re-verification is spouses who have received Permanent Disability status from Social Security.

Timing:

For current employees: Evidence must be provided prior to the tax filing deadline of the impacted year. If evidence is not provided, the employee will be responsible for the Spousal Surcharge for the calendar year retroactive back to the original date of the waiver for the year.

It is imperative that if you know your spouse will earn over \$15,080 in a calendar year that the spousal surcharge is appropriately updated as soon as possible.

Health Insurance Per Pay Contributions

23.24 Health Insurance Per Pay Contributions

ESPA-Support Staff (24 pays per year)

	Medical	Dental	Vision	EE Annual Max
EE Only	\$12.92	\$0.00	\$0.00	\$310.00
EE + Child	\$19.38	\$0.00	\$0.00	\$465.00
EE + Children	\$27.13	\$0.00	\$0.00	\$651.00
EE + Spouse	\$28.42	\$0.00	\$0.00	\$682.00
Family (EE + Spouse + Child(ren))	\$37.46	\$0.00	\$0.00	\$899.00
Spousal Surcharge	\$100.00	\$0.00	\$0.00	\$2,400.00

LIUEA-Professional (24 pays per year)

	Medical	Dental	Vision	EE Annual Max
EE Only	\$42.50	\$0.00	\$0.00	\$1,020.00
EE + Child	\$63.75	\$0.00	\$0.00	\$1,530.00
EE + Children	\$89.25	\$0.00	\$0.00	\$2,142.00
EE + Spouse	\$93.50	\$0.00	\$0.00	\$2,244.00
Family (EE + Spouse + Child(ren))	\$123.25	\$0.00	\$0.00	\$2,958.00
Spousal Surcharge	\$150.00	\$0.00	\$0.00	\$3,600.00

Act 93-Administrators (24 pays per year)

	Medical	Dental	Vision	EE Annual Max
EE Only	\$42.50	\$0.00	\$0.00	\$1,020.00
EE + Child	\$63.75	\$0.00	\$0.00	\$1,530.00
EE + Children	\$89.25	\$0.00	\$0.00	\$2,142.00
EE + Spouse	\$93.50	\$0.00	\$0.00	\$2,244.00
Family (EE + Spouse + Child(ren))	\$123.25	\$0.00	\$0.00	\$2,958.00
Spousal Surcharge	\$150.00	\$0.00	\$0.00	\$3,600.00

Confidential (24 pays per year)

	Medical	Dental	Vision	EE Annual Max
EE Only	\$12.92	\$0.00	\$0.00	\$310.00
EE + Child	\$19.38	\$0.00	\$0.00	\$465.00
EE + Children	\$27.13	\$0.00	\$0.00	\$651.00
EE + Spouse	\$28.42	\$0.00	\$0.00	\$682.00
Family (EE + Spouse + Child(ren))	\$37.46	\$0.00	\$0.00	\$899.00
Spousal Surcharge	\$125.00	\$0.00	\$0.00	\$3,000.00



Flexible Spending Accounts

Your Spending Account User Guide

Let's get started.



Manage your account anywhere with our member website and mobile app.



Get the app

Download the **Highmark Blue Shield Spending Account app** from your phone's app store and use the info below to register.

- **Registration ID:** Enter your Employer ID SPA090570 or 16-digit debit card number linked to this account.
- **Employee ID:** You can find this ID on the front of your member card. Enter all 12 digits and add an additional zero at the end.



Access your online account

First-time user? No problem. Just go to highmarkblueshield.com and click **Register** to create your account.

Click on the **Claims & Spending** tab and then the blue **Access** button to set up your personal dashboard. This is where you'll do things like choose your communication preferences and submit your claims.

Real-Time Alerts

Stay on top of your spending accounts with real-time notifications on your account. Just click on **your name** on the upper right part of the screen and then select **Communication Settings** to customize how you receive messages — text, email, or both.



Manage your claims

To submit a claim, pay your health plan expenses, upload a receipt, and do anything else claim-related, just click on the **Claims & Spending** tab.

To pay a provider for a deductible or other expense, go to **Claims** and then **Claims Activity** under the menu in the upper left corner. Just click on **Pay Claim** next to the claim you want to pay.

Your spending account debit card

You (and your spouse, if applicable) will receive a debit card in the mail soon. You can manage your cards and request additional cards for your dependents by clicking on **your name** on the top right part of the screen and then selecting **Debit Card(s)**.

You may be able to request cards for dependents not on your medical plan by clicking **Adding a Family Member** in your **Profile**.

A few things to note about your debit card:

- You can't withdraw cash from an ATM with this card.
- You may be asked to submit a receipt when you use your debit card.
- You have 90 days to resolve any balance due on your card, or the transaction will be reported to the IRS as taxable income.

Did you know?

You can view your claim status and balances from anywhere with the app.

Highmark Blue Shield is an independent licensee of the Blue Cross Blue Shield Association.

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。请拨打您的身份证背面的号码（TTY：711）。





Disability



Group Short Term Disability Insurance

Group Short Term Disability insurance from Standard Insurance Company helps provide financial protection for insured members by promising to pay a weekly benefit in the event of a covered disability.

The cost of this insurance is paid by Lincoln Intermediate Unit 12.

Eligibility

Definition of a Member	You are a member if you are a citizen or resident of the United States or Canada and a: • Regular Professional and Administrative employee of Lincoln Intermediate Unit 12 working at least 91 days but less than 188 days in a school year who is actively working at least 35 hours per week; OR • Regular Professional and Administrative employee of Lincoln Intermediate Unit 12 working 188 days or more in a school year who is actively working at least 17.5 hours per week; OR • Regular Support Staff employee of Lincoln Intermediate Unit 12 who is actively working at least 25 hours per week You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Eligibility Waiting Period	You are eligible on the first of the month that follows or coincides with the date you become a member.

Benefits

Weekly Benefit	66 2/3 percent of the first \$3,000 of weekly predisability earnings as of the date of disability, reduced by deductible income (e.g., work earnings, workers' compensation, state disability, etc.)
Maximum Weekly Benefit	\$2,000
Minimum Weekly Benefit	\$15

Benefit Waiting Period	For Disability caused by accidental Injury: If your Total or Partial Disability occurs within 30 days after an accident: 0 days or the end of your accumulated sick leave, whichever is longer. For Disability caused by Physical Disease, Pregnancy or Mental Disorder: If your Total or Partial Disability begins later than 30 days after an accident: 7 days or the end of your accumulated sick leave, whichever is longer.
Definition of Disability	For the benefit waiting period and while the Short Term Disability benefits are payable, you are considered disabled if you: • Are unable – as a result of physical disease, injury, pregnancy or mental disorder – to perform with reasonable continuity the material duties of your own occupation, and • Suffer a loss of at least 20 percent of your predisability earnings when working in your own occupation You are not considered disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license. You will no longer be considered disabled when your earnings from any occupation meet or exceed 80 percent of your predisability earnings.
Maximum Benefit Period	180 days

Other Features and Services

- Reasonable Accommodation Expense Benefit
- Return to Work Incentive
- Temporary Recovery Provision

This information is only a brief description of the group Short Term Disability insurance policy sponsored by Lincoln Intermediate Unit 12. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reduction in benefits, exclusions and when The Standard and Lincoln Intermediate Unit 12 may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For more complete details of coverage, contact your human resources representative.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 13275-D-PA-165232 (12/21)

7444282-1075053



Group Long Term Disability Insurance

Group Long Term Disability insurance from Standard Insurance Company helps provide financial protection for insured members by promising to pay a monthly benefit in the event of a covered disability.

The cost of this insurance is paid by Lincoln Intermediate Unit 12.

Eligibility

Definition of a Member	You are a member if you are a citizen or resident of the United States or Canada and a: • Regular Professional and Administrative employee of Lincoln Intermediate Unit 12 working at least 91 days but less than 188 days in a school year who is actively working at least 35 hours per week; OR • Regular Professional and Administrative employee of Lincoln Intermediate Unit 12 working 188 days or more in a school year who is actively working at least 17.5 hours per week; OR • Regular Support Staff employee of Lincoln Intermediate Unit 12 who is actively working at least 25 hours per week You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Eligibility Waiting Period	You are eligible on the first of the month that follows or coincides with the date you become a member.

Benefits

Monthly Benefit	50 percent of the first \$16,000 of monthly predisability earnings, reduced by deductible income (e.g., work earnings, workers' compensation, state disability, etc.)
Maximum Monthly Benefit	\$8,000
Minimum Monthly Benefit	\$100
Benefit Waiting Period	180 days

Definition of Disability

For the benefit waiting period and the first 24 months that Long Term Disability benefits are payable, you will be considered disabled if, as a result of physical disease, injury, pregnancy or mental disorder:

- You are unable to perform with reasonable continuity the material duties of your own occupation, and
- You suffer a loss of at least 20 percent of your predisability earnings when working in your own occupation.

You are not considered disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license.

After the own occupation period of disability, you will be considered disabled if, as a result of a physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of any occupation.

Maximum Benefit Period

If you become disabled before age 62, Long Term Disability benefits may continue during disability until age 65 or to the Social Security Normal Retirement Age (SSNRA) or 3 years 6 months, whichever is longest. If you become disabled at age 62 or older, the benefit duration is determined by the age when disability begins:

Age	Maximum Benefit Period
62	To SSNRA, or 3 years 6 months, whichever is longer
63	To SSNRA, or 3 years, whichever is longer
64	To SSNRA, or 2 years 6 months, whichever is longer
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69+	1 year

Other Features and Services

- 24 hour coverage, including coverage for work-related disabilities
- Employee Assistance Program
- Reasonable Accommodation Expense Benefit
- Rehabilitation Incentive Benefit
- Rehabilitation Plan Provision
- Return to Work Incentive
- Survivors Benefit
- Temporary Recovery Provision
- Waiver of Premium while Long Term Disability benefits are payable

This information is only a brief description of the group Long Term Disability insurance policy sponsored by Lincoln Intermediate Unit 12. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reduction in benefits, exclusions and when The Standard and Lincoln Intermediate Unit 12 may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For more complete details of coverage, contact your human resources representative.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 13271-D-PA-165232 (10/23)

7444282-1075052



Life Insurance

Employer-paid Life and Accidental Death and Dismemberment (AD&D)

Lincoln Intermediate Unit #12 - Eligible Full Time Administrators, Executive Staff, Support Staff, Professional Employees, Confidential Staff, and Eligible Part-Time Professional Employees

Protect your family

Life insurance provides the people you love with financial support when you can't be there—and when they need it most.

How it works

Your employer is providing coverage for you, at no cost to you!

Benefits For you	Refer to your Employment Agreement for policy amount —with no medical questions asked. Benefits are reduced to 50% at age 70. Your coverage ends at termination of employment or retirement.
----------------------------	---



Reasons why you may need life insurance



Provide financial support for others



Pay household expenses



Pay tuition



Leave an inheritance or philanthropic gift



Pay funeral or medical expenses

Accidental Death and Dismemberment (AD&D)

This coverage includes an equal amount of AD&D insurance that provides a benefit if you suffer a covered accidental injury or die from a covered accident.	Benefits – This is a partial list. Refer to the certificate for the full list of covered accidental injuries.			
	Accidental injury	The plan pays	Accidental injury	The plan pays
	Accidental death	100%	Loss of speech only or hearing only	50%
	Quadriplegia	100%	Loss of limb (arm or leg)	50%
	Loss of sight of one eye	50%	Loss of thumb and index finger on same hand	25%

Additional considerations

If I become terminally ill	You may apply to receive a portion of your life insurance to help cover medical and living expenses. This is not long-term-care insurance. It will reduce the total amount of the life insurance payment we pay to your beneficiary(ies). Receipt of the Accelerated Benefit may be taxable and may affect your eligibility for public assistance programs.
If I become Totally Disabled	If we determine that you are Totally Disabled and cannot work, your life insurance coverage may continue at no cost. You must meet certain requirements, as detailed in the Certificate.
If I leave my employer	Depending upon state variations and your employer's plan, you may have an option to continue group coverage when your employment terminates. Your employer can advise you about your options.

Life and AD&D FAQ

How is my benefit claim filed and paid?

You or your beneficiary(ies) and your employer will complete the appropriate claims forms and submit these to Sun Life. Our claims examiners review the claim and gather additional information if necessary. We will notify you or your beneficiaries when the decision is made. If your death claim is approved, beneficiaries may

elect to receive a lump sum payment or to have the benefit paid into an account where the funds accumulate interest and can be withdrawn at any time. (State restrictions apply and options may vary by state.) If your AD&D claim for an accidental injury is approved, the benefit amount will be paid directly to you.

Read the important plan provisions section for more information including limitations and exclusions.

Important plan provisions

The following coverage(s) do not constitute comprehensive health insurance (often referred to as “major medical coverage”) and do not satisfy the requirement for Minimum Essential Coverage under the Affordable Care Act. They do NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York State Department of Financial Services.

To become insured, all persons must be actively at work and performing their regular duties at their usual place of business on the proposed effective date or their date of coverage will be deferred until they return to active work. Refer to the Certificate for details and similar requirements for dependent coverage.

Limitations and exclusions

The below exclusions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see the Certificate or ask your benefits administrator for details.

Accidental Death and Dismemberment

We will not pay a benefit that is due to or results from: suicide while sane or insane; injuring oneself intentionally; committing or attempting to commit an assault, felony or other criminal act; war or an act of war; active participation in a riot, rebellion or insurrection; voluntary use of any controlled substance/illegal drugs; operation of a motorized vehicle while intoxicated; bodily or mental infirmity or disease or infection unless due to an accidental injury; riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.

Information about services offered

Value-added services are not insurance, are offered only on specific lines of coverage and carry a separate charge, which is added to the cost of the insurance. The cost is included in the total amount billed. The entities that provide the value-added services are not subcontractors of Sun Life and Sun Life is not responsible or liable for the care, services, or advice provided by them. Sun Life reserves the right to discontinue any of the Services at any time.

This Overview is preliminary to the issuance of the Policy. Refer to your Certificate for details. Receipt of this Overview does not constitute approval of coverage under the Policy. In the event of a discrepancy between this Overview, the Certificate and the Policy, the terms of the Policy will govern. Product offerings may not be available in all states and may vary depending on state laws and regulations.

Sun Life Financial companies include Sun Life and Health Insurance Company (U.S.) and Sun Life Assurance Company of Canada (collectively, “Sun Life Financial” or “Sun Life”).

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York, under Policy Form Series 93P-LH, 98P-ADD, 12-GP-01, 13-ADD-C-01, 15-GP-01, 15-LF-C-01, 15-ADD-C-01, 12-DI-C-01, 16-DI-C-01, TDBPOLICY-2006, TDI-POLICY, 12-AC-C-01, 16-AC-C-01, 12-SD-C-01, 16-SD-C-01, and 16-CAN-C-01.

© 2018 Sun Life Assurance Company of Canada, Wellesley Hills, MA 02481. All rights reserved. Sun Life Financial and the globe symbol are registered trademarks of Sun Life Assurance Company of Canada. Visit us at www.sunlife.com/us.

GVBH-EE-6701

SLPC 29219 08/18 (exp 08/22)



Voluntary Life and Accidental Death and Dismemberment (AD&D) insurance

Lincoln Intermediate Unit #12 | All Eligible Full-Time Employees and Part-Time Professional Employees

Protect your family

The people you love and support could face financial challenges if you were no longer around. Life insurance provides your loved ones with money they can use for household expenses, tuition, mortgage payments and more.

How it works

You have the opportunity to purchase additional life insurance, beyond what your employer has provided for you. Your employer is offering you and your coworkers this coverage as a group, at a group rate. You are responsible for paying all or a portion of the cost. Choose the benefit that best meets your needs and your budget.

Benefits

For you	You can choose from \$50,000 to \$200,000 in increments of \$10,000, not to exceed 5 times your basic annual earnings. The benefit amount is reduced to 50% at age 70. Your coverage ends at termination of employment or retirement.
---------	--



What does life insurance mean for the Jones family?

Jason and Charlotte just bought their first house and are expecting their first child. They didn't think they could afford life insurance—and they didn't think they needed it because they're young and healthy.

However, Jason's best friend from high school was recently killed in a car accident. Sadly, his wife is selling their home because she can't afford the mortgage on her own.

Jason and Charlotte started to rethink life insurance, and were surprised to find options at work that meet their budget.

Since most people would have trouble paying living expenses after several months if their primary wage earner died, it may be worth asking, who depends on you?*

Accidental Death and Dismemberment (AD&D)

This coverage includes an equal amount of AD&D insurance that provides a benefit if you suffer a covered accidental injury or die from a covered accident.	Benefits – This is a partial list. Refer to the certificate for the full list of covered accidental injuries.			
	Accidental injury	The plan pays	Accidental injury	The plan pays
	Accidental death	100%	Loss of speech only or hearing only	50%
	Quadriplegia	100%	Loss of limb (arm or leg)	50%
	Loss of sight of one eye	50%	Loss of thumb and index finger on same hand	25%

Additional considerations

If I become terminally ill	You may apply to receive a portion of your life insurance to help cover medical and living expenses. This is not long-term-care insurance. It will reduce the total amount of the life insurance payment we pay to your beneficiary(ies). Receipt of the Accelerated Benefit may be taxable and may impact your eligibility for public assistance programs.
If I become Totally Disabled	If we determine that you are Totally Disabled and cannot work, your life insurance coverage may continue at no cost. You must meet certain requirements, as detailed in the Certificate.
If I leave my employer	Depending upon state variations and your employer's plan, you may have an option to continue group coverage when your employment terminates. Your employer can advise you about your options.
If I've had a life change	You may be able to adjust your coverage as your needs change (e.g., you get married or have a baby). Certain changes require you to answer health questions. Ask your employer for details.

Life and AD&D FAQ

Do I have to answer health questions to enroll?

You will be required to answer health questions if (1) you do not elect coverage when it's first available to you and you want to elect at a later date; (2) you request an amount higher than the Guaranteed Issue amount noted in the table, if offered; or (3) you want to increase coverage at a later date. You will need to fill out and submit our Evidence of Insurability application which must be approved by Sun Life before the coverage takes effect.

How is my benefit claim filed and paid?

You or your beneficiary(ies) and your employer will complete the appropriate claims forms and submit

these to Sun Life. Our claims examiners review the claim and gather additional information if necessary. We will notify you or your beneficiaries when the decision is made. If your death claim is approved, beneficiaries may elect to receive a lump sum payment or to have the benefit paid into an account where the funds accumulate interest and can be withdrawn at any time. (State restrictions apply and options may vary by state.) If your AD&D claim for an accidental injury is approved, the benefit amount will be paid directly to you.

Read the important plan provisions section for more information including limitations and exclusions.

* Facts About Life 2016, LIMRA.com, September 2016, accessed June 2018.

Important plan provisions

The following coverage(s) do not constitute comprehensive health insurance (often referred to as “major medical coverage”) and do not satisfy the requirement for Minimum Essential Coverage under the Affordable Care Act. They do NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York State Department of Financial Services.

To become insured, all persons must be actively at work and performing their regular duties at their usual place of business on the proposed effective date or their date of coverage will be deferred until they return to active work. Refer to the Certificate for details and similar requirements for dependent coverage.

Limitations and exclusions

The below exclusions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see the Certificate or ask your benefits administrator for details.

Life

If cause of death is suicide, no amount of contributory Life insurance will be paid if suicide occurs within a specific time period after the insurance or increase in insurance becomes effective. Please see the Certificate for details.

Accidental Death and Dismemberment

We will not pay a benefit that is due to or results from: suicide while sane or insane; injuring oneself intentionally; committing or attempting to commit an assault, felony or other criminal act; war or an act of war; active participation in a riot, rebellion or insurrection; voluntary use of any controlled substance/illegal drugs; operation of a motorized vehicle while intoxicated; bodily or mental infirmity or disease or infection unless due to an accidental injury; riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.

Information about services offered

Value-added services are not insurance, are offered only on specific lines of coverage and carry a separate charge, which is added to the cost of the insurance. The cost is included in the total amount billed. The entities that provide the value-added services are not subcontractors of Sun Life and Sun Life is not responsible or liable for the care, services, or advice provided by them. Sun Life reserves the right to discontinue any of the Services at any time.

This Overview is preliminary to the issuance of the Policy. Refer to your Certificate for details. Receipt of this Overview does not constitute approval of coverage under the Policy. In the event of a discrepancy between this Overview, the Certificate and the Policy, the terms of the Policy will govern. Product offerings may not be available in all states and may vary depending on state laws and regulations.

Sun Life Financial companies include Sun Life and Health Insurance Company (U.S.) and Sun Life Assurance Company of Canada (collectively, “Sun Life Financial” or “Sun Life”).

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York, under Policy Form Series 93P-LH, 98P-ADD, 12-GP-01, 13-ADD-C-01, 15-GP-01, 15-LF-C-01, 15-ADD-C-01, 12-DI-C-01, 16-DI-C-01, TDBPOLICY-2006, TDI-POLICY, 12-AC-C-01, 16-AC-C-01, 12-SD-C-01, 16-SD-C-01, and 16-CAN-C-01.

© 2018 Sun Life Assurance Company of Canada, Wellesley Hills, MA 02481. All rights reserved. Sun Life Financial and the globe symbol are registered trademarks of Sun Life Assurance Company of Canada. Visit us at www.sunlife.com/us.

GVBH-EE-6701

SLPC 29219 08/18 (exp 08/22)



Rates

Employee - Coverage and **monthly** cost for Employee Voluntary Life and AD&D.

Rates are effective as of July 1, 2022.

The chart below shows possible coverage amounts and their **monthly** costs.

Find your age bracket (as of the effective date of coverage) to see the cost for the coverage amount you choose.

Coverage amounts	Age and cost	
	<100	
\$10,000		2.50
\$20,000		5.00
\$30,000		7.50
\$40,000		10.00
\$50,000		12.50
\$60,000		15.00
\$70,000		17.50
\$80,000		20.00
\$90,000		22.50
\$100,000		25.00
\$110,000		27.50
\$120,000		30.00
\$130,000		32.50
\$140,000		35.00
\$150,000		37.50
\$160,000		40.00
\$170,000		42.50
\$180,000		45.00
\$190,000		47.50
\$200,000		50.00

KNOW YOUR BENEFITS.

From Lincoln Intermediate Unit #12



Updating Your Beneficiary Designations

When you signed up for life insurance, a retirement plan or a similar financial account, you likely named a beneficiary and promptly forgot about it. But it's important to periodically update your beneficiaries in order to make sure the right people receive your assets.

Types of Beneficiaries

Your beneficiary is the person or entity that will receive the assets from your life insurance policy or other financial accounts after your death. There are two types of beneficiaries, and you can name one or more people or entities for each type.

Primary beneficiary – This is the first person who will receive the proceeds of your life insurance or financial accounts. You can name multiple primary beneficiaries, and they will then share the assets.

Contingent beneficiary – These people are the “backup,” or secondary, beneficiaries because they will only receive the proceeds of your accounts if the primary beneficiaries have died, cannot be located or refuse to accept.

Why It Matters

The beneficiary designations for your retirement savings, life insurance and other financial accounts take precedence over your will. If you want your wishes to be followed after your death, you need to keep your beneficiaries updated. If you have not listed anyone as a beneficiary, your assets will follow a default order to determine who will receive it, such as your spouse, your children, your parents and then your siblings. Listing a beneficiary—and keeping it updated—will save time, effort and potential conflict after you're gone.

It's important to periodically update your beneficiary designations in order to make sure the right people receive your assets.

Common Errors

Even if you did name someone as a beneficiary, you need to update the names whenever there's a change in who you want to receive your assets. A few common mistakes include not adding a spouse after marriage, not adding children as they are born, leaving an ex-spouse named after a divorce and leaving parents and siblings listed after you married and started your own family.

When to Update

Whenever you experience a life change such as marriage, divorce, death of a spouse or child, birth of a child or grandchild or similar event that alters your family, you should review your beneficiary designations and make any necessary changes. You should also update your beneficiary listing when a beneficiary changes his or her name, such as an adult child getting married. If you're not sure how to change your beneficiary, check with your human resources department, life insurance carrier or financial institution, and someone there should be able to guide you to the correct forms or process to change it.



Tax Sheltered Annuity Account 403(b) (Optional)

Lincoln Intermediate Unit 12 School District 403(b) Plan Universal Availability Notice

To: All Employees of Lincoln Intermediate Unit 12 School District

In compliance with the requirements of IRC §403(b)(12)(A)(ii) this Notice will advise you of the voluntary 403(b) program established and maintained for the benefit of our employees. The following information provides details of the Plan and outlines the procedures for enrollment.

Eligibility

All employees of the Employer are eligible to participate in the plan.

Contributions

When you enroll in the program, the amounts you designate as salary deferrals are withheld from your wages and forwarded to an investment provider of your choice. Contributions may be changed, started or stopped at any time. Several types of contributions are available in your Plan:

Pre-Tax Salary Deferrals. These are amounts contributed into a 403(b) plan that are deferred from your paycheck before federal income taxes are applied. State income taxes may or may not be applicable.

Roth Salary Deferrals. These amounts are also deferred from your paycheck, but are subject to federal and state income taxes. When you withdraw monies, however, the funds may be excluded from taxation. Special rules apply to Roth contributions and you should contact your tax advisor before electing this option.

- For **2023**, you may defer from your wages, a maximum of \$22,500 to all 403(b) and 401(k) plans unless you will reach 50 years of age during the year. In that case, you would be eligible to contribute an additional \$7,500. Deferrals may not exceed 100% of your wages.

Employer Contributions. The Plan also allows your Employer to make contributions to the Plan on your behalf.

Rollovers. You may be able to rollover funds you received as an eligible rollover distribution from another employer's plan. Before you can complete a rollover into this Plan, you must first receive an acceptance authorization before the monies can be applied to your account.

Limitation on Aggregate Annual Additions Notice

Your Elective Deferrals may not exceed contribution limits as determined by Applicable Law. There may be excess contributions to your 403(b) if you own more than 50% ("control") of another business and maintain a retirement plan for that business. In such event, the maximum contribution to all plans you control and your 403(b) accounts or annuities may not exceed IRC Section 415 limits for the year, plus the age 50 catch-up limit, if applicable. Your Employer is responsible for knowing you may control another business. You must notify your Employer that you have control of another business to ensure you have not exceeded this limit. If there is an excess between multiple plans, the excess must be removed from the 403(b).

Plan Investment Options

Your contributions to the 403(b) Plan must be made to an approved investment provider.

NOTE: Before enrolling in the Plan, you MUST first establish an account with one of the Providers listed in this Notice. If a valid contract or account number has not been received by PenServ prior to receipt of a salary deferral, the contribution will be returned to your Employer.

Once an investment contract is executed, a Salary Reduction Agreement that includes the Contract Number should be completed and submitted to your benefits representative or PenServ Plan Services, Inc., as instructed in your 403(b) Enrollment Guide.

Lincoln Intermediate Unit 12 School District 403(b) Plan Universal Availability Notice

Assistance

You may join the Plan or receive assistance by first contacting your Employer's Benefit Representative, the Plan's Third Party Administrator or one of the Investment Companies listed below. Additional information on Plan options is available by contacting PenServ Plan Services, Inc. at (800) 849-4001 or from the Plan's web site.

Investment Provider Options

Provider and Product Name	Product Type	Contact
AIG Retirement Services	Annuities	Mike Waverka Phone (717) 736-3812 michael.waverka@aig.com Phone (800) 448-2542 www.aigrs.com
Brighthouse Life Insurance Company	Annuities / Mutual Funds	Phone (800) 882-1292 www.brighthousefinancial.com
Equitable	Annuities	Phone (800) 628-6673 www.equitable.com
Horace Mann Insurance Company	Annuities	Brett Farrance Phone (717) 766-1645 brett.farrance@horacemann.com Phone (800) 999-1030 https://www.horacemann.com
Invesco	Mutual Funds	Phone (800) 959-4246 www.invesco.com
Kades-Margolis	Mutual Funds	Phone (800) 433-1828 ext. 4 https://4kmc.com/
Lincoln Financial Group	Annuities / Mutual Funds	Phone (800) 454-6265 http://www.lfg.com
Lincoln Investment Planning	Mutual Funds	Sean Logue Phone (717) 633-5761 slogue@lincolninvestment.com

Lincoln Intermediate Unit 12 School District 403(b) Plan Universal Availability Notice

MetLife	Annuities / Mutual Funds	Phone (800) 638-5433 http://www.metlife.com
MG Trust - PenServ Plan Services - American Funds	Mutual Funds	American Funds, General Enrollment Phone 800-849-4001
Midland National Life Insurance Company	Annuities	Phone (877) 586-0240 https://www.midlandnational.com
Vanguard	Mutual Funds	Phone (800) 569-4903 www.vanguard403bservices.com/application

Third Party Administrator

PenServ Plan Services, Inc.
Plan Record-keeper
Phone (800) 849-4001
www.penserv.com
Email: 403badministration@penserv.com

Plan Web Site is available at:

www.penserv.com

Select: Login to Your Account

Accounting Manager

Lincoln Intermediate Unit 12 School District
Wendy Danner
Phone (717) 624-6419
Email: wrdanner@iu12.org



Employee Assistance Program

Life Happens.....There is Help

Life Happens. We can help.

WellSpan EAP is available to all FT and PT employees and eligible family members of Lincoln Intermediate Unit #12.

Life's demands and pressures can affect our emotional well-being, job performance, home life and health. WellSpan EAP is a confidential and voluntary program that provides face-to-face assessment, short-term counseling, referral and follow-up services. Care is designed so that employees and their dependent family members can seek help without worrying that someone at work will find out about their problem. Life happens. We can help.

Services

Our licensed professionals offer expert care in a compassionate environment, respectful of your needs. Your privacy is protected by strict confidentiality laws as well as professional ethical standards. Details of your participation and your discussions with EAP cannot be released to anyone without your written consent, except in extreme cases where you represent a danger to yourself or others.

The EAP is **free**. It's a prepaid benefit purchased by your employer. ***Regardless of health insurance coverage, all FT and PT employees, their spouses and their eligible dependents receive three (3) EAP counseling sessions per person from Jan. to Dec. each year at no cost; with no co-pays or deductibles.*** You are automatically enrolled.

Your Needs

We work with you to address whatever issues you wish to discuss. Some of the more common problems include, but are not limited to:

- Alcohol and drug use
- Anxiety
- Depression
- Family & child issues
- Grief and loss
- Managing change
- Marital & relationship conflict
- Stress
- Other life problems



Ongoing Care

WellSpan EAP does not require authorization for services, however if the provider asks for an authorization number please have the provider call WellSpan EAP directly.

For many people, a few visits with an EAP counselor are enough to identify and resolve a problem. For others, additional services may be recommended.

The EAP counselor will provide you with services or refer you to community resources that fit your treatment needs, your insurance plan and any special circumstances.

WellSpan EAP also offers more than just counseling services. Visit our web site for free online resources, health and wellness information and an expanded provider listing at WellSpan.org/EAP.

WellSpan EAP does not issue authorization numbers for services. However, if the provider asks for an authorization number or needs to confirm the number of sessions available, please have them call WellSpan EAP directly at 1-800-673-2514.

We're here to meet your needs! If you have any customer service issues, have any questions or need assistance, please call customer service at 1-800-673-2514, Monday – Friday, 7:30 a.m.-4:30 p.m.

To Request WellSpan EAP Services:

- Call the provider directly to schedule an appointment. Visit WellSpan.org/EAP and use the Provider Search Tool to find a provider
- Mention you want to use WellSpan EAP and provide the name of your employer
- When scheduling, you will be asked for your insurance information in case you go beyond your free EAP sessions
- If you have questions, need assistance, or live outside of South-Central PA, please call us at **1-800-673-2514** – we are happy to help!

Office hours vary by provider and location. Many providers offer evening hours during the week. Your provider's office will work with you to find an appointment time that meets your needs.

Be assured that this information will be kept confidential. No one, including your employer, will be informed that you contacted us.

Emergency services are available 24 hours a day, seven days a week. Individuals in crisis can call our crisis intervention hotline toll-free at **1-800-673-2496** to speak directly with a crisis counselor.



Medical and Prescription Resources

Here's How to Have a Virtual Doctor's Visit



**Haven't had a visit yet?
It's easy — here's how.**

From check-in to diagnosis, virtual doctor visits are designed to be comfortable and familiar, while being as simple as possible. Here's how it works:

Create an account.

Follow the simple directions.

1. Visit **amwell.com** or **doctorondemand.com** and follow the instructions to register or download their mobile apps. You can use either or both of these services.
2. Enter your name, address, etc.
3. Complete the brief online health history form.
4. Enter your health insurance information.



Select your doctor.

You can choose the doctor that's right for you.

1. Look through doctor's profiles.
 2. Choose a doctor and click **Start Visit**.
- Note: In some cases, a doctor may be assigned to you.

Enter your health info and start the visit.

Tell us what you'd like to discuss.

1. Tell us if the visit is for you or your child.
2. Tell the doctor the reason for your visit.
3. Begin your live video visit.

Wrap up.

Get information fast after your visit.

1. View the doctor's notes and diagnosis.
2. If you are prescribed medication, it will automatically be sent to your pharmacy.

It's that easy. So what are you waiting for? See a virtual doctor today!

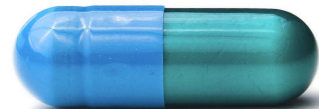
Most virtual visits are covered in the same way as they would be if you received in-person care. Medical (pediatric) services are subject to the telemedicine service benefit. Psychology services are subject to the outpatient mental health benefit. Contact the number on the back of your ID card to determine if you have these benefits available. Cost sharing may vary. Virtual Diet & Nutrition and Pregnancy & Newborn (Lactation Consulting) Service are not eligible. You will be responsible for the full cost of these services. All benefits under your health plan are subject to the terms of the benefit agreement and applicable state laws.



SAVE TIME AND MONEY

USE MAIL ORDER PHARMACY.

For long-term or maintenance medicines, take advantage of our mail order pharmacy. You may save time and money. Order and refill prescriptions, request renewals, and check your order status. Choose your payment option. Pay now or spread the cost over three months. Standard shipping is free.



How to Get Started

Ask your doctor to write a new prescription for up to a 90-day supply, plus refills for up to one year, if appropriate. Then choose one of these options:



MAIL IN YOUR PRESCRIPTION

Complete the mail order form. Then send it and your payment to the address listed. To get the form:

- Log in to your member website at **highmarkblueshield.com**.
- Click on the **Prescriptions** tab at the top of the page.
- Find the **Save With Mail Order** section.
- Click the **Mail order options & forms** link.



ASK YOUR DOCTOR TO FAX YOUR PRESCRIPTION

Give your doctor's office your member ID number and ask the office to call **1-888-327-9791** for fax instructions. You will be billed later or called for your method of payment.

OR

Whichever option you choose, you will usually receive your 90-day supply within three to five days after the order is received.

If you have questions, please call the Member Service number on your member ID card.

Highmark Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association.

10/16

CS206595



HIGHMARKBLUESHIELD.COM



Common questions about home delivery

What is home delivery?

Your prescription benefit offers delivery of maintenance medications – those you need on a long-term basis – right to your door, with free standard shipping. (You should use a retail pharmacy for medications you take on a short-term basis, such as antibiotics.)

How easy is it to try home delivery?

Very easy. Visit www.highmarkblueshield.com, sign in then choose which of your current maintenance medications you'd like to receive through home delivery. Or you can call us at the number on your ID card. We'll take care of the rest.

Do I need to call my doctor about this?

Most people prefer to have us contact their doctor to get a new 90-day prescription for home delivery. Just get started as described above, and we'll follow up with your doctor if necessary.

How long will it take to get my medication?

When you fill a prescription through home delivery for the first time, you should receive your medication within two weeks after Express Scripts receives your order. Refills are usually processed sooner – within 3 to 5 days.

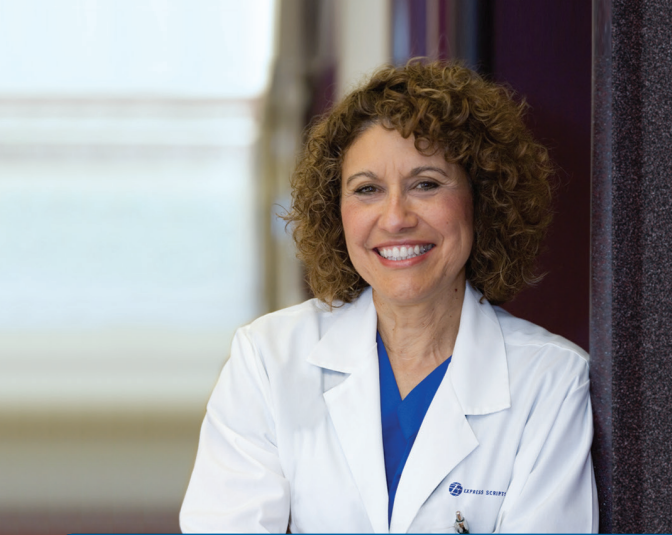
www.highmarkblueshield.com

Highmark Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association. Blue Shield and the Shield symbol are registered service marks of the Blue Cross and Blue Shield Association. Highmark is a registered mark of Highmark Inc.

Express Scripts is an independent company that administers your prescription drug benefit for your health plan.



© 2017 Express Scripts Holding Company.
All Rights Reserved.
EME24364
BR45160A



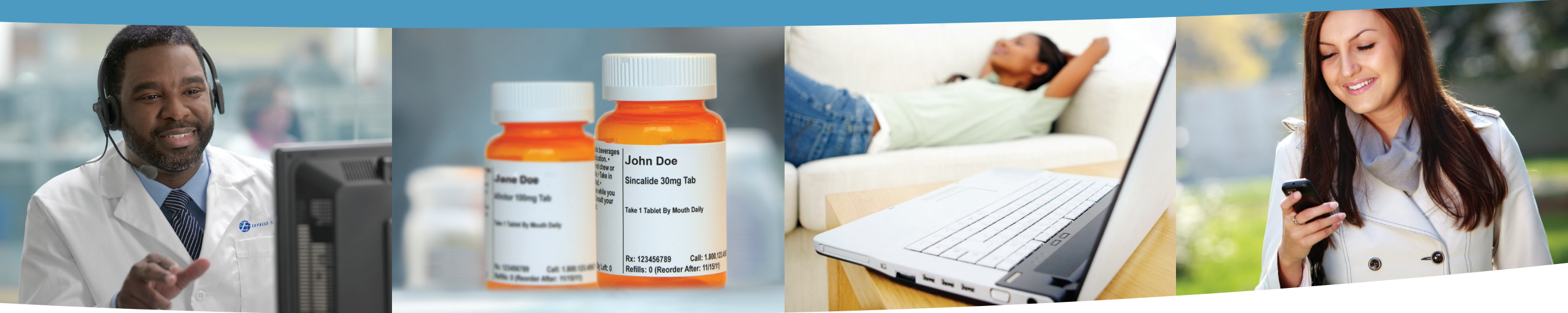
**Home delivery:
Enhanced pharmacy
care, convenience
and cost savings**

Home delivery from the Express Scripts PharmacySM can help you **stay healthy and lower your costs**. It's all part of your prescription benefit – at your door and at your fingertips.



**Join the millions of others who have
chosen to get their medications
delivered at home, for less.**





To save you time and money on prescription drugs, choose home delivery today.

You'll get up to a 90-day supply of maintenance medications, with free standard shipping.



Health and safety support

- Our pharmacists are available 24/7 to help answer your medication questions.
- Specialist pharmacists have in-depth training in the medications used to treat specific conditions, such as high blood pressure, high cholesterol and diabetes.



Cost-saving services

- You'll typically pay less by getting up to a 90-day supply.
- Savings notifications let you know when you have new ways to save.
- Prescription benefit specialists can help you find other cost-saving opportunities, such as using generics.



At-home convenience

- Enjoy free standard delivery right to your home.
- Automatically receive refill reminders by email so you never run out.
- Refill your medication by phone or online.
- With your permission, we will contact your doctor when it's time to renew.



Online services

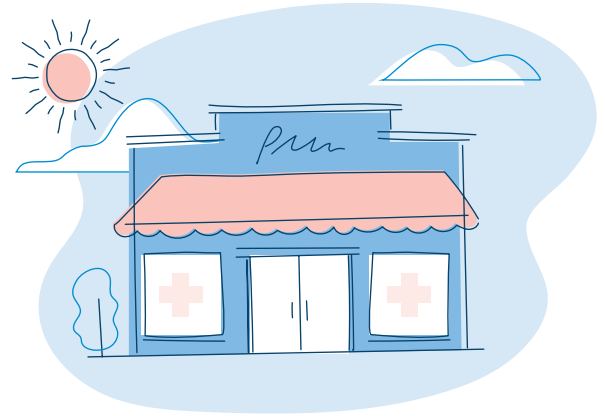
- Track your prescriptions and home delivery refills.
- View claims, balances and prescription history.
- Receive alerts if there's a prescription-related safety issue.

Get started with home delivery and review your online benefits.

Visit www.highmarkblueshield.com

Smart90[®] Pharmacy Network

Members can choose to get 90-day maintenance medications at a CVS retail pharmacy or delivered by the Express Scripts Pharmacy.



How It Works

If you are taking a long-term maintenance medication and have been getting it filled at a non-CVS Smart 90 pharmacy:

A. You can go to a CVS pharmacy to get a 90-day supply,

Or

B. You can choose to get a 90-day supply delivered by mail from Express Scripts.

If you keep filling a 30-day supply at a non-CVS Smart 90-day supply pharmacy:

- The prescription is filled the first two times as a courtesy. And you'll get a communication reminding you to choose **A** or **B** above after these two refills.
- If you still don't choose **A** or **B** above, you'll have to pay 100% of the prescription cost. And you'll continue to be reminded of the importance of choosing A or B above.

Benefits



You are free to choose between retail and mail order for your 90-day maintenance medications.



For retail, you have access to 9,100 CVS stores in the CVS/Smart90 network.



Having medicine delivered sets you up for success to take your prescriptions on time and as ordered.



For home delivery, you have 24/7 access to pharmacists, including those who are experts in chronic and complex conditions.

Benefits of the Smart90[®] Program

66.9%

of patients are adherent to their 30 day prescriptions at a retail pharmacy

84%

of patients are adherent to their 90 day prescriptions at a retail pharmacy

Things you should consider

	90 days at retail via CVS Smart90	90 days with home delivery via Express Scripts
Pharmacist Support	If you have questions or need to discuss your prescription, you may have to wait and will need to discuss at the store counter.	If you have questions or need to discuss your prescription, you have the convenience and privacy of Express Scripts phone support.
Clinical Expertise	Retail pharmacists are generalists.	Express Scripts pharmacists include condition-specific specialists with knowledge of chronic and complex conditions
Patient History	Pharmacists can see only the prescriptions you filled at that pharmacy or chain.	Pharmacists at Express Scripts can see your complete history of prescriptions that are delivered via mail or filled at any retail location.
Convenience	You can typically pick up your prescription same day, but need to travel to the retail store.	Your prescriptions are mailed to your home in 2 to 3 days after order is processed.
Payment	No installation plan offered; you'll pay for the 90-day supply up front.	Extended Payment Plan is available that breaks the 90-day supply into 3 copay installments with no fee.

If you've got questions, Highmark has answers.

Highmark is here to help make sure you get access to the best care. If you have questions about this program, please call Member Service at the number on the back of your ID card.

Express Scripts is an independent company that administers your prescription benefit for your health plan.

Highmark Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association.

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted.

Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。请拨打您的身份证背面的号码（TTY：711）。 10/19 HC409739



Get to know Copay Armor.

Protection from high-cost medications.

Certain medications can be life-changing, but often these drugs come with a high price tag. To ease the strain on your wallet, we're introducing Copay Armor — a copay assistance program available through your Highmark plan that reduces or completely covers the cost of certain specialty medications.

How it works

Copay Armor, powered by PillarRx Consulting, helps to leverage manufacturer assistance dollars to lower your prescription out-of-pocket costs. No matter what, your out-of-pocket costs will always be the same or less than what you're currently paying.

You're never alone with Copay Armor

The team at PillarRx works with you through personalized service. From reducing stress to reducing costs, someone's there every step of the way.

Why you'll love it

- You'll save money — low to \$0 out-of-pocket costs.
- Copay Armor works at any in-network pharmacy.
- The PillarRx team is always there to assist you.
- There is no additional cost to enroll in Copay Armor.

What to expect next

Be on the lookout for an enrollment phone call from a member of the PillarRx team. You'll also be receiving an official welcome letter in the mail.



Fitness Your Way

by Tivity Health™

Get access to nearly 9,500 fitness locations

Enroll Now

Whether you want to lose weight and maximize your energy or manage stress and improve your mood, here's a great, low-cost way to meet your goals. Fitness Your Way allows you to join a network of fitness facilities for a discounted rate, so you can work out anywhere when it's convenient for you — at a cost that doesn't stretch your budget.

How It Works

Fitness Your Way gives you access to nearly 9,500 fitness locations, including select national chains. As a Fitness Your Way member, you can visit any participating fitness location — anytime, anywhere — as often as you like.

Pay only **\$29 a month***, plus a low **\$29 enrollment fee**, and make a three-month commitment. Do it all online. Then put your fitness plan into action.

How to Enroll

Log in to highmarkblueshield.com (or follow instructions to register).

- Select **Member Discounts**.
- Scroll to **Discounts & Rewards** and select **Blue365 Discounts**.
- Select **Login** (or register for Blue365 by following the instructions).
- Once registered or logged in, select **Browse All Deals** and select **Fitness Your Way**.
- Select **Redeem Now** to enroll.
- Start using your membership right away! Print your card or download it to your smart phone and present it at any participating facility.

Note: You will be billed for \$29 monthly. If you prefer, you can call 1-888-242-2060 to enroll. For member web support, please call 1-877-298-3918. The fitness center discount is separate and distinct from your health benefits plan.



MEMBER DISCOUNTS

SAVE ON NON-COVERED PRODUCTS AND SERVICES

The mind – body connection is important to the healing process. Your health care coverage includes access to a wide range of discounts on health-and-wellness-related products and services from national, well-known brands. Take a more active role in your health by using these discounts ... and save up to **30 percent**.

STARTING AN EXERCISE PROGRAM?

Get discounts on fitness centers, personal trainers and running shoes.

THINKING ABOUT IMPROVING YOUR DIET?

Save on nutrition counseling, diet programs and vitamin supplements.

NEED TO RELAX?

Try yoga, tai chi or massage at discounted rates.

INTERESTED IN COMPLEMENTARY OR ALTERNATIVE MEDICINE?

Experience the benefits of acupuncture, mind – body therapies or holistic medicine.

HAVE VISION OR HEARING ISSUES?

Buy hearing aids at discounted prices or explore eye surgery options.

Learn more. To search the member discounts available to you or to find a practitioner in the discount program, go to your member website and complete the login process by entering your login ID and password. If you do not have a login ID and password, select **Register** and follow the instructions. Select **Member Discounts** and click on **Blue365 Discounts**.

When you visit a practitioner, just show your ID card to get your discount. You are responsible for paying the practitioner directly at the time the product is purchased or the service is received.

The member discount program is separate and distinct from your health benefits plan.



Highmark Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association.

Blue365 is a registered mark of the Blue Cross and Blue Shield Association.

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。请拨打您的身份证背面的号码（TTY：711）。

27295 10/16

CS103860



IF YOU ARE PREGNANT, JOIN BABY BLUEPRINTS®!

Expectant mothers who live a healthy lifestyle are more likely to have a healthy baby. But having a baby can be an over-whelming event filled with questions and confusion.

To help expectant mothers better understand every stage of pregnancy and make more informed care and lifestyle-related decisions, we are offering Baby Blueprints Maternity Education and Support Program.

This free program provides members with access to in-depth educational information on all aspects of pregnancy through multiple online offerings. Baby Blueprints also gives participants access to individualized support throughout their pregnancy from a nurse Health Coach.

Enrolling in Baby Blueprints is convenient. Expectant mothers simply call toll-free at 1-866-918-5267 to enroll over the phone. They will then receive a confirmation mailing with helpful pregnancy tips.

Highmark Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association.

Baby Blueprints is a registered mark of the Blue Cross and Blue Shield Association.

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

27302 4/17

CS103948

Making time for your mental health

Your guide to Highmark's mental health resources

Mental health issues are different for everyone, which is why it's important to find the care option that's right for you. Whether you're considering medication, want to learn more about self-care, or just want to talk to someone, Highmark is here to help.

Below are some of the support systems, services, and care options available to you.



Who should I reach out to if I need help?

- Call your primary care physician.
- Schedule an in-person or telemedicine appointment with a mental health provider.
- A Highmark behavioral health specialist.
- Blues On Call™.

How can I find the care that's right for me?

- For help finding an in-network doctor or facility, contact the My Care Navigator™ team by calling the phone number on the back of your member ID card.
- Download the Highmark Plan app to quickly and conveniently find in-network care nearby.
- Call the Member Service number on the back of your Highmark ID card to request to speak with a Highmark behavioral health specialist.
- Speak with a Highmark wellness coach at 1-800-650-8442, Monday – Friday, 8:30 a.m. – 8:30 p.m. ET for help with stress or sleep management.

What other services do I have access to?

- **Sharecare®** – personalized health programs and resources, plus Sharecare Windows for access to videos to help reduce stress and improve relaxation.
- **WholeHealth Living™** – discounts through the largest alternative medicine network in the nation.
- **Bright Heart Health** – substance use counseling and treatment through telemedicine.
- **Highmark Community Support** – a tool that connects people seeking help with local nonprofits and services in their communities.
- **Telemedicine through your doctor's office** – get access to a doctor you know and trust from your phone, tablet, or computer. Keep in mind that your doctor's office may not offer this option, so make sure to check with your health care provider.
- **Telemedicine through Amwell** – get 24/7 access to U.S. licensed, board-certified doctors and therapists by visiting **Amwell.com** and creating an account using your member ID card.

Where can I go to learn more?

Every plan is a little different. For more information about available services and your specific benefits and costs for care, you can visit **highmarkblueshield.com** or call the Member Service number on the back of your Highmark member ID card.

If you or someone you know is in crisis, contact the Suicide Prevention Lifeline at 1-800-273-TALK (8255), or dial 911 in case of emergency.

YOUR PERSONAL

Well360

Clarity Team

IS HERE TO HELP YOU NAVIGATE
YOUR HEALTH CARE.



The Well360 Clarity team is motivated to
make sure you always receive high-quality care.

This team of advocates is made up of medical, benefits, and service experts
who can help you make the best decisions when it comes to:

- Finding high-quality specialists in orthopaedics, women's care, cardiology, gastrointestinal, ophthalmology, nephrology, endocrinology, and neurology.
- Knowing where to go to get the right care — like your doctor, a telemedicine visit, or imaging services.
- Managing a health condition.
- Scheduling appointments.
- Answering your questions about benefits, claims, and billing.

**Call your Well360 Clarity team at
866 727 4943 any time you need
help navigating your health care.**

**Watch the video at
welcome2clarity.com/bs for more
info about your Well360 Clarity
team.**

The best part?

You can call your Well360 Clarity team any time you're faced with an important care decision like those above. In certain cases, they may even reach out to you. You can also call them whenever you have a benefit or billing question, or if you need help scheduling or preparing for appointments or finding programs and resources to help you better manage your care.



WELLNESS SOLUTIONS

Sharecare

YOUR PERSONALIZED
DIGITAL HEALTH HUB



Lincoln Benefit Trust

Say hello to your online health and wellness hub.

Create your account at mycare.sharecare.com. Once you're in, Sharecare's unique features can help you reach your health and wellness goals.

RealAge® Test

Join over 45 million people who have taken the RealAge Test and see if your body is older — or younger — than you think. Then get tips on how to roll back your age.

Green Days

Track your health goals easily by “living in the green.” Each time you reach a Green Day, you're one step closer to lowering your RealAge.

Challenges

Enjoy some friendly competition as you strive to stay healthy.

Other Features

Check out the **Benefits** tab within Sharecare to see what other features are available to you.

Sharecare Windows

Focus on your mind, body, and spirit with videos and virtual reality. Take a look at the **Inspirations** feature for help reducing stress and improving relaxation.

Customized Content

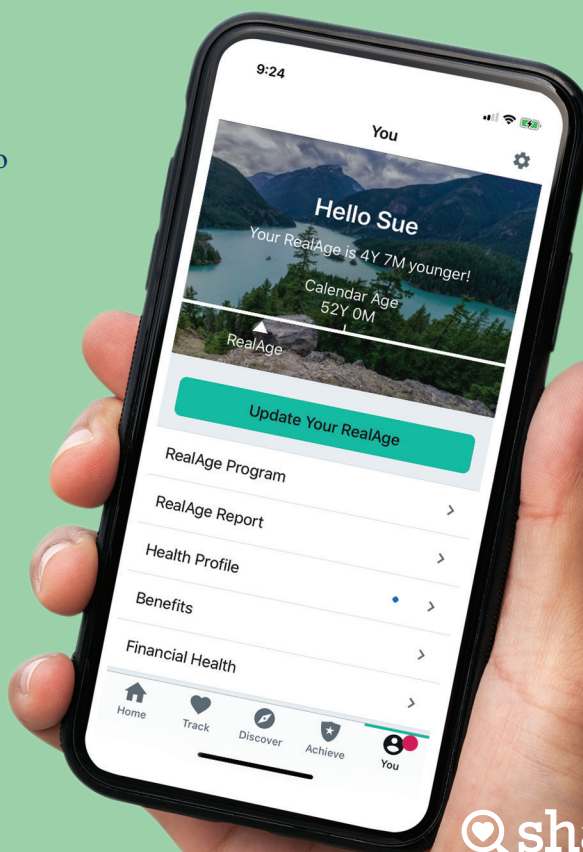
Check out articles and videos that match your personal goals. To follow specific topics, visit the **Health Topics** area.

Financial Health Guidance

Take a quick assessment and receive additional financial content relevant to your life.

AskMD

Looking for health advice? Type in your symptoms and get answers.



It just gets better and better.

Your health plan is offering even more game-changing tools and resources.

Check them out:

Support from live, online coaches and nurses

Already have a coach or nurse you enjoy working with through your health plan? No problem.

Ask them about staying connected through the convenient **Coach** chat feature — which you can find under the **Achieve** tab. It makes it easy for you to reach out to them when you need a little encouragement.

Considering working with a coach or nurse for the first time? Good for you. Whether you want to eat healthier, quit smoking, or manage a chronic condition, Sharecare gives you access to experienced coaches and nurses who can help you stay on track with your health and wellness goals.

Custom Solutions Hub

A one-stop destination for all of your health and wellness solutions, this feature — which you can find under the **You** tab within Sharecare — gives you access to an easy-to-use interface with a convenient, comprehensive list of the services available to you. Plus, it makes managing your wellness solutions a whole lot simpler.

Register and take the RealAge Test at mycare.sharecare.com and make sure to enter your information exactly as it appears on your Highmark member ID card. Then don't forget to download the Sharecare app.

Sharecare is a registered trademark of Sharecare, Inc., an independent and separate company that provides a consumer care engagement platform for Highmark members. Sharecare is solely responsible for its programs and services, which are not a substitute for professional medical advice, diagnosis or treatment. Sharecare does not endorse any specific product service or treatment. Health care plans and the benefits thereunder are subject to the terms of the applicable benefit agreement.

Highmark Blue Shield is an independent licensee of the Blue Cross Blue Shield Association.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

11/20 MX160288



Important Notices

Important Regulations and
Notices Regarding Your Health Coverage



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 9-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Kelly Reynolds, HR Generalist, Work Comp and Benefit Plans 717-624-6441

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Lincoln Intermediate Unit 12		4. Employer Identification Number (EIN) 23-1743636	
5. Employer address 65 Billerbeck Street		6. Employer phone number 717-624-6411	
7. City New Oxford	8. State PA	9. ZIP code 17350	
10. Who can we contact about employee health coverage at this job? Kelly Reynolds			
11. Phone number (if different from above)		12. Email address klreynolds@iu12.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Per the terms of the applicable employee contract.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Per the terms of the applicable employee contract: spouses, and children, and stepchildren until the age of 26 may be covered based on employees's scheduled hours.

☐ We do not offer coverage.

- ☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

**** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.**

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? _____

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	INDIANA – Medicaid Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki) Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	KANSAS – Medicaid Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	LOUISIANA – Medicaid Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	MASSACHUSETTS – Medicaid and CHIP Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	MISSOURI – Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPProgram@mt.gov	NEBRASKA – Medicaid Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RItE Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

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

OMB Control Number 1210-0137 (expires 1/31/2026)

COBRA Continuation Coverage General Notice Instructions

General Notice of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage (or are eligible to elect coverage) under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; Or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both) for Retirees Only.

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Lincoln Intermediate Unit 12 Human Resources Director. Please include a court approved divorce decree including the mailing address for your former dependent.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. To apply for this extension, please provide the Social Security notice of disability to the Lincoln Benefit Trust (mail to the New Oxford address at the end of this notice) prior to the end of the 18 month COBRA period.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, [Children's Health Insurance Program \(CHIP\)](#), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

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

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Lincoln Intermediate Unit Employee Healthcare Benefit Plan

Attn: Human Resource Director
P.O. Box 70
New Oxford, PA 17350

FOR YOUR INFORMATION

Annual Women's Health and Cancer Rights Act Notification

Dear Member:

In October 1998, the U.S. government enacted the federal Women's Health and Cancer Rights Act of 1998.

This law requires us to inform our plan members, each year, about major provisions of the law. These provisions require health plans that cover mastectomies to also cover (after any applicable deductible and coinsurance):

- All stages of reconstruction and surgery of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications of a mastectomy, including lymphedema.

Questions?

If you have questions about the Women's Health and Cancer Rights Act, please call the toll-free Member Service phone number on the back of your plan identification card.



HIGHMARKBLUESHIELD.COM



HMD&S

120 Fifth Avenue

Pittsburgh, PA 15222

Highmark Blue Shield is an independent licensee of the Blue Cross Blue Shield Association.

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

10/21 Z MX1055148



Vendor Contact Information and Online Registration Information

Do you have a question about your coverage?

Contact the appropriate vendor directly for questions regarding benefits, claims process, choosing a doctor, ID cards, and copayments and deductibles.



Contact Information

Benefit	Provider	Web Site	Phone Number
Medical	Highmark Blue Shield	www.highmarkblueshield.com	1-866-727-4943
Prescription Drug Coverage	Highmark Blue Shield	www.highmarkblueshield.com	1-866-727-4943
Dental	Delta Dental	www.deltadental.com	1-800-932-0783
Vision	Davis Vision	www.davisvision.com	1-800-999-5431
FSA	Highmark Blue Shield	www.highmarkblueshield.com	1-866-727-4943
Life / AD&D	Sun Life	www.sunlife.com/us	1-800-247-6875
Employee Assistance	WellSpan	www.wellspaneap.org	1-800-673-2514
Retirement Plan	PSERS	www.psers.pa.gov	1-888-773-7748

ARE YOU REGISTERED?

Are you registered on your member website? If not, take a couple of minutes to complete an online form and choose a login ID and password. Your information will process promptly.

These couple of minutes will be time well spent. Your member website gives you all kinds of tools and programs to help you:

- Understand your health status, learn what you’re doing right and where you need to improve
- Better manage all aspects of a chronic health condition
- Enhance your health and wellness habits
- Get quality information and patient reviews on health care providers
- Share your own provider experiences with other members
- Get estimated cost information on common health care procedures and surgeries
- Access important medical information to make informed care decisions
- Learn about healthy alternatives to high-cost, high-risk surgeries
- Review recommended preventive care for all members of the family, at every stage of health

- Save money on lab services and urgent care
- Get the tools you need to reduce stress, eat healthy, get fit and stop smoking, for good! And lots, lots more!



Highmark Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association.

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

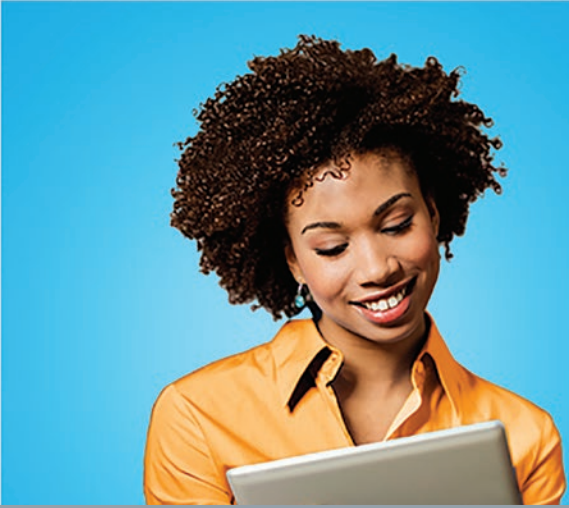
27329 10/16

CS208366



Log In or Register

WELCOME



HOW TO MAKE THE
MOST OF YOUR
MEMBER WEBSITE!



Access helpful **health care tools** to manage your care costs, choose the right providers and plan for your care.



FIND A DOCTOR

Locate primary care doctors, specialists, hospitals, imaging and surgery centers, urgent care centers, and pharmacies near you. Get quality information about providers. Check out the Patient Experience Reviews and write one of your own.



CARE COST ESTIMATOR

Get cost estimates and quality information on surgical and imaging procedures, lab tests, and office visits to help you shop for the best value.



PRESCRIPTION SERVICES

Manage your prescription coverage, find pharmacies near you, view your prescription history, update your contact information, and more with your prescription coverage.

YOUR MEMBER HOME PAGE:

IT ALL STARTS HERE!

WELCOME

Other member information >>

ID Card >>

Coverage summary >>

HEALTH CARE TOOLS

FIND A DOCTOR

CARE COST ESTIMATOR

MEMBER DISCOUNTS

REWARDS PROGRAM

WELLNESS PROFILE

This is one example of what your member home page may look like. What you see may vary depending on your plan design.

QUICK LINKS

OTHER MEMBER INFORMATION

Check your member information and account settings, update your member profile, change your password, manage your site preferences, and more.

ID CARD

View and print your virtual ID card.

COVERAGE SUMMARY

Get information about your benefits, access your benefit booklet and more.

Review your claims to see:

- Current claims
- Payment status
- Claims and payment history

Get information about our wellness programs to help you save money while living healthier.

MEMBER DISCOUNTS

Enjoy discounts on a variety of products, events and services.

REWARDS PROGRAM

Get information on how you can earn rewards.

WELLNESS PROFILE

Complete your Wellness Profile, and you'll receive the following:

- Health assessment — Find out where you stand with your health today and learn where and how you can improve.
- Risk report — Learn about where your health needs the most attention.
- Personalized action plan — Get a plan customized to your unique needs.

85

Where's My ID Card?

If you've been looking for your dental plan ID card, we have good news for you: **You don't need one!**



Just tell your dental office that you're covered by Delta Dental and provide your **name**, your **date of birth**, your **social security number** (or enrollee ID number) and the **name of your employer**.

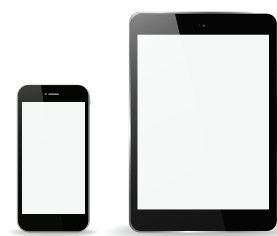
Got dependents on your plan? Tell them to provide your details.

Want an ID card anyway?



Print one from your computer

- Go to **deltadentalins.com**
- Log in to Online Services > Click on **Print ID Card** > Print



Pull it up on your smartphone

- Go to **deltadentalins.com**
- Log in to your Online Services account > Select **My ID card** from the main menu



Say hello to the brand-new Davis Vision mobile app



Download the Davis Vision mobile app.



Find an eye care provider

Easily find an eye care provider based on your current location, city / ZIP code or search by name.



Check your eligibility & benefits

Quickly check your current or future eligibility status. Need a little more detail? You can also review your benefit.



Track your glasses

Order glasses from an independent provider? Conveniently check their progress in the app.



Request an ID card

Need your member information? Find it and personalize it with your photo (optional).



Review your claims & status

Check out your current claims and history. Plus, upload a photo of your receipt to easily submit an out-of-network claim.



Other tools & resources

Be sight-savvy with these calculators, a frame try-on tool, a vision reference library and more.

SEE WHAT'S NEXT.

For more information, visit www.davisvision.com/app

Follow us online





This Open Enrollment Guide covers the highlights of Lincoln Intermediate Unit 12's Benefit Programs. While we have tried to be as accurate as possible in developing this information, the collective bargaining agreement, other agreements, and the Summary of Benefits governs in all areas. Lincoln Intermediate Unit 12 intends to continue these programs but reserves the right to change or end them at any time.

For an electronic version of this Open Enrollment Guide with clickable links, please visit the Benefits Web Page:

<https://www.iu12.org/Page/478>

Requests for a copy of the Summary Plan Description should be emailed to:
HRDept@iu12.org

