Open Enrollment Quick Reference Guide
November 2018

LEHIGH UNIVERSITY

Flex Benefits Updates for 2019

This is your annual Flex Benefits Open Enrollment quick reference guide. It contains information and links you should review to select your flexible benefits for the 2019 benefit plan year, which runs from January 1 to December 31, 2019. This year, the online Open Enrollment period runs November 5 through 19, 2018. Your benefits choices take effect January 1, 2019. For complete information, consult the the 2019 Flexible Benefits Enrollment and Reference Guide on the Lehigh Benefits website, available Monday, November 5.

WHAT'S NEW?

Autism Services - Major Coverage Change

Beginning January 1, 2019, Lehigh University medical insurance plans will cover autism treatment services for eligible participants. The HDHP and PPO plans use Magellan for behavioral health coverage; the Keystone HMO and PPO Plus plans use IBH.

As a result, Lehigh employees who are eligible for Act 62 Medical Assistance and who also participate in the university's medical insurance plan will have primary autism treatment services coverage through the Lehigh plan and secondary coverage through Medical Assistance as of January 1, 2019. More information about how private insurance and Medical Assistance work together can be found in a fact sheet at this link: https://www.disabilityrightspa.org/wp-content/uploads/2018/03/PAAutismInsuranceActFEB2018.pdf

If you are currently accessing autism treatment services for a dependent child through the Pennsylvania Medical Assistance program you will need to contact your care providers to inform them of this change.

If you have any questions regarding this change, please contact **Patricia Florkowski** in Human Resources at 610-758-5167.

Long Term Disability (LTD) Coverage

It has been more than 30 years since we have updated the salary levels and duration of coverage in our LTD plan.

Please note: The limitations outlined in this coverage is for "own occupation," disability, meaning a disability preventing someone from working in their current position. These limits **do not apply** if you become totally and permanently disabled. In that case, coverage lasts until Social Security age of retirement.

Beginning January 1, 2019, the following levels and durations will apply:

- **Employees with base salary of less than $40,000**: 24 months of coverage
- **Employees with base salary of $40,000 to $69,999**: 60 months of coverage
- **Employees with base salary of $70,000 or more**: coverage until Social Security retirement age.

Updated explanations of our LTD coverage will be available on the Lehigh Benefits portal as we near the new benefits year.

Also:

- **Medical coverage monthly premiums** are increasing. Plan premiums are listed on page three.
- **Total Out of Pocket Maximums** have been increased in all plans. As of last year, maximums are now managed as a single total figure including healthcare and pharmacy expenses.
- **IMPORTANT REMINDER**: If you wish to have a healthcare or dependent care Flexible Spending Account (FSA) in 2019 or make employee contributions to a Health Savings Account (HSA) in 2019, you must make these elections during Open Enrollment. FSAs and employee contributions to HSAs DO NOT automatically roll forward from the previous year.

BE WELL

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Summary of Medical Plan Options

	PPO		PPO Plus		HDHP		Keystone HMO***
Network	National		National		National		21 County/ Lehigh Valley
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network
Annual Deductible							
Individual	$200	$500	$0	$500	$1,350	$2,500	$0
Family	$600	$500 /person	$0	$500 /person	$2,700*	$5,000*	$0
Coinsurance	20%	30%	10%	20%	20%	30%	N/A
Out-of-Pocket Maximum for all medical and prescription drug charges							
Individual	$3,500	No limit	$3,500	No limit	$6,750	No limit	$3,500
Family	$7,000	No limit	$7,000	No limit	$13,500	No limit	$7,000
Physician Services							
Office Visit	$25 copay/visit	30% coinsurance	$25 copay/visit	20% coinsurance	20% coinsurance	30% coinsurance	$25 copay/visit
Specialist Visit	$40 copay/visit	30% coinsurance	$40 copay/visit	20% coinsurance	20% coinsurance	30% coinsurance	$40 copay/visit
Preventive Care (Administered in accordance with Preventive Health Guidelines & PA state mandates)	No charge	Mandated screenings and immunizations: 30% coinsurance; Routine physical exams: Not covered	No charge	Mandated screenings and immunizations: 20% coinsurance; Routine physical exams: Not covered	No charge	Mandated screenings and immunizations: 30% coinsurance; Routine physical exams: Not covered	No charge
Hospital Services							
Inpatient Coverage	20% coinsurance	30% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance	$200/admission
Outpatient Hospital	20% coinsurance	30% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance	No charge
Emergency Room	$100 copay/service, waived if admitted		$100 copay/visit, waived if admitted		20% coinsurance		$100 copay/visit, waived if admitted
Urgent Care	$40 copay/service	30% coinsurance	$40 copay/service	20% coinsurance	20% coinsurance	30% coinsurance	$40 copay/ service
Maternity Services							
Prenatal/ Postpartum Care	20% coinsurance	30% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance	No charge
Hospital	20% coinsurance	30% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance	No charge
Mental Health **							
Inpatient	20% coinsurance	30% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance	No charge
Outpatient	$25 copay/visit	30% coinsurance	$25 copay/visit	20% coinsurance	20% coinsurance	30% coinsurance	$25 copay/visit
Substance Abuse **							
Inpatient	20% coinsurance	30% coinsurance	No charge	20% coinsurance	20% coinsurance	30% coinsurance	No charge
Outpatient	$25 copay/visit	30% coinsurance	$25 copay/visit	20% coinsurance	20% coinsurance	30% coinsurance	$25 copay/visit
Prescription Drugs							
Generic	10% coinsurance	Coinsurance plus amount over Express Scripts allowable amount	10% coinsurance	Coinsurance plus amount over Express Scripts allowable amount	10% coinsurance	Coinsurance plus amount over Express Scripts allowable amount	10% coinsurance
Brand Forumulary	20% coinsurance	Coinsurance plus amount over Express Scripts allowable amount	20% coinsurance	Coinsurance plus amount over Express Scripts allowable amount	20% coinsurance	Coinsurance plus amount over Express Scripts allowable amount	20% coinsurance
Brand Non-Forumulary	30% coinsurance	Coinsurance plus amount over Express Scripts allowable amount	30% coinsurance	Coinsurance plus amount over Express Scripts allowable amount	30% coinsurance	Coinsurance plus amount over Express Scripts allowable amount	30% coinsurance

*For all coverage levels other than employee only, the entire family deductible must be met before the HDHP plan starts paying medical and pharmacy benefits to anyone in the plan. Medical and pharmacy expenses count toward the deductible.
**Depending on which medical plan you choose, Mental Health and Substance Abuse benefits are provided through either Magellan Health Services or Integrated Behavioral Health. Preauthorization is required in all plans. Failure to preauthorize with KHP results in no benefit.
***Care from out-of-network providers is not covered, other than in an emergency, as determined by Capital Blue Cross.
See the **Summary of Benefits and Coverage** and **Plan Design Details** sections of the **2019 Enrollment and Reference Guide** to learn more about specific coverages and limits as well as preauthorization information.

Understanding Medical Coverage Plan Language

The following are definitions of terms used in the description of medical coverage. Understanding these terms will make it easier for you to compare the benefits provided under each of the plans.

Allowed Charge: That portion of a charge that the plan determines is reasonable for covered services that have been provided to the patient. Also known as the "allowance." Amounts in excess of the allowed charge are not paid by the plan. If the services were provided by a participating provider, the amount in excess of the allowed charge is waived by the provider. If the services were provided by a non-participating provider, the patient may be responsible for paying the additional amount (see "Balance Billing").

Balance Billing: Occurs when a provider of services or supplies declines to accept the payment level determined by a medical plan as payment in full. The provider then bills the insured for the amount of the charge that exceeds plan payment plus deductible, coinsurance, and/or copayment.

Coinsurance [CI]: The portion of a covered charge that is paid by both the insured and the plan. It is the sharing of charges as defined by the plan. Typically these amounts are expressed in terms of the "percentage paid by the plan versus percentage paid by the insured," such as 80 percent by the plan and 20 percent by you; 70 percent by the plan and 30 percent by you; or 50 percent by the plan and 50 percent by you. Coinsurance amounts may affect out-of-pocket maximums.

Copayment [CP]: A flat dollar amount paid to the provider by the insured for a covered service or supply at the time it is received. An example would be paying the physician $25 at the time of an office visit. Copayments do not affect the deductible and coinsurance maximum but do contribute to the out-of-pocket maximum that includes applicable physician copayments.

Covered Charge: An allowed charge for service that the plan is designed to accept and for which the plan will pay, if all other conditions (like deductibles and coinsurance) have been met. Charges that are not covered (like Balance Billing) do not affect deductibles, coinsurance, or out-of-pocket maximums.

Deductible [D]: The total amount of covered charges that the insured must pay in full during the plan year before any payment is made by the plan.

Out-of-Pocket Maximum: The maximum amount that would be paid by the insured for covered charges during a plan year, usually a combination of deductible, coinsurance, and copayments. The amount does not include plan charges for services that are not covered, and charges that are in excess of plan allowable charges (see "Balance Billing").

Preventive Care: Any covered medical service or supply that is received in the absence of symptoms or a diagnosed medical condition. Preventive care includes preventive health services like physical examinations, certain immunizations, and screening tests. Preventive care can also provide specific programs of education, exercise, or behavior modification that seek to manage disease or change lifestyle: programs for diabetes management, smoking cessation, childbirth preparation and the like. Medical plans clearly define the types of services, supplies, and programs they offer as preventive benefits and they provide them based upon protocols established in the medical community with regard to factors like frequency, patient age, and suitability. The Patient Protection and Affordable Care Act also requires particular preventive services for particular individuals to be covered at no cost, provided the covered services are received from a network provider. These services can be reviewed at https://www.healthcare.gov/preventive-care-benefits.

2019 Monthly Medical Insurance Prices

	University Contribution	Employee Premiums			
		HDHP Plan	PPO	PPO Plus	Keystone HMO
Individual	$527	$30	$204	$276	$98
Employee + Spouse/Partner	$1,090	$115	$505	$666	$276
Employee + Child(ren)	$991	$98	$449	$594	$242
Employee + Family	$1,571	$170	$733	$966	$400

Vision and Prescription Drug Plan Information

Davis Vision Program

Service/Product	Your In-Network Cost	Out-of-Network Reimbursement to You
Eye Exam	$0	$32
Eyeglass Lenses		
Standard Single vision	$0	$25
Bifocal	$0	$36
Trifocal	$0	$46
Post Cataract	$0	up to $72
Non-standard (i.e. no line bifocals, tints, coatings)	Fixed Costs	No Additional Benefit
Frames	$0 for Davis fashion selection frames. Amount over $110 for non-Davis frames at Visionworks, less 20% overage discount.Other providers: amount over $60.	$30
Contact Lenses		
Prescription and Fitting	$0	Daily Wear: $20 Extended Wear: $30
Contact Lenses	Amount over $75, less 15% discount on overage	Specialty: $48 Disposable: $75
Medically Necessary Contacts (w/prior approval)	$0	up to $225

1-877-923-2847 (prior to initial enrollment)
1-800-999-5431 (once enrolled) or www.davisvision.com

Coordination of Benefits/ Spousal Surcharge

If you have dependents covered by Lehigh's medical insurance plan, you will be asked to complete a Coordination of Benefits questionnaire. You will receive the form from Capital BlueCross. This form will ask you if your dependents' other parent also has coverage for them on a plan from his or her employer. It also asks if your adult children (under age 26) have coverage with their employers.

In general, all participants receive primary coverage from the medical plan that covers them as an employee, and dependent children receive primary coverage from the parent whose birthday comes first in the calendar year. Secondary coverage comes from the medical plan of the other employer, or the other parent, respectively.

If you choose to have your spouse or partner covered by Lehigh's medical insurance plan, you will be charged a $100/month surcharge until you complete a Spousal Surcharge Waiver request and HR approves it.

The waiver request form is provided during the online enrollment process. Failure to submit the waiver request during Open Enrollment will result in the monthly surcharge beginning on January 1. If you provide the form later and it is approved, the surcharge will stop; however, you will not receive a refund for prior months.

Express Scripts Prescription Drug Benefit

Lehigh's prescription drug program is based on a three-tiered formulary that determines the amount of coverage you will receive for your drugs. Below are the coverage levels for each tier.

	Retail	Mail Order
Generic	10% ($25 maximum) per 30-day supply	10% ($75 maximum) per 90-day supply
Formulary Brand Name	20% ($50 maximum) per 30-day supply	20% ($150 maximum) per 90-day supply
Non-Formulary Brand Name	30% ($100 maximum) per 30-day supply	30% ($300 maximum) per 90-day supply

If you have questions about whether your prescriptions are considered "formulary" or "non-formulary," contact Express Scripts at 1-866-383-7420 or www.express-scripts.com; **for other questions relating to the prescription plan** contact the Benefits Service Center at 1-844-342-4002.

Flex Dental Benefit Summary

Diagnostic and Preventive Service Benefits - Paid at 100% of MAC*. Does not count against maximum annual benefits of $1,000 per person

Semi-annual cleaning, polishing and examination
Annual bitewing X-rays
Complete X-ray series (every five years)
Fluoride treatment (under age 19)
Sealant: Under age 16. One sealant per permanent first and second molars in three years.
Emergency treatment: Palliative (to alleviate pain), not restorative

Basic Service Benefits - Paid at 80% of MAC*

Inpatient consultation
Anesthetics: Novocain, IV sedation, general
Basic restoration: Amalgam and composite fillings
Non-surgical periodontics
Endodontics
Oral surgery
Simple extraction
Repair of crowns, inlays, onlays, bridges and dentures

Major Service Benefits - Paid at 50% of MAC*

Surgical periodontics
Inlays, onlays and crowns
Prosthetics: Dentures and bridges; no implants

Orthodontics (under age 19) - Paid at 50% of MAC*

Orthodontic lifetime benefit maximum of $1,000 per person

*MAC: Maximum Allowable Charge - The negotiated charge the plan pays to providers.

The Preventive Incentive

To encourage good oral health and help save you money, United Concordia Dental's plan covers Class I diagnostic and preventive procedures in full. Annual preventive care for each person covered under the plan includes:

- Two cleanings
- Two exams
- One set of X-rays.

In addition, the coverage of these costs does not count toward your annual maximum. For more information on The Preventive Incentive, contact United Concordia Dental customer service at 1-800-332-0366.

2019 Monthly Dental Prices	
United Concordia Dental	
Employee Only	$35.26
Employee + One	$70.52
Employee + Two or More	$91.18

To view a list of participating dentists, visit United Concordia's website at www.ucci.com/, select "Find a Dentist," and select "Advantage Plus" to find participating dentists in Pennsylvania, and "National Fee-For-Service" to find dentists in all other states.

A Note About International Travel

All four of Lehigh's medical coverage plans are administered by Capital BlueCross, which is a member of the BlueCross-BlueShield Association.

That affiliation makes the BlueCross Blue Shield Global Core program available to employees and dependents covered under any Lehigh medical plan. BlueCross Blue Shield Global Core provides access to an international network of traditional inpatient, outpatient, and professional healthcare providers, as well as participating hospitals, around the world.

If you plan to travel outside the US, you can find information about the program and its services - including the process for locating a doctor or hospital - by calling 1-800-810-BLUE. Outside the US call collect at 1-804-673-1177. You can also visit the Global Core website at https://www.bcbsglobalcore.com.

If you are traveling on university business outside the US, you can also use the International SOS program travel services assistance plan that can help with medical, personal, travel and security assistance in times of need. International SOS is not medical insurance, but is another source of support. Learn more about International SOS and other university travel insurance issues by calling the International Programs Office (610-758-3351) or Risk Management (610-758-3899).

Need Help?

Need an answer to a benefit coverage question? Here's a list of resources to get your questions answered. Clip and save this list for future reference. This list is also available at: https://hr.lehigh.edu/resources.

Provider	Phone	Web Address
AFLAC	800-433-3036	www.aflacgroupinsurance.com
Capital Blue Virtual Care (telehealth)	855-818-DOCS	https://www.capbluecross.com/wps/portal/cap/home/explore/resource/virtual-care
Lehigh Benefits/Benefitfocus	844-342-4002	Log In Via Connect Lehigh
Capital BlueCross and Keystone Health Plan	800-216-9741	www.capbluecross.com
Health Advocates	866-695-8622	email: answers@healthadvocate.com web: healthadvocate.com/members
Health Equity (HSA administration)	866-346-5800	www.healthequity.com
Integrated Behavioral Health (mental health/substance abuse benefits in Keystone Health Plan and PPO Plus)	800-395-1616	www.ibhcorp.com To access EAP/WorkLife: user id: lehigh password: univ03
Magellan (mental health/substance abuse benefits in HDHP and PPO)	866-322-1657	www.magellanhealth.com
Express Scripts	866-383-7420	www.express-scripts.com
Davis Vision	877-923-2847 or 800-999-5431	www.davisvision.com control code: 4100
United Concordia Dental	800-332-0366	www.ucci.com
WageWorks (FSA administration)	855-774-7441	www.wageworks.com

Campus Visits by Insurance Vendors

Representatives from Capital BlueCross, Express Scripts, Davis Vision, Integrated Behavioral Health and United Concordia dental insurance will be on campus during Open Enrollment.

Take some time to visit with our vendors and ask questions about how Lehigh's benefit plans work. Human Resources representatives will also be available.

Wednesday, November 7
12:00 - 2:00 p.m.
Iacocca Hall, Siegel Gallery

Thursday, November 8
12:00 to 2:00 p.m.
University Center, Room 306

Notice of Privacy Practices

Lehigh University has a Benefit Plans Notice of Privacy Practices. You have a right to receive a paper copy of this Notice of Privacy Regulations at any time. To obtain a paper copy of this notice, send your written request to:

Lehigh University Human Resources
306 South New Street, Suite 437
Bethlehem, PA 18015

You may also obtain a copy of this notice at https://hr.lehigh.edu. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact the Director of Human Resources Services at the above address or call 610-758-3900.

Frequently Asked Questions

Q: What is the last date to file Capital BlueCross claims for the HDHP, PPO or PPO Plus medical plans?
A: Claims must be filed within twelve (12) months of the date of service for any of the Capital BlueCross medical plans.

Q: How often may I change from one health insurance plan to another within our medical plans?
A: The only time you can change to another plan is during the annual open enrollment period, held this year from November 5 - 19. If you are dissatistifed with your current coverage, please contact Human Resources. It is important to tell us about any problems you encounter.

Q: I am expecting a baby/adopting a child soon. When and how should I add my new child to my coverage?
A: Adding a child to your family is a Qualifying Life Event. As a result, you have thirty one (31) days from the date of birth or adoption placement to add a child (under the age of 26) to your insurance. You should add your child as soon as possible during that timeframe.

Remember: Open Enrollment insurance elections are for the 2019 plan year. Therefore, if you need to add a child to your insurance coverage for the remainder of 2018, you need to provide the appropriate information and documentation outside of the Open Enrollment process. To do so, log into Lehigh Benefits and select "Life Event" in the "Manage Account" section on the left side of the screen before beginning Open Enrollment. You will be prompted to provide information and documentation on your new dependent.

Completing the Life Event section triggers the system to add your child to your insurance for the remainder of 2018. You may continue on to select your 2019 benefits through the Open Enrollment process. If your new child is not yet listed as a dependent, you'll need to add them when prompted.

Q: I am getting married soon. Can I add my new spouse and/or stepchild(ren) to my coverage or do I have to wait until there is an open enrollment period?
A: **The instructions in the question above regarding adding a new child also apply in this situation.** You have thirty one (31) days from the date of your marriage to add your spouse and/or stepchild(ren) to your health and/or dental coverage, purchase dependent life insurance, and/or increase your supplemental life insurance. After thirty one days, you must wait for the next open enrollment period. If your spouse has access to health insurance through his or her employer, keep the spousal surcharge in mind when considering adding him or her to your medical plan. See the full Flexible Benefits Enrollment and Reference Guide online on the **Lehigh Benefits website.**

Q: My child just turned age 26 and has no health insurance plan. Can he or she stay on my medical plan?
A: No. Your dependent or adult children can only remain covered under a university medical, dental, life insurance, or FSA program until the end of the month in which they reach age 26. He or she will be offered COBRA continuation medical and dental coverage at that time. He or she can also visit www.healthcare.gov to see options for purchasing individual medical insurance. If your child is disabled, special rules may apply. Please contact HR for more information.

Q: I am helping my 25-year old pay for major dental work. Can I be reimbursed through my Flexible Spending Account (FSA)?
A: Yes. As a result of The Affordable Care Act, qualifying medical expenses incurred by your adult child (under 26 years old) are eligible for reimbursement through your FSA. The same documentation requirements apply.

Q: What is the difference between "pre-tax" and "post-tax" long-term disability (LTD) plans?
A: If you purchase LTD coverage on a **pre-tax** basis, this means you pay federal income tax on the benefit if you become disabled, but you pay no federal income tax on the premium. If you choose the **post-tax** option, you pay federal income tax on the premium, but no federal income tax on the benefit (the income you would receive if you became disabled).

Q: I enrolled my non-working spouse/partner on my insurance plan. How do I avoid being charged the Spouse/Partner Surcharge?
A: The Spouse/Partner Surcharge of $100 per month is assessed when an employee's spouse/partner has access to medical insurance via an employer or former employer but still chooses to be enrolled in Lehigh's plan as primary coverage. If your spouse/partner does not have such access, you must complete the online Spouse/Partner Surcharge Waiver Request form to avoid being charged. If you do not complete the spousal surcharge waiver request by the end of open enrollment on November 19, 2018, you may be charged the surcharge starting in January 2019. You will continue to be charged $100 monthly if you do not submit a waiver request that is then approved by HR. Please note that if your waiver request is accepted, the surcharge will stop, but prior months' charges will not be refunded.

More About Your Benefits

Health Advocate Services

Health Advocate's Health Advocacy service provides employees and their families with confidential, one-on-one help from an industry expert who knows the ins and outs of the complex healthcare system. Personal Health Advocates are skilled at working with healthcare providers, insurance plans and other health-related organizations to resolve complex clinical and administrative issues, including:

- Assistance with eldercare and Medicare issues
- Finding Doctors
- Healthcare coaching
- Help obtaining second opinions
- Help resolving claim disputes
- Navigating insurance plans
- Researching treatments
- Scheduling appointments
- Uncovering bill mistakes

Important Reminder for Healthcare FSA Users

The **WageWorks HealthCare Card** is a debit card that you can use at the point of sale to access your healthcare FSA funds when paying for allowable charges. Once the year turns over from 2018 to 2019, you will only be able to use the card to pay for 2019 expenses. You will need to file for reimbursement of 2018 expenses via the WageWorks website or app no later than March 31, 2019.

Voluntary Benefits

Lehigh offers employees the following voluntary critical illness and accident insurance products through AFLAC.

Accident Insurance

Accident insurance supplements your medical plan by paying benefits in cases of accidental injuries. Lehigh offers two options: Low or High, with corresponding premium rates. Benefits are paid directly to you, are tax-free and are paid in addition to any other insurance plans you may have.

Critical Illness Insurance

When a serious illness strikes, critical illness insurance can provide financial support to help you through certain illnesses like cancer, heart attack or stroke. If you enroll, it provides a lump sum payment to cover out of pocket expenses not covered by medical insurance, including day care, housekeeping and more.

There are two coverage options: $10,000 and $20,000. Please note that there is no duplication of coverage. If you and your spouse/partner both have this insurance for a dependent, you will receive only one payment.

Enrollment is Easy with Lehigh Benefits

Enroll on the Web

- Log in to "Connect Lehigh" from the upper left corner of the **Inside Lehigh** homepage
- Select the "Employee" tab
- Select "Lehigh Benefits" from the list of applications.
- Select the button under the words "Enroll Now!" that reads "Click Here to View Your Benefits."

Or Use The App

- Download the Benefitfocus app from The App Store or the Google Play Store
- Log in by using the ID **"lehighbenefits"** on the initial screen, then sign in with your Lehigh ID and password.

Whether you use the web or the app, you'll be asked to confirm your dependents and answer a few questions before you begin enrollment. You can review your current elections, use the comparison shopping tool to view estimated out of pocket costs for you in each plan, change your elections, update your beneficiary information and more.