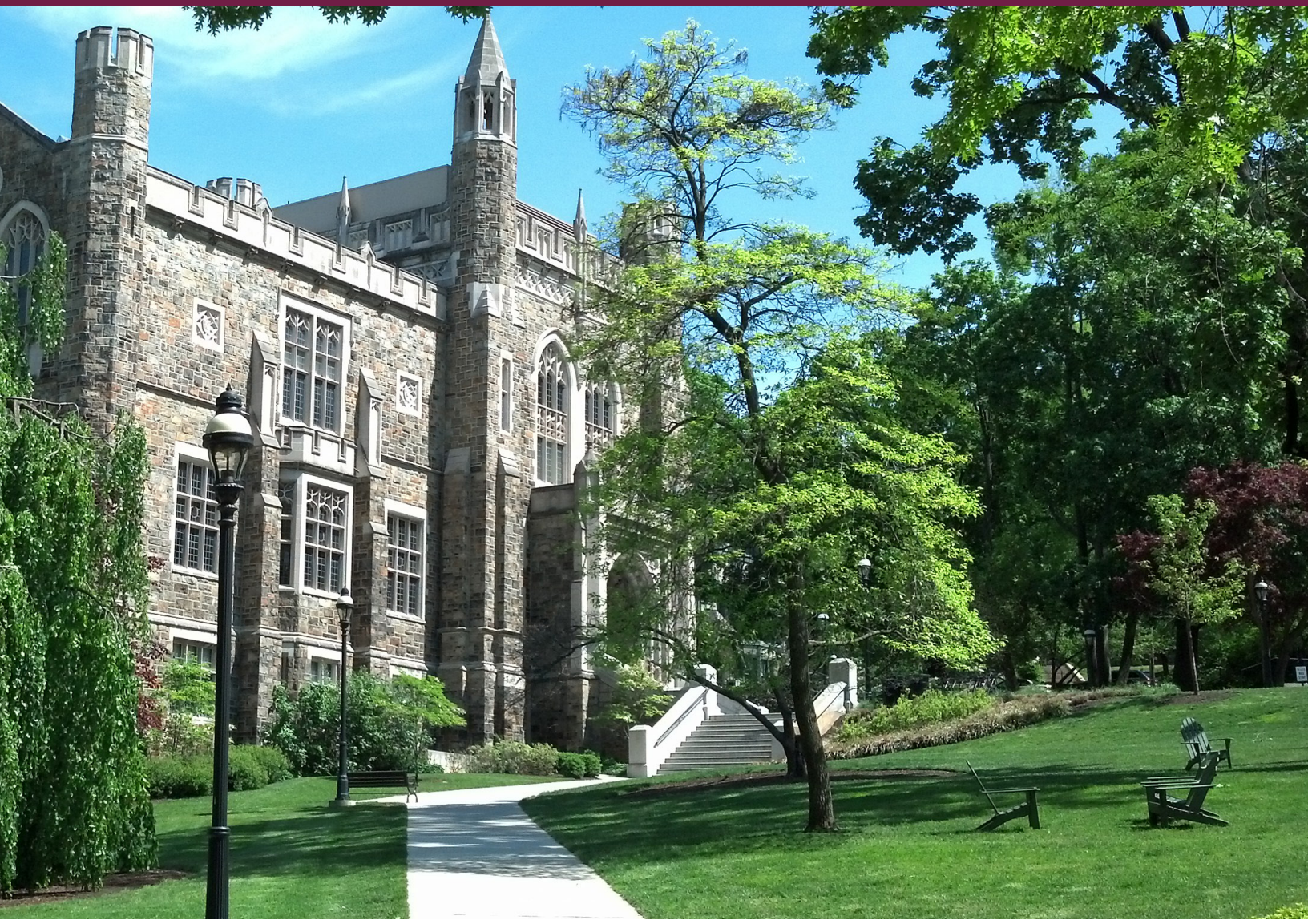
LEHIGH UNIVERSITY

2018 Flexible Benefits Enrollment & Reference Guide

This booklet contains all of the information needed to understand your Flexible Benefits for 2018.



BE WELL

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see the Legal Notices section for details.

Contents

Introduction to Your Benefits

Lehigh University is committed to providing you and your family with a comprehensive and competitive benefits package. Our goal is to provide high-quality, valuable benefits that are sustainable for both you and the University in the long term.

This Flexible Benefits Enrollment & Reference Guide provides details about the benefits available to you through Lehigh for 2018:

- Medical (including Prescription Drug and Vision)
- Dental
- Spending and savings accounts
- Life insurance (for you and your dependents)
- Disability
- Voluntary accident and critical illness

Consider all your benefit plan choices carefully. Read this guide to find out what's new for the upcoming year and the important changes we have made. Think about which plans make the most sense for you and your family, and, finally, make any needed changes during Open Enrollment. Be sure to compare each plan's features and your payroll contributions, and consider which plan best fits your needs.

Open Enrollment is your once-a-year chance to make changes to your benefits. During Open Enrollment you can:

- Change plans
- Add or delete dependents from your coverage
- Change coverage levels
- Enroll in a Health Care or Dependent Care Flexible Spending Account (FSA)
- Elect to contribute to the Health Savings Account (HSA) if you enroll in the High Deductible Health Plan (HDHP) option for 2018.

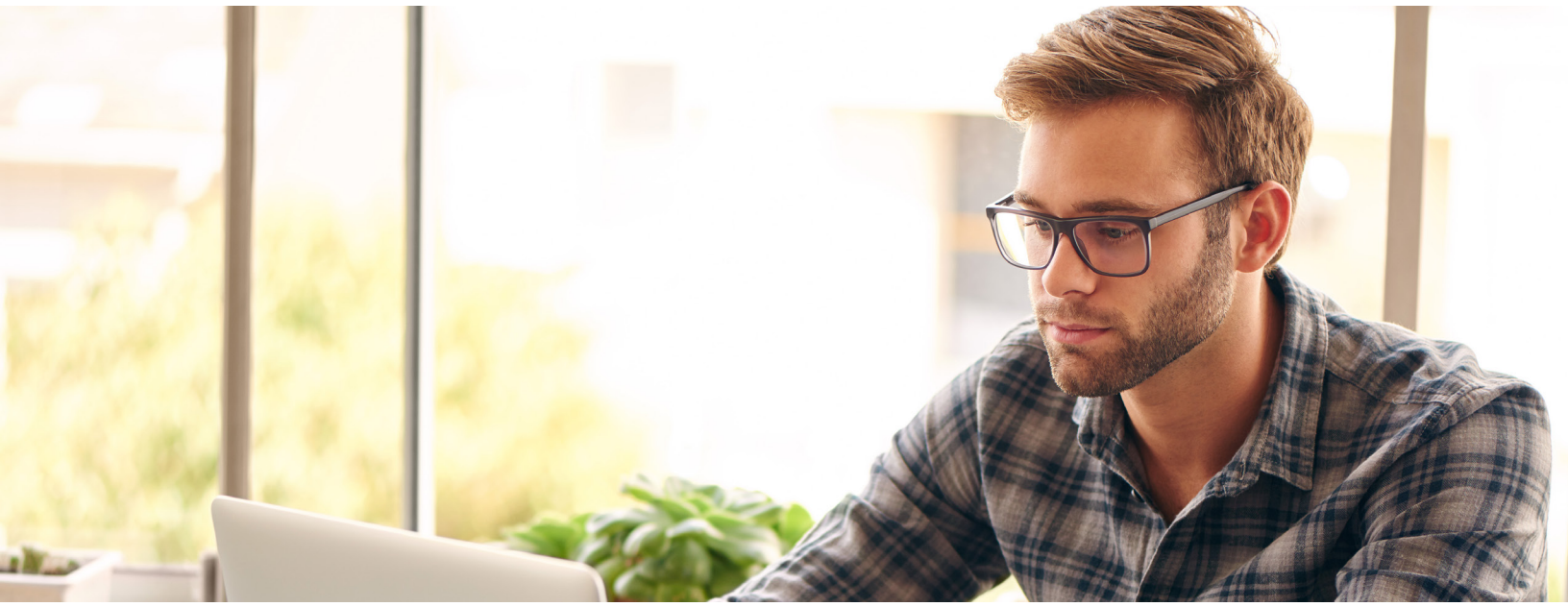
The benefit elections you make during Open Enrollment are effective from January 1, 2018 through December 31, 2018.

After Open Enrollment ends, you will not be able to make benefit changes until next year's Open Enrollment unless you experience a Qualifying Life Event (QLE) (e.g., you get married or become a parent).

WHAT'S NEW FOR 2018?

We want you to be aware of several important changes and enhancements for 2018. Be sure to review all of the detailed benefit information in this booklet and utilize the comparison tool in the online Lehigh Benefits enrollment system to make the choices that are best for you:

- The PPO 100 plan has been replaced with PPO Plus. There are significant differences between these plans.
- The PPO 80 plan has been replaced with PPO.
- There are changes to items such as co-pays, coinsurance, deductibles, out of pocket maximums and premiums across our plans. In some cases, these are decreases and in some cases they are increases.
- The prescription drug plan has been changed from 2 tiers to 3 tiers. The third tier includes non-formulary drugs.
- We have added a health advocate service to our benefits. Learn more about this service on page 7.



Benefits Eligibility

You are eligible for benefits if you are a full-time (or work at least 75% of a full work schedule), salaried member of Lehigh's faculty or staff employed in a benefits-eligible position.

You can also enroll your eligible dependents, including your:

- Spouse/partner
- Child(ren) up to the end of the month in which they become age 26
- Disabled child(ren) without age limitation (coverage, and its continuation, is subject to required certification with the carrier)

All benefits included in the Flexible Benefits Plan — flexible spending accounts and medical, dental, life, dependent life, and long-term disability insurances — are available to new staff members on the first of the month following their first work day. For new faculty members, benefits are available beginning on their first work day. However, their coverage does not begin until enrollment selections are completed online in Lehigh Benefits.

Learn more about eligibility and submitting your election on the Lehigh Benefits website or by calling the Lehigh Benefits Service Center at 1-844-342-4002.

Don't Miss Your Chance to Enroll!

- **If you are a current employee**: Enrollment for 2018 benefits will be November 6 - 20, 2017 for coverage effective January 1, 2018.
  - If you do nothing during open enrollment, your current elections will continue in 2018 with the exception of flexible spending accounts and employee HSA contributions, which must be renewed annually.
- **If you are a new hire**: New employees (both faculty and staff members) must enroll within 30 days of your first day of work.
  - Coverage for faculty members is effective as of their first day of work provided they complete their enrollment in Lehigh Benefits within the first thirty days of employment.
  - Coverage for staff members is effective on the first of the month following your start date, provided completed enrollment materials are received within 30 days of your first work day.
  - **If you miss your enrollment period deadline,** you will be assigned Lehigh's default benefit coverage of PPO individual coverage at a monthly cost of $179. No dependents will be enrolled in medical coverage; nor will dental insurance, supplemental or dependent life insurance, or FSAs be available to you or any dependents.

Keep in mind you will not be able to make a change to your benefits during the year unless you experience a Qualifying Life Event (QLE).

Enrollment Is Easy

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 is labeled "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.

Changing Your Coverage During the Year

The benefit elections you make during Open Enrollment take effect on the following January 1.

Your elections remain in effect until the next Open Enrollment period, unless you experience a Qualifying Life Event (QLE), such as getting married or divorced or having or adopting a baby. You can add or drop dependents from your coverage as the result of a QLE, however you cannot change your medical plan election (e.g., you can add a new spouse to your medical coverage, but you can't change from the PPO to the HDHP as a result of getting married).

It is your responsibility to notify Lehigh Benefits within 31 days of a QLE and request appropriate flexible benefit changes when:

- Your child is:
  - Born
  - Reaches age 26
  - Gains or loses access to medical coverage as a result of his or her own employment
- You get married or divorced or dissolve a partnership

If you fail to submit a QLE change request within 31 days, we will retroactively cancel coverage in the case of a dependent whose benefit eligibility ends. However, we cannot refund premiums paid for coverage that was not available. In other words, paying for coverage that your dependent is not entitled to receive will not create that entitlement. It simply means that you are paying more for coverage than you need to. Furthermore, you may jeopardize your dependent's access to COBRA coverage by failing to notify Lehigh Benefits in a timely fashion.

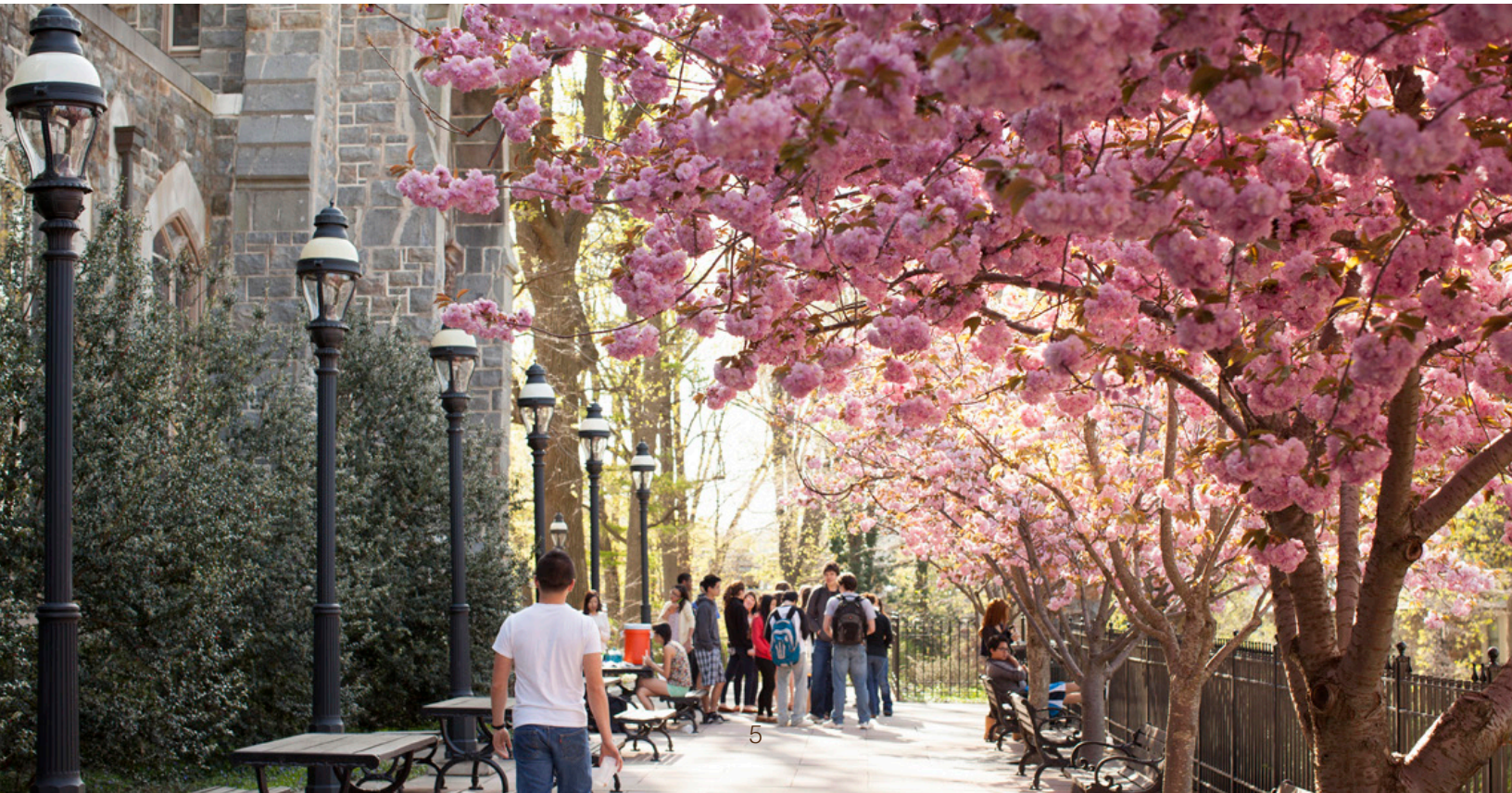
Learn more about QLEs by visiting the Lehigh Benefits website or calling the Lehigh Benefits Service Center at 1-844-342-4002.

What Happens to Your Coverage if You Leave Lehigh?

Your coverage does not end right away if you separate from the University. The Consolidated Omnibus Budget Reconciliation Act's (COBRA) continuation coverage provides you the option of continuing your medical and/or dental plan for up to 18 months. You would be responsible for paying the entire premium amount to Conexis (Lehigh's COBRA administrator) plus a 2% administrative fee.

The provisions of COBRA also apply to dependents that lose coverage, including a child who turns 26. For medical and dental coverage, it is your responsibility to notify Lehigh Benefits when your child reaches age 26 or you may jeopardize your dependent's access to COBRA coverage.

Additional information is available through the Lehigh Benefits website or by calling 1-844-342-4002.



Your 2018 Medical Options

Lehigh offers four medical plans through Capital Blue Cross. While all of the options cover the same services and treatments, and cover preventive care in full when received from in-network providers, they differ in how much you pay in payroll contributions and what you pay when you receive care. To make an informed decision about which option is right for you and your family, evaluate your health care needs and review how you pay for services under each option.

IN-NETWORK PREVENTIVE CARE

Preventive care is 100% covered in all health care plans when received from in-network providers. Preventive care includes services such as physical examinations and certain immunizations.

Preventive services are divided into three groups:

- Adults
- Women
- Children

Go to the **Preventive Care** section for details.

Your medical options include:

- Capital Blue Cross Preferred Provider Organization (PPO) plans:
  - PPO
  - PPO-Plus
- Capital Blue Cross High Deductible Health Plan (HDHP)
- Keystone Health Maintenance Organization (HMO)

When you enroll in a medical plan through the University, you are automatically enrolled in Prescription Drug coverage through Express Scripts and Vision coverage with Davis Vision.

The PPO Plans

With the PPO or PPO Plus plans, you have a choice each time you need care — you may choose health care providers within the plan's network or visit any provider outside the network. However, you'll typically pay more for care when you use out-of-network providers. That's because Capital Blue Cross negotiates discounted fees for covered services with providers in their network, which allows us to set the in-network annual deductible at a lower level than the annual deductible for out-of-network care.

If you choose a PPO plan, you will pay more in premium contributions, but less when you receive care.

The HDHP

The HDHP gives you more control over how you spend — or save — your health care dollars. If you enroll in the HDHP, you can contribute to a tax-advantaged Health Savings Account (HSA) that includes a contribution from Lehigh. You can also choose to contribute up to annual IRS limits. Use this account to help pay for eligible health care expenses today, or to save for future medical, dental, and vision expenses. See the **Health Savings Account** section for more information.

Like the PPO plan, you have the freedom to see both in-network and out-of-network providers, but you'll typically pay more for services from out-of-network providers and you'll have to satisfy a higher out-of-network deductible. Additionally, the HDHP network is the same network that is available in the PPO and PPO Plus plans.

The HDHP has a higher annual deductible than the PPO plans, but you'll pay less in payroll contributions. It's important to note that the full family deductible must be satisfied before the plan pays benefits for anyone covered in the plan. **If you cover any dependents, you must meet the entire family deductible before the plan begins reimbursing your medical or prescription drug expenses. One family member, or all family members combined, can satisfy the deductible.**

Although they cover the same services, there are some key differences between the HDHP and the PPOs:

HDHP	PPO
• Lower payroll deductions • Pay more out-of-pocket when receiving care • Higher annual deductible • Lehigh contribution to the HSA	• Higher payroll deductions • Pay less out-of-pocket when receiving care • Lower annual deductible • No HSA

Find more information about this plan by reading the HDHP User's Guide available on Lehigh Benefits.

WHO SHOULD ENROLL IN THE HDHP?

Do you expect your usage to be moderate to low (only wellness visits and occasional illness)? If so, consider the plan with the higher deductible. You could save money by paying less from your paycheck for your coverage. If you are concerned about the risk of unexpected expenses, consider purchasing voluntary accident or critical illness insurance.

NEW FOR ALL PLANS: HEALTH ADVOCATES

Core Advocacy Program offers access to a personal advocate and clinical resources to help resolve a wide range of issues, including but not limited to:

- 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

The Keystone HMO

The HMO provides the maximum level of coverage with lower premiums and the lowest out-of-pocket costs. In addition, you will not be responsible for first satisfying an annual deductible before the plan pays benefits. In return, you'll be required to receive care from in-network providers, manage your care through a Primary Care Physician (PCP) and receive referrals from your PCP if you would like to receive care from a specialist. Care received from out-of-network providers will not be covered, other than in an emergency, as determined by Capital Blue Cross. This may be the most cost-effective option for employees living in the 21 county area surrounding the University who are comfortable with using only in-network providers.

2018 Monthly Medical Premiums

PLAN	Individual	Employee + Spouse/Partner	Employee+ Child	Employee+ Family
University Contribution (All Plans)	$511	$1,058	$962	$1,525
HDHP	$26	$101	$86	$149
PPO	$179	$443	$394	$643
PPO Plus	$242	$584	$521	$847
Keystone Health Plan (HMO)	$86	$242	$212	$352

Summary of Medical Plan Options

The table below provides a summary comparison for key benefits across the medical plan options available for 2018. See the Summary of Benefits and Coverage and Plan Design Details sections of this guide for more information about each plan and covered preventive services.

	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	$3,000	No limit	$3,000	No limit	$6,650	No limit	$3,000
Family	$6,000	No limit	$6,000	No limit	$13,300	No limit	$6,000
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 **2018 Enrollment and Reference Guide** to learn more about specific coverages and limits as well as preauthorization information.

Preventive Care

Preventive care is any covered medical service or supply that is received in the absence of symptoms or a diagnosed medical condition. Preventive care includes preventive services such as physical examinations, certain immunizations, and screening tests.

Federal laws covering medical, dental and/or vision preventive care change often. Check to see what's covered at **https://www.healthcare.gov/preventive-care-benefits**.

Telehealth

American Well (also known as Amwell) telehealth service gives covered employees access to board-certified physicians through phone or video consults. You can use American Well if you have a health problem and need urgent care, if you're not sure you need emergency care, or if you're simply traveling and need a doctor's advice. Doctors can diagnose, recommend treatment and even write short-term prescriptions (through video consult only) for most non-emergency medical issues. This benefit is included in all medical plans offered by the University. **The copay is $10 for HMO and PPO subscribers, and $49 for HDHP subscribers.**

Visit **www.capbluecross.com/telehealth** to find approved local telehealth providers or call American Well's patient support at 1-855-818-DOCS to talk to an agent.

HOW TO CHOOSE YOUR MEDICAL PLAN

Using the comparison tools on Lehigh Benefits will help you find the plan that's best for you.

Start by using the guided shopping application that asks basic questions about your preferences related to how you use health care services and suggests plans that best fit those preferences.

You can also use the Lehigh Benefits powerful financial modeling tool to project the total cost of your medical coverage elections using:

- the average claims experience of Lehigh employees, if you have not participated in the plan in the past, or,
- your own claims experience if you've been covered by a Lehigh plan since Fall 2016,
- the national average claims experience for persons with similar age, gender, and regional demographics as you and your dependents, and
- customized modeling of your projected medical claims for next year.

Take the time to review plan features — such as an HSA with a contribution from Lehigh — and not just what you contribute from your paycheck. Consider your needs and preferences:

1. How much coverage do I need?
- See how the services you'll likely need in 2018 are covered under each medical plan
- Do you need supplemental coverage?

2. What will be my total cost?
- Out of your paycheck: Your contributions for coverage
- Out of your pocket: What you pay when you receive care
  - Copays
  - Deductibles
  - Coinsurance

3. How do I prefer to pay?
- Pay more from my paycheck, and less when I need care (lower deductible plans)
- Pay less from my paycheck, and more when I need care (higher deductible plans)
  - Consider your ability to cover large/unexpected medical bills

4. Do I want an HSA?
- Only available to employees in the HDHP
- Lehigh contributes to your HSA (in 2018, $600 individual/$1,200 family)
- You can also contribute through pre-tax payroll deductions
- Money carries over year to year — build tax-free savings to pay for eligible health expenses, now or in the future
  - Additional restrictions apply

Prescription Drug Plan

All of Lehigh's medical plans include prescription drug benefits through Express Scripts. You can fill your prescriptions at retail pharmacies or through the Express Scripts Home Delivery program. While you have the option to choose which delivery option fits into your lifestyle, you will save time and may save money by having your medication delivered by mail.

Using generic drugs, which cost less than brand-name drugs, can save you money. A generic drug is a drug that contains the same active ingredients as the brand name drug, but can only be produced after the brand-name drug's patent has expired. With the introduction of our three-tiered plan, it's important to check with your doctor and pharmacy to see if any of your current medications are non-formulary and subject to higher charges.

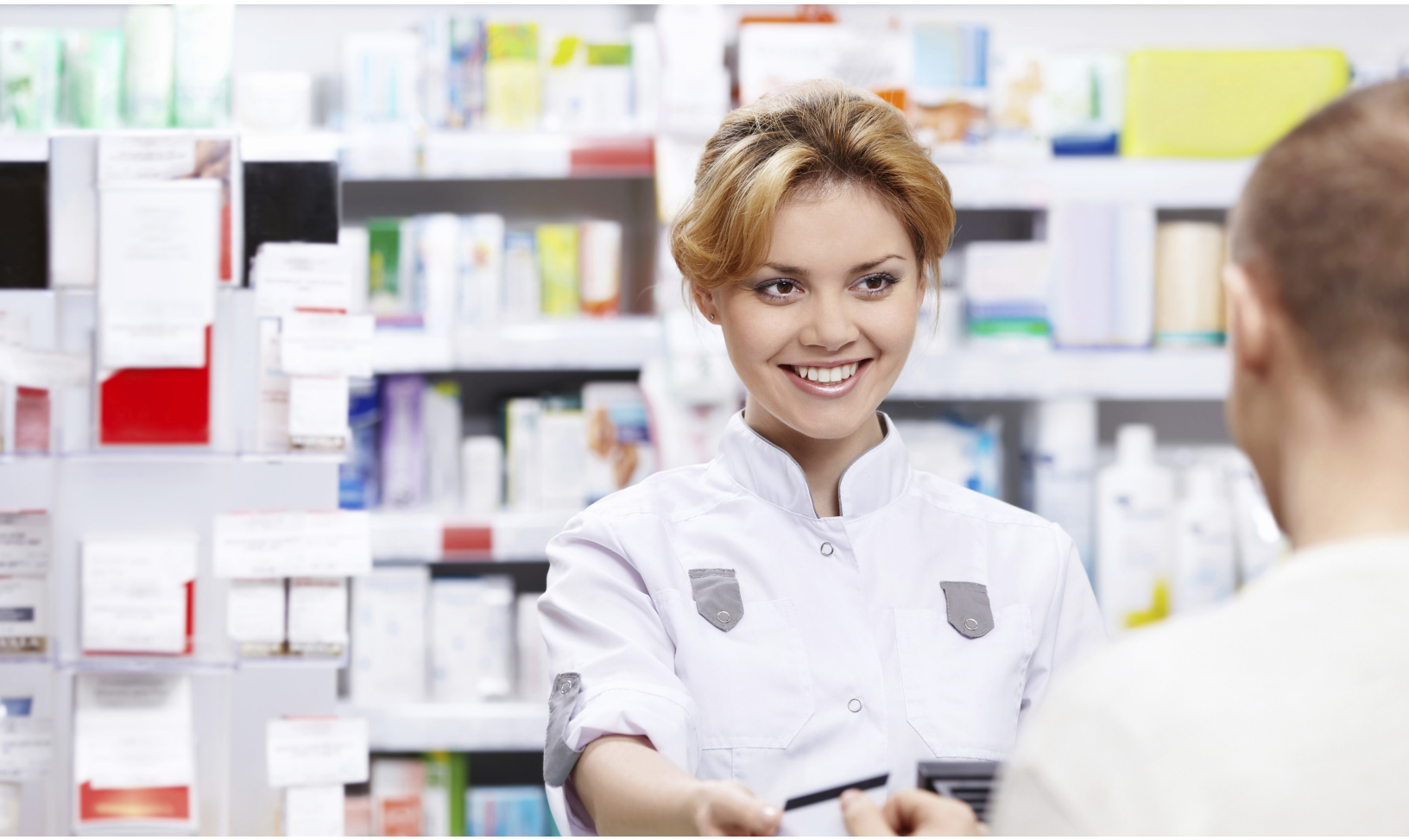
FILLING YOUR PRESCRIPTIONS BY MAIL ORDER COULD SAVE YOU MONEY

You are not required to select mail order, but it may be the best, most economical choice:

- **FREE shipping** right to your door
- **25% average savings** over retail
- **90-day supply**, so you won't worry about running out
- **24/7 access** to a pharmacist from the privacy of your home
- **Automatic refills** every three months

	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

For definition of "formulary" and "non-formulary," consult the glossary on page 19. 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.



Vision Coverage

Vision coverage through Davis Vision is also included in your medical plan coverage. The vision plan provides a benefit for an exam and lenses and frames on a yearly basis. You have the freedom to see any vision provider you choose, but the plan generally covers services at a higher level when you receive care from doctors who participate in the Davis Vision network. If you decide to go to an out-of-network provider, you'll be reimbursed for exams and eyewear according to the schedule of benefits detailed below.

To find a provider who participates in the Davis Vision network, call 1-800-999-5431 or go to **www.davisvision.com** and follow prompts for general access or member access, as appropriate. The Lehigh University client control code for general access is 4100.

Prior to initial enrollment, call 1-877-923-2847.

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% discount on overage; amount over $60 at other providers.	$30
Contact Lenses		
Prescription Evaluation 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 Contact Lenses (w/prior approval)	$0	up to $225

Dental Coverage

Dental coverage is available even if you waive medical coverage through Lehigh. Unlike medical, where the University pays the majority of your cost for coverage (i.e., the monthly premium), Lehigh does not contribute toward the cost of your dental coverage. You pay the full cost for the coverage, however your contributions are based on attractive group coverage rates.

You have the flexibility to receive care from any dentist you choose, but you will pay less when you visit a dentist who participates in the United Concordia dental provider network. This is because network providers cannot charge more than the Maximum Allowable Charge (MAC). This restriction does not apply to out-of-network providers. When you receive care from an out-of-network provider, you are responsible for any charges in excess of the MAC.

Visit United Concordia's website at **www.ucci.com** or call 1-800-332-0366 to find a participating provider.

United Concordia Dental Benefit Summary (Maximum annual benefit of $1,000 per person)
Diagnostic & Preventive Service Benefits — Paid at 100% (Does not count toward maximum annual benefit)
Semi-annual cleaning, polishing, and examination Annual bitewing X-rays Complete X-ray series (every five years) Fluoride treatment (under age 12) Sealant: Once per lifetime (primary molars through age 10; secondary molars through age 15) 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, crowns Prosthetics: Dentures and bridges; no implants
Orthodontia (under age 19) — Paid at 50% of MAC*
Orthodontia lifetime benefit maximum of $1,000 per person

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

The Preventive Incentive

Preventive care is important for your teeth, too. Cleanings and regular exams for each covered individual are covered at 100% and do not count against the $1,000 annual maximum benefit limit. United Concordia's plan annually includes:

- Two cleanings
- Two exams
- One set of x-rays

2018 MONTHLY DENTAL PREMIUMS

Employee Only	$35.26
Employee + One	$70.52
Employee + Two or More	$91.18

Tax-Advantaged Accounts

Health Savings Account (HSA)

The HSA is a tax-advantaged savings account you can use to help cover the costs of your health care when you enroll in the High Deductible Health Plan (HDHP). Lehigh's HSA administrator is HealthEquity. Here are some important things to know about the HSA:

- **Money from Lehigh.** Lehigh will contribute up to $600 per year to your HSA when you enroll in employee only coverage, and up to $1,200 per year to your account for any other level of coverage. Note, this contribution will be made per pay period and will be prorated based on the date your coverage begins. You must open an HSA in order to receive the Lehigh contribution.
- **Works like a bank account.** Use the money to pay for eligible health care expenses — use your HSA debit card to pay when you receive care or reimburse yourself for payments you've made (up to the available balance in the account).
- **You can save.** You decide how much to save and can change that amount at any time. Contribute up to the 2018 annual IRS limit of $3,450 for individuals or $6,900 for family coverage (these amounts include Lehigh's contribution); $1,000 additional contribution allowed for employees age 55+.
- **Never pay taxes.** Contributions are made from your paycheck on a before-tax basis, and the money will never be taxed when used for eligible expenses.
- **It's your money.** Unused money can be carried over each year and invested for the future — you can even take it with you if you leave your job. This includes the contribution from Lehigh.
- **Can be paired with a Limited Purpose Flexible Spending Account (LPFSA).** You can use your HSA for eligible medical, dental and vision expenses. You can use your LPFSA for tax savings on eligible dental and vision expenses.

For more information about the HSA, including how to set up an account and rules and restrictions, contact HealthEquity at 1-866-346-5800 or **www.healthequity.com** or visit the resource center at **learn.healthequity.com/lehighuniversity/hsa**.

Flexible Spending Accounts (FSAs)

Flexible Spending Accounts (FSAs) let you set aside money from your paycheck — before federal income taxes — to pay for certain out-of-pocket health care and/or dependent care expenses, reducing your taxable income. Consider enrolling in one to help pay for your expenses. The type of FSA in which you can participate is based on your medical plan election.

If you elect either PPO or the HMO, you can participate in either or both of the following:

- Health Care FSA
- Dependent Care FSA

If you elect the HDHP, you can participate in either or both of the following:

- Limited Purpose Health Care FSA (covers dental and vision claims)
- Dependent Care FSA

If you elect any of the four medical plan options, or if you waive medical coverage through Lehigh, you can participate in the Dependent Care FSA.

Health Care FSA

- You can use the money in your Health Care FSA to reimburse yourself for eligible expenses, including medical, prescription, dental, hearing, and vision care expenses that exceed or are not covered by your medical plan.
- When you enroll, you can elect to contribute up to $2,650 annually.
- Plan carefully when deciding how much to contribute to your FSA. You can carry over only $500 of any unclaimed balance in a Health Care FSA into the new year.
- **Note: You cannot contribute to the Health Care FSA if you enroll in the HDHP.**

Limited Purpose FSA (LPFSA)

- You can use the money in your LPFSA to reimburse yourself for eligible dental and vision care expenses that are not paid by your dental or vision plan.
- Plan carefully when deciding how much to contribute to your FSA. You can carry over only $500 of any unclaimed balance in a LPFSA into the new year.
- **Note: You can only contribute to the LPFSA if you enroll in the HDHP.**

Dependent Care FSA

- You can use the money in your Dependent Care FSA to reimburse yourself for eligible child care expenses for dependents **under age 13** when it is necessary for you and/or your spouse to work or attend school full-time;
- Or you can use the money in your account for expenses for other eligible dependents (including your spouse) who are incapable of caring for themselves, depend on you for more than half of their support, and live with you for more than half of the year.
- When you enroll, you can elect to contribute up to:
  - $2,500 annually if you are married and file separate income tax returns
  - $5,000 annually, combined between you and your spouse, if your spouse has an account through another employer
- Money in your account does not roll over year to year, so plan carefully. **If you don't use it, you'll lose it.**

Additional information is available through the Lehigh Benefits website or by calling 1-844-342-4002.

Wageworks Healthcare FSA Debit Card

Lehigh's FSAs are administrered by Wageworks, which offers a debit card for convenient direct payments from your FSA account at the point of sale when you receive qualified services.

Please note that any claims from the prior year (2017) that you need to pay after December 31, 2017 must be paid via a claims submission on the Wageworks website. Your debit card will turn over to the 2018 claims year and cannot be used to pay for 2017 expenses beginning January 1, 2018.

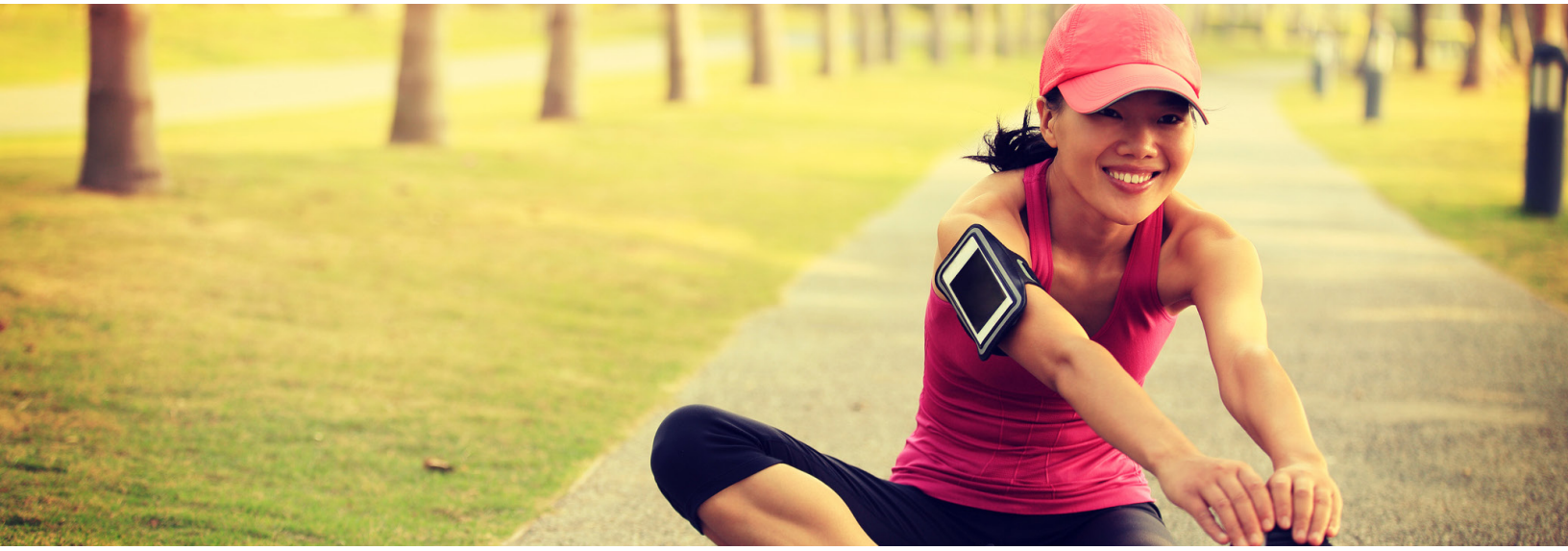
QUALIFIED MEDICAL EXPENSES FOR FSA USE

You can use your Health Care FSA for expenses that would generally qualify as medical, dental and vision expenses, including, but not limited to:

- Deductibles
- Office visits
- Prescription drugs
- Hospital stays
- Lab work or x-rays
- Eyeglasses or contact lenses
- Hearing aids
- Dental work
- Crutches, braces or wheelchairs

Compare the HSA and FSAs

Account Feature	HSA	Limited Purpose FSA	Health Care FSA	Dependent Care FSA
Available if you enroll in the…	HDHP	HDHP	• PPO-80 • PPO-100 • Keystone HMO You can also contribute to the Health Care FSA if you waive medical coverage through Lehigh, provided neither you nor your spouse is enrolled in a high deductible health plan elsewhere	All medical plans, or no coverage (you do not need to be enrolled in a medical plan through Lehigh to enroll in the Dependent Care FSA)
Maximum annual contribution (including Lehigh contribution)	• $3,450 Employee only • $6,900 all other coverage levels • $1,000 additional contribution allowed for employees age 55+ Note: Lehigh contributes up to $600 for employee only coverage and $1,200 for all other levels of coverage	$2,650	$2,650	$5,000 (combined employee/spouse amount)
Eligible expenses	Qualified health care expenses (including medical, prescription drug, dental and vision)	Qualified dental and vision expenses only	Qualified health care expenses (including medical, prescription drug, dental and vision)	Qualified expenses for dependents (**not to be used for health care expenses for dependents)**
Earns interest tax free	Yes	Not applicable	Not applicable	Not applicable
Carryover of unused funds to the next year	Yes	Up to $500	Up to $500	No
Portability if you leave Lehigh	Yes	No	No	No
Access to contributions	Current account balance only	Entire amount elected for the year	Entire amount elected for the year	Current account balance only



Financial Protection

Life and disability insurance can provide important financial protection as well as peace of mind for you and your family by replacing income or covering medical expenses in the case of injury or death. Selecting the right level of coverage to ensure adequate protection begins with you.

PROOF OF INSURABILITY
New employees can elect up to the maximum amount without submitting evidence of insurability for themselves and their dependents.

For all future enrollments, however, employees are required to provide evidence of insurability for increasing coverage by more than one times salary during any plan year.

Life Insurance

Basic Life Insurance

As part of Lehigh's benefits program, you automatically receive Basic Life Insurance benefits equal to one times your salary at no cost to you. For purposes of life insurance, your salary is your base salary as budgeted at the start of the plan year (i.e., January 1) or your hire date if you're a new employee.

Supplemental Life Insurance

You have the option to purchase Supplemental Life Insurance for you and your dependents

- **For you:** You can purchase supplemental coverage in increments of one to four times your salary. The combined maximum total coverage available for Basic Life Insurance and Supplemental Life Insurance is five times your base salary, up to a limit of $1,500,000. The cost of the supplemental coverage is based on your age:

Age (as of January 1)	Monthly Premium for $1,000 of Coverage
16 to 29	$0.038
30 to 34	$0.044
35 to 39	$0.071
40 to 44	$0.110
45 to 49	$0.165
50 to 54	$0.231
55 to 59	$0.352
60 to 64	$0.638
65 to 69	$1.100
Over 70	$1.837

- **For your dependents:** You can buy life insurance for your spouse/partner, your child(ren), or both. Dependent life insurance can cover a child from 15 days of age up to the end of the month in which he or she becomes age 26. You are the beneficiary for any dependent life insurance you select.

Dependent Life Premiums		
Coverage Options	Monthly Premium	Dependent Life Insurance Amount
Spouse/Partner	$2.20	$10,000
	$4.40	$20,000
	$6.60	$30,000
Child(ren)	$0.40	$5,000
	$0.80	$10,000

Under current law, premiums for dependent life insurance cannot be paid with tax-free dollars. The cost of the dependent life insurance option you choose will be paid through salary deduction on an after-tax basis.

Important Tax Note for Life Insurance

Because the cost of life insurance is paid with pre-tax dollars, some taxable income will result from the value of coverage over $50,000. There are no tax consequences for coverage of $50,000 or less. If your coverage exceeds $50,000, the Internal Revenue Service (IRS) requires the University to include the taxable value of the premium that purchases life insurance in excess of $50,000 on your W-2 form. The IRS defines the taxable value, and this value may be different from the actual premium paid. The difference in the amount of extra taxable income is generally minimal unless you are crossing an age bracket during the plan year.

Lehigh determines the age-based premium using your age on January 1; the IRS uses your age on December 31. In addition, you'll pay FICA (Social Security and Medicare) taxes on that amount as well if your pay is less than the Social Security wage base maximum.

HOW MUCH LIFE INSURANCE DO YOU NEED?

In evaluating your life insurance needs, it is important to look at the present and plan for the future to make informed decisions. Here are some key questions to consider when evaluating life insurance:

- What are your financial commitments and for what expenses would your family be responsible if you should die?
- What other resources are available to those who are financially dependent on you?
- What standard of living do you want your dependents to have without you?
- How much life insurance do you already have?

Long-term Disability Insurance

Lehigh's Short-term Disability (STD) plan, as defined in the Faculty and Staff Guides, provides coverage for the first 26 weeks (six months) of disability. Once you have exhausted your STD benefit, Lehigh's Long-term Disability (LTD) plan continues to replace a portion of your earnings — 66 2/3% of your LTD Base Salary — if you are still unable to work for an extended period of time due to an illness or injury. The University pays the full cost of this coverage.

- For the period January 1 through June 30, your LTD Base Salary is your base salary as of January 1.
- For the period July 1 through December 31, your LTD Base Salary is your base salary as budgeted for the new fiscal year.

Selecting Pre- or Post- Tax Premium Payments

You decide if you want the premium for your LTD coverage paid pre- or post-tax. The choice you make affects how your benefit is taxed when paid.

- Purchasing LTD coverage on a "pre-tax" basis means paying federal income tax on the benefit if you become disabled but paying no federal income tax on the premium.
- Purchasing LTD coverage on a "post-tax" basis means paying federal income tax on the premium but paying no federal income tax on the benefit if you become disabled. It is necessary to pay for the benefit on a "post-tax" basis for a period of thirty-six months to make the benefit 100 percent free of federal taxation.

To qualify for LTD benefits, you will generally need to be totally disabled and, as a result, unable to work for 180 continuous days. The insurance company, not Lehigh, determines whether you are disabled and eligible for LTD. Once benefit payments begin, they can continue for as long as you are totally disabled and until you reach your Normal Retirement Age (as defined by your access to full Social Security income benefits) or longer if your disability begins after age 60.

Other sources of disability income are taken into consideration to determine the benefit provided. Disability benefits received from any state disability plan, Social Security, and the LTD portion of the disability plan, combined, won't exceed 66 2/3% of your benefits eligible pay.

Additional information, including how to file a claim, is available through the Lehigh Benefits website or by calling 1-844-342-4002.

Voluntary Benefits – Accident and Critical Illness

In addition to your primary medical plan, you may want to consider voluntary Accident and/or Critical Illness coverage through Aflac. These plans are intended to supplement your primary medical plan. These are not standalone medical plans. They provide additional coverage to help pay expenses your medical plan may not cover. These plans do not provide the level of medical insurance coverage you need in order to meet health care reform requirements. You pay the full cost of coverage through post-tax payroll deductions, which means your benefit, when paid, is tax free.

About Accident Insurance

You can't always avoid accidents — but you can help protect yourself from accident-related costs that can strain your budget. Accident insurance supplements your medical plan by providing cash benefits in cases of accidental injuries. You can use this money to help pay for medical expenses not covered by your medical plan, such as your deductible or coinsurance, or for ongoing living expenses, such as your mortgage or rent.

You have two benefit coverage options: Low or High.

Benefits are paid:

- Directly to you, unless assigned to someone else.
- In addition to any other coverage, such as through your medical plan.
- Tax free, because you pay for each of these benefits with after-tax money.
- The policy pays you a benefit up to a specific amount for:
  - Dislocation or fracture
  - Initial hospital confinement
  - Intensive care
  - Ambulance
  - Medical expenses
  - Outpatient physician's treatment

The actual benefit amounts depend on the type of injuries you have and the medical services you need.

About Critical Illness Insurance

When a serious illness strikes, critical illness insurance can provide financial support to help you through a difficult time. It protects against the financial impact of certain illnesses, such as a heart attack or cancer. You receive a lump-sum benefit to cover out-of-pocket expenses for your treatment that are not covered by your medical plan. You can also use the money to take care of your everyday living expenses like housekeeping services, special transportation services and day care.

You have two benefit coverage options: $10,000 or $20,000.

Benefits are paid directly to you, unless assigned to someone else.

Glossary

Annual Deductible
The amount you pay each year out of your own pocket before your medical plan covers a portion of the cost for covered expenses through coinsurance. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible. Note that if you enroll in any coverage level other than "employee only" for the High Deductible Health Plan (HDHP), you will need to meet the entire family deductible before the plan pays benefits. Any one family member, or any combination of family members, can satisfy the deductible.

Balance Billing
When a provider bills you for the difference between the provider's charge and the allowed amount under your benefit plan. For example, if the provider's charge is $100 and the allowed amount under your plan is $70, the provider may bill you for the remaining $30. An in-network provider (sometimes called a preferred provider, depending on your plan) may not balance bill you for covered services.

Coinsurance
The way you share in the cost for most covered services after you meet the deductible. For example, if the coinsurance amount is 80%, then your medical plan pays 80% of the cost and you pay for the remaining 20% out-of-pocket. When you choose an in-network provider, the coinsurance you pay is significantly lower than for an out-of-network provider.

Co-payment
A fixed amount (for example, $25) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service (e.g., office visit for a pediatrician vs. specialist visit for an orthopedist).

Covered Charge
The charge for services rendered or supplies furnished by a provider that qualifies as an eligible service and is paid for in whole or in part by your plan. May be subject to deductibles, copayments, coinsurance, or maximum allowable charge, as specified by the terms of the insurance contract.

Covered Service
A service or supply (specified in the plan) for which benefits may be available. The plan will not pay for services that are not covered by the plan.

Dependent
Individuals who rely on you for support including children and spouse, generally qualify as dependents for health care and insurance benefits.

Emergency Room Care
Care received in an emergency room.

Formulary (Prescription Drug Coverage)
The Plan includes a list of preferred drugs that are either more effective at treating a particular condition than other drugs in the same class of drugs, or as effective as and less costly than similar medications. Non-preferred (non-formulary) drugs may also be covered under the prescription drug program, but at a higher cost-sharing tier. Collectively, these lists of drugs make up the Plan's Formulary. The Plan's Formulary is updated periodically and subject to change. To check where your medications fall within the plan's formulary please call Express Scripts at 1-866-383-7420.

In-Network
Doctors and other health care providers, hospitals, clinics, laboratories and outpatient facilities that have negotiated discounted rates with your plan. Depending on your plan, you may have the choice to receive care from either an in-network provider or an out-of- network provider, but you'll generally pay more if you choose to see an out-of-network provider. In some cases, your plan will refer to network providers as "preferred" providers.

Maximum Allowable Charge (MAC)
The limit the plan has determined to be the maximum amount payable for a covered service.

Out-of-Network
Doctors and other health care providers, hospitals, clinics, laboratories and outpatient facilities that do not have negotiated discounted rates with your plan. You will generally pay more when you receive care from an out-of-network provider because that provider is not bound by contracted pricing. You are responsible for paying the difference between the amount the plan is willing to pay (sometimes called the maximum allowable charge) and the provider's charge.

Out-of-Pocket Maximum
The most you will pay during the plan year for in-network care before your plan begins to pay 100% of eligible expenses. This limit does not include your premium or expenses for services not covered by your plan, nor does it include balance billing, amounts above the Maximum Allowable Charge (MAC) for your plan, or out-of-pocket costs for Davis Vision plan services and products. It's important to check your plan and see what other charges may not be included.

Preferred Provider
A provider who has a contract with your plan to provide services to you at a discount. In some cases, there may be a "preferred network" as a subset of your plan's overall network. In this instance, preferred providers offer additional savings on covered services.

Primary Care Physician (PCP)
A physician who directly provides or coordinates a range of health care services for a patient. You are required to select a primary care physician (PCP) to receive benefits through the HMO plan.

Premium
A health insurance premium is the monthly fee that is paid to an insurance company or health plan to provide health coverage. You and Lehigh both contribute to pay the cost of your premium, with Lehigh paying the majority of the cost.

Prescription Drugs
Medications that by law require a prescription.

Preventive Care
Any covered service or supply that is received in the absence of symptoms or a diagnosed condition. Preventive care includes preventive health services like physical examinations, certain immunizations screening tests, and dental cleanings. 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 etc. 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 **www.healthcare.gov/preventive-care-benefits.**

Specialist
A specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. The Keystone HMO plan requires a referral to see a specialist, while the PPO plans and the HDHP do not require a referral.

Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Frequently Asked Questions

When is Open Enrollment?

For current employees: Open Enrollment begins on November 6th and ends on November 20th. Open Enrollment is your once-a-year chance to make changes to your benefits. You will not be able to make benefit changes until next year's Open Enrollment unless you experience a Qualifying Life Event (QLE) (e.g., you get married or have a baby). You must notify Lehigh Benefits of your QLE within 31 days of the event.

For new hires: You must enroll within 30 days of your first day of work.

What changes can I make during Open Enrollment?

During enrollment you can:

- Change plans
- Add or delete dependents from your coverage
- Change coverage levels
- Enroll in a Health Care or Dependent Care Flexible Spending Account (FSA), and/or elect the Health Savings Account (HSA) if you enroll in the High Deductible Health Plan (HDHP) option for 2018

How do I enroll?

1. Login to "Connect Lehigh" from the upper left corner of the Inside Lehigh home page
2. Select the Employee tab, then "Lehigh Benefits" from the list of applications.
3. Click on the "Click Here to View Your Benefits" button and proceed.

You can also now enroll via the Benefitfocus app.

1. Download the Benefitfocus App via the App Store or the Google Play Store.
2. Sign into the system with the ID "lehighbenefits."
3. Log in using your Lehigh ID and password.

Who is eligible for benefits through Lehigh University?

You are eligible for benefits if you are a full-time (or work at least 75% of a full work schedule), salaried member of Lehigh's faculty or staff employed in a benefits-eligible position.

You can also enroll your eligible dependents, including your spouse/partner, child(ren) up to the end of the month in which they become age 26, and disabled child(ren) without age limitation (coverage and its continuation is subject to required certification with the carrier).

More information is available through Lehigh Benefits or by calling the Benefits Service Center at 1-844-342-4002.

When will my changes become effective?

For current employees: The benefit elections you make during Open Enrollment are effective from January 1, 2018 through December 31, 2018.

For new hires:

- Coverage for faculty members is effective as of their first day of work provided they complete their enrollment in Lehigh Benefits within the first thirty days of employment.
- Coverage for staff members is effective on the first of the month following your start date, provided completed enrollment materials are received within 30 days of your first work day.

What happens if I do not enroll by the deadline?

New Employees: If you miss your enrollment period deadline, you will be assigned Lehigh's default benefit coverage, the PPO plan at an employee cost of $179 per month. No dependents will be enrolled in medical coverage; nor will dental insurance, supplemental or dependent life insurance, or flexible spending accounts be available to you or any dependents.

Current Employees: You will receive the same coverage you had in the prior year, with the exception of any flexible spending account or health savings account employee contributions which must be renewed annually.

How do I know what benefits to select?

You should select your benefits based on the needs of you and your family, as well as your financial situation. Use the tools available on the Lehigh Benefits website to help you make informed decisions about your benefits.

Are there any changes to the medical plans for 2018?

PPO 100 has been replaced with PPO Plus, which includes a 10% coinsurance provision. PPO80, now known as PPO, has a 20% coinsurance after a $200 individual or $600 family deductible and has removed the co-insurance maximum. Review the complete details of this plan within this document and use the Lehigh Benefits modeling tool to compare plans.

Several changes to deductibles, co-pays, coinsurance, and out of pocket maximums are taking place across all of our plans. See the **Your 2018 Medical Options, Summary of Benefits and Coverage and Plan Design Details** sections of this publication for information about the plans available to you.

What is a Health Savings Account (HSA)?

An HSA is a tax-advantaged savings account that you can use like a bank account to pay for qualified medical, dental and vision expenses. You can use the money in your HSA this year or, if you don't use it now, you can save it for use in the future — even in retirement.

To be eligible to contribute money to an HSA, you must be enrolled in a High Deductible Health Plan (HDHP). See the **Health Savings Account (HSA)** section to find more information.

If I need more information regarding Open Enrollment, where can I find support?

See the **Where to Go for Help** section on the next page to find contact information for Lehigh's benefit providers. You may also call the Lehigh Benefits Service Center at 1-844-342-4002.

How do I find a provider?

For all medical plans, visit **https://www.capbluecross.com** and click *Find a Provider*. You must choose your network in order to see the list of all available in-network providers.

- Select *PPO Network* for PPO, PPO Plus, and HDHP
- Select *HMO Network* for Keystone

To find a dental provider, visit **www.ucci.com** and click *Find a Dentist*. You must select Concordia Advantage Plus as your network before seeing all available in-network providers.

To find a vision provider, visit **www.davisvision.com** and click *Find a Provider*.

For all plans other than the Keystone HMO, you have the option to receive care from any provider you choose regardless of whether he or she participates in the plan's network. Keep in mind that you'll typically pay more for care when you use out-of-network providers.

Where to Go for Help

Contact/Provider	Type of Benefit	Telephone Number	Web Address
LehighBenefits/ Benefitfocus	Enroll in your benefits	1-844-342-4002	**Email: LehighBenefits@benefitfocus.com**
Capital Blue Cross and Keystone Health Plan Central Group #00515044	Medical Insurance	800-216-9741	**www.capbluecross.com**
American Well	Telehealth	1-855-818-DOCS	**www.capbluecross.com/telehealth**
Integrated Behavioral Health	Mental Health/ Substance Abuse benefits in Keystone Health Plan and PPO Plus	800-395-1616	**www.ibhcorp.com** To access EAP/Work Life resources: User ID: lehigh Password: univ03
Magellan Health Services	Mental Health/ Substance Abuse benefits in PPO and HDHP	866-322-1657	**www.magellanhealth.com/MBH**
Express Scripts Group #LEHIGHU	Prescriptions Plan	866-383-7420	**www.express-scripts.com** Create an account for full access. Your ID number is your LIN.
Davis Vision Group #LHU	Vision Insurance	877-923-2847 or 800-999-5431	**www.davisvision.com** **Control code: 4100**
United Concordia Group #250021021	Dental	800-332-0366	**www.ucci.com**
WageWorks	Flexible Spending Account Administration	855-774-7441 or 877-924-3967	**www.wageworks.com**
HealthEquity	Health Savings Account Administration	1-866-346-5800	**www.healthequity.com**
Aflac	Voluntary Benefits Administration	1-800-433-3036	**www.aflacgroupinsurance.com**

Legal Notices

Review the following notices which are required by law to help you understand your rights. If you have any questions, please call Lehigh University Human Resources at 610-758-3900.

Women's Health and Cancer Rights Act of 1998 (WHCRA) Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call Lehigh's Human Resources at (610)758-3900.

Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) Notice

Under federal law, group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notices Required By the Patient Protection and Affordable Care Act

Retroactive Cancellation of Coverage (Rescission)

Your medical benefit cannot be cancelled retroactively except in the case of fraud, intentional misrepresentation of material fact, or failure to pay required contributions on a timely basis. A 30 day notice will be provided if coverage is rescinded. An example of fraud or intentional misrepresentation may include things such as retaining your former spouse on your medical benefits after your divorce decree is final. As a University medical plan participant, it is your responsibility to notify Human Resources of any changes to a dependent's status within 31 days of a status change event. Failure to provide timely notice to Human Resources constitutes intentional misrepresentation of material fact.

The Designation of Primary Care Providers

The Keystone Health Plan Central Health Maintenance Organization Plan (KHPC) generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the plan network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of participating primary care providers, contact the plan at 800-216-9741. You do not need prior authorization from KHPC or from any other person (including your primary care doctor) in order to obtain access to obstetrical or gynecological care from a health care professional in the plan network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan at 800-216-9741.

The ACA's individual mandate requires that nearly everyone have medical coverage or pay a penalty. If you are benefits-eligible and enroll in a Lehigh health plan, you will be in compliance with the individual mandate.

- Our health plans offer the level of coverage to satisfy the individual mandate.
- Our health plans offer affordable coverage with at least the minimum benefit value (called "minimum essential coverage") required under the ACA.
- Anyone can shop in the public health insurance marketplace. While some low-income individuals qualify for subsidized coverage, Lehigh employees generally will not qualify because of the cost and benefit value of our health plans.
- If you shop in the health insurance marketplace, you may find the options offered to be more expensive than the University's coverage because Lehigh pays a large part of the cost for your medical coverage. Generally, in the public marketplace, you will pay the entire cost of your coverage.
- For more information about the ACA, visit **www.healthcare.gov**.

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 August 10, 2017. Contact your State for more information on eligibility.

Alabama - Medicaid	**FLORIDA – Medicaid**
Website: **http://myalhipp.com/** Phone: 1-855-692-5447	Website: **http://flmedicaidtplrecovery.com/hipp/** Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: **http://myakhipp.com/** Phone: 1-866-251-4861 Email: **CustomerService@MyAKHIPP.com** Medicaid Eligibility: **http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx**	Website: **http://dch.georgia.gov/medicaid** - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: **http://myarhipp.com/** Phone: 1-855-MyARHIPP (855-692-7447)	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: **http://www.indianamedicaid.com** Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: **https://www.healthfirstcolorado.com/** Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: **http://www.dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp** Phone: 1-888-346-9562

KANSAS – Medicaid	NEVADA – Medicaid
Website: **http://www.kdheks.gov/hcf/** Phone: 1-785-296-3512	Medicaid Website: **http://dwss.nv.gov/** Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: **http://chfs.ky.gov/dms/default.htm** Phone: 1-800-635-2570	Website: **http://www.dhhs.nh.gov/oii/documents/hippapp.pdf** Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: **http://dhh.louisiana.gov/index.cfm/subhome/1/n/331** Phone: 1-888-695-2447	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
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: **http://www.maine.gov/dhhs/ofi/public-assistance/index.html** Phone: 1-800-442-6003 TTY: Maine relay 711	Website: **https://www.health.ny.gov/health_care/medicaid/** Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: **http://www.mass.gov/eohhs/gof/departments/mass-health/** Phone: 1-800-862-4840	Website: **http://www.dma.ncdhhs.gov/** Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: **http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp** Phone: 1-800-657-3739	Website: **http://www.nd.gov/dhs/services/medicalserv/medicaid/** Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm** Phone: 573-751-2005	Website: **http://www.insureoklahoma.org** Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** Phone: 1-800-694-3084	Website: **http://healthcare.oregon.gov/Pages/index.aspx** **http://www.oregonhealthcare.gov/index-es.html** Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: **http://www.ACCESSNebraska.ne.gov** Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha 402-595-1178	Website: **http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm** Phone: 1-800-692-7462

RHODE ISLAND – Medicaid	VIRGINIA – Medicaid and CHIP
Website: **http://www.eohhs.ri.gov/** Phone: 855-697-4347	Medicaid Website: **http://www.coverva.org/programs_premium_assistance.cfm** Medicaid Phone: 1-800-432-5924 CHIP Website: **http://www.coverva.org/programs_premium_assistance.cfm** CHIP Phone: 1-855-242-8282
SOUTH CAROLINA – Medicaid	**WASHINGTON – Medicaid**
Website: **http://www.scdhhs.gov** Phone: 1-888-549-0820	Website: **http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program** Phone: 1-800-562-3022 ext. 15473
SOUTH DAKOTA - Medicaid	**WEST VIRGINIA – Medicaid**
Website: **http://dss.sd.gov** Phone: 1-888-828-0059	Website: **http://mywvhipp.com/** Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
TEXAS – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: **http://gethipptexas.com/** Phone: 1-800-440-0493	Website: **https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf** Phone: 1-800-362-3002
UTAH – Medicaid and CHIP	**WYOMING – Medicaid**
Medicaid Website: **https://medicaid.utah.gov/** CHIP Website: **http://health.utah.gov/chip** Phone: 1-877-543-7669	Website: **https://wyequalitycare.acs-inc.com/** Phone: 307-777-7531
VERMONT– Medicaid	
Website: **http://www.greenmountaincare.org/** Phone: 1-800-250-8427	

To see if any other states have added a premium assistance program since August 10, 2017, 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 12/31/2019)

Creditable Coverage Disclosure Notice

Important Notice from Lehigh University About
Your Prescription Drug Coverage and Medicare
October 6, 2017

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Lehigh University and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Lehigh University has determined that the prescription drug coverage offered by the Express Scripts plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Lehigh University coverage will not be affected. You can retain your existing coverage and choose not to enroll in a Part D plan now. Or, you can enroll in a Part D plan as a supplement to, or in lieu of, the other coverage.

Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current Lehigh University coverage, be aware that you and your dependents will be able to enroll back into the Lehigh University benefit program during the open enrollment period under the plan, providing you are an active, benefits eligible employee at that time.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Lehigh University and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information at 610-758-3900. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Lehigh University changes. You also may request a copy of this notice at any time.

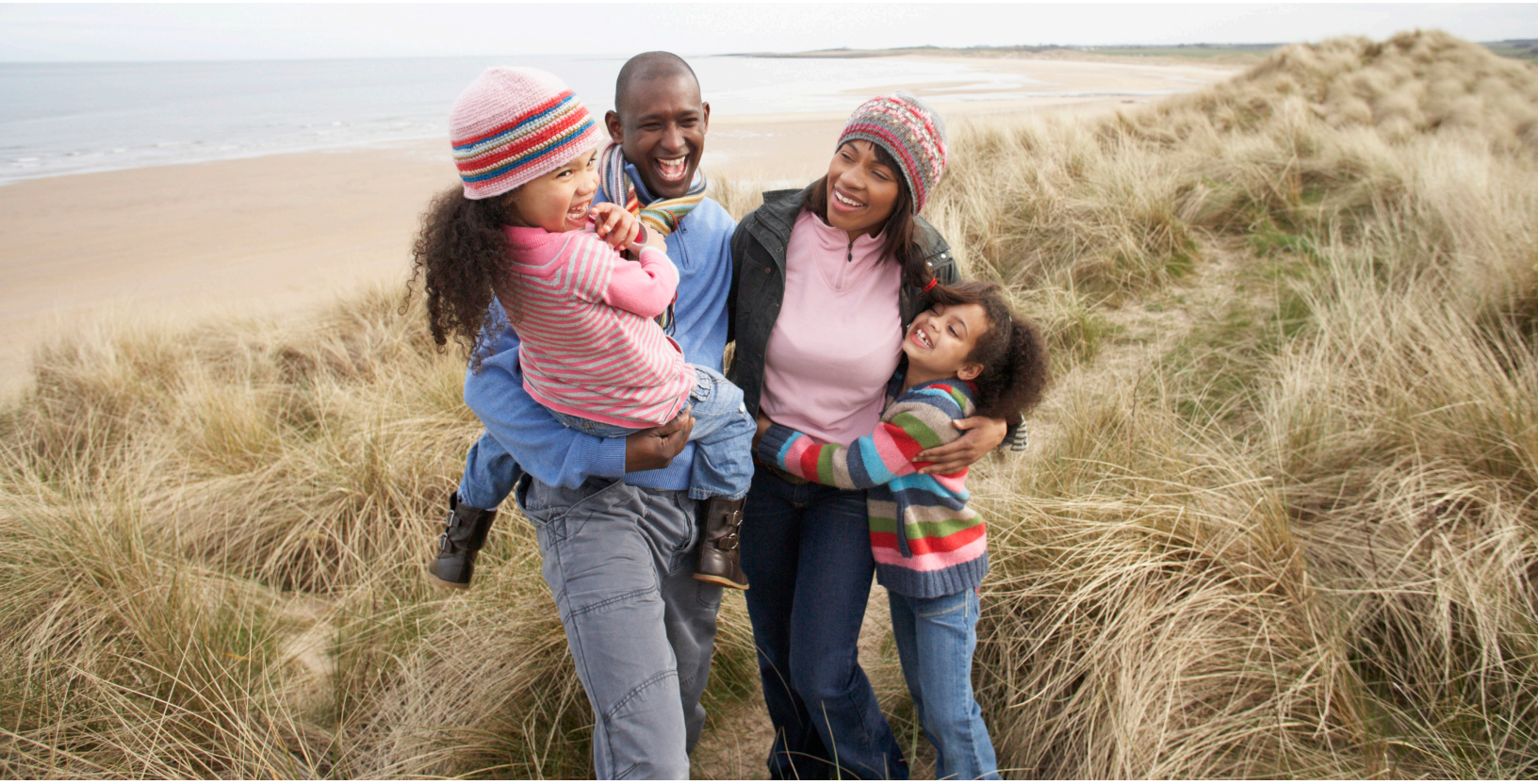
For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 6, 2017
Name of Entity/Sender: Lehigh University
Contact – Position/Office: Director of Human Resource Services
Office of Human Resources
Address: 428 Brodhead Avenue
Bethlehem, PA 18015
Phone Number: 610-758-3900



Lehigh University Benefit Plans Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Lehigh University sponsors the following employee welfare benefit plans (collectively referred to as the "Plans"):

- PPO, administered by Capital Blue Cross,
- PPO Plus, administered by Capital Blue Cross,
- Keystone Health Plan Central HMO, administered by Capital Blue Cross,
- High Deductible Health Plan, administered by Capital Blue Cross,
- Behavioral Health Benefits, administered by Magellan Behavioral Health and Integrated Behavioral Health,
- Employee Assistance Program, administered by Integrated Behavioral Health,
- United Concordia Dental, insured by United Concordia Life and Health Insurance Co.,
- Davis Vision, insured by Highmark Blue Shield,
- Express Scripts Pharmacy Benefits, administered by Express Scripts,
- Health Care Flexible Spending Accounts, administered by WageWorks, and
- Health Savings Account, administered by HealthEquity.

The Plans are required by law to maintain the privacy of your health information and to provide you with notice of their legal duties and privacy practices with respect to your health information. If you have any questions about any part of this Notice or if you want more information about the Plans' privacy practices, please contact:

Director, Human Resource Services
Lehigh University Human Resources
428 Brodhead Avenue
Bethlehem, PA 18015
Phone: 610-758-3900

How the Plans May Use or Disclose Your Health Information

The following categories describe the ways that we (the Lehigh University Benefits Staff) may use and disclose your health information. For each category of uses and disclosures, we will explain what we mean and present examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

1. **Payment Functions.** We may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits. For example, payment functions may include confirmation of eligibility and demographic information to ensure accurate processing of enrollment changes.
2. **Health Care Operations.** We may use and disclose health information about you to carry out necessary insurance-related activities. For example, such activities may include submitting claims for stop-loss coverage; auditing claims payments; and planning, management, and general administration of the benefits plans.
3. **Required by Law.** As required by law, we may use or disclose your health information. For example, we may disclose your health information to a law enforcement official for purposes such as complying with a court order or subpoena and other law enforcement purposes; we may disclose your health information in the course of any administrative or judicial proceeding; or we may disclose your health information for military, national security, and government benefits purposes.
4. **Health Oversight Activities.** We may disclose your health information to health agencies in the course of audits, investigations, or other proceedings related to oversight of the health care system. For example, we will report medical plan enrollment information to the Medicare: Coordination of Benefits IRS/SSA/CMS Data Match Project.
5. **Worker's Compensation.** We may disclose your health information as necessary to comply with worker's compensation or similar laws.

When the Plans May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Policies, we will not use or disclose your health information without written authorization from you. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose health information about you for the reasons covered by your written authorization, though we will be unable to take back any disclosures we have already made with your permission.

Statement of Your Health Information Rights

1. **Right to Request Restrictions.** You have the right to request restrictions on certain uses and disclosures of your health information. The Plans are not required to agree to the restrictions that you request. If you would like to make a request for restrictions, you must submit your request in writing to:

   Director, Human Resource Services
   Lehigh University Human Resources
   428 Brodhead Avenue
   Bethlehem, PA 18015

2. **Right to Request Confidential Communications.** You have the right to receive your health information through a reasonable means or at an alternative location. There are two standard locations used for distribution of plan information. If you are an employee of the University, most information about the plans will be sent to your campus address. On occasion, information may be distributed through the U.S. Postal Service. The standard location for the U.S. Postal Service delivery of plan communications will be your home address, as listed in Lehigh's records. If you are not a current employee of Lehigh University, our standard location for sending plan information to you is your home address, as listed in Lehigh's records. To request an alternative means of receiving confidential communications, you must submit your request in writing to:

   Director, Human Resource Services
   Lehigh University Human Resources
   428 Brodhead Avenue
   Bethlehem, PA 18015

We are not required to agree to your request.

3. **Right to Inspect and Copy.** You have the right to inspect and copy health information about you that may be used to make decisions about your plan benefits. To inspect and copy such information, you must submit your request in writing to:

   Director, Human Resource Services
   Lehigh University Human Resources
   428 Brodhead Avenue
   Bethlehem, PA 18015

If you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request.

4. **Right to Request Amendment.** You have the right to request that the Plans amend your health information that you believe is incorrect or incomplete. We are not required to change your health information and, if your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To request an amendment, you must also provide a reason for your request in writing to:

   Director, Human Resource Services
   Lehigh University Human Resources
   428 Brodhead Avenue
   Bethlehem, PA 18015

5. **Right to Accounting of Disclosures.** You have the right to receive a list or "accounting of disclosures" of your health information made by us, except that we do not have to account for disclosures made for purposes of payment functions or health care operation, or those made to you. To request this accounting, you must submit your request in writing to:

   Director, Human Resource Services
   Lehigh University Human Resources
   428 Brodhead Avenue
   Bethlehem, PA 18015

Your request should specify a time period of up to six years and may not include dates before April 14, 2003. The Plans will provide, on request, one list per 12-month period free of charge; we may charge you for additional lists.

6. **Right to Paper Copy.** 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, 428 Brodhead Avenue, Bethlehem, PA 18015. You may also obtain a copy of this Notice at our website, **https://hr.lehigh.edu/open-enrollment/lehigh-university-benefit-plans-notice-privacy-practices**. 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:

   Director, Human Resource Services
   Lehigh University Human Resources
   428 Brodhead Avenue
   Bethlehem, PA 18015
   Phone: 610-758-3900

Changes to this Notice of Privacy Practices
The Plans reserve the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that it maintains. We will promptly revise our Notice and distribute it to you whenever we make material changes to the Notice. Until such time, the Plans are required by law to comply with the current version of this Notice.

Complaints
Complaints about this Notice of Privacy Practices or about how we handle your health information should be directed to:

Vice President for Finance and Administration
Lehigh University
27 Memorial Drive West
Bethlehem, PA 18015
Phone: 610-758-3178

The Plans will not retaliate against you in any way for filing a complaint. All complaints about the Privacy Practices described in this Notice must be submitted in writing. If you believe your privacy rights have been violated, you may also file a complaint with the Secretary of the Department of Health and Human Services.

Effective Date of This Notice: April 14, 2003; Updated October 26, 2017

Summary of Benefits and Coverage
Appendix 1

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage: about health care coverage, contact Capital Blue Cross at 1-800-216-9741 or www.capbluecross.com; about prescription drug coverage, contact Express Scripts at 1-866-383-7420 or www.express-scripts.com; and about vision coverage, contact Davis Vision at 1-800-999-5431 or www.davisvision.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-888-428-2566 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,350 individual / $2,700 family participating providers; $2,500 individual / $5,000 family non-participating providers. Deductible applies to all services, including prescription drug, before any copayment or coinsurance are applied.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Network preventive services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For participating providers $6,650 individual / $13,300 family; for non-participating providers $0 individual combined out-of-pocket limit for medical and prescription drug.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Pre-authorization penalties, premiums, balance billing charges, vision care costs, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a network provider?	Yes. For a list of participating providers, see www.capbluecross.com or call 1-800-962-2242. See www.davisvision.com or call 1-800-999-5431 for vision care participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

*For more information about preauthorization, see www.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	30% coinsurance	None
	Specialist visit	20% coinsurance	30% coinsurance	None
	Preventive care/screening/ immunization	No charge	Mandated screening and immunizations 30% coinsurance; Routine Physical exams; Not covered	Deductible does not apply to services at participating providers. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance for lab and 20% coinsurance for tests. 20% coinsurance for outpatient radiology.	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com or call 1-866-383-7420.	Generic drugs	10% coinsurance (retail and mail order)	10% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Preferred brand drugs	20% coinsurance (retail and mail order)	20% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Non-preferred brand drugs	30% coinsurance (retail and mail order)	30% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Specialty drugs	20% coinsurance for preferred brand drugs and 30% coinsurance For non-preferred brand drugs	Not covered	Some drugs may require purchase through Accredo Specialty Pharmacy.

*For more information about preauthorization, see www.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	Services at non-participating ambulatory surgical facilities 30% coinsurance.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance	None
	Inpatient services	20% coinsurance	30% coinsurance	None
If you are pregnant	Office visits	20% coinsurance	30% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	90 visit limit *See preauthorization schedule attached to your certificate of coverage.
	Rehabilitation services	20% coinsurance	30% coinsurance	None
	Habilitation services	20% coinsurance	30% coinsurance	None
	Skilled nursing care	20% coinsurance	30% coinsurance	100 day limit
	Durable medical equipment	20% coinsurance	30% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
	Hospice services	20% coinsurance	30% coinsurance	None
If your child needs dental or eye care More information about participating providers and	Children's eye exam	No charge	Full cost less $32	Limited to one exam per year
	Children's glasses	No charge for standard lenses and select frames; Amount over $60 for provider frames	Full cost less $55 for standard lenses and any frame	Limited to one pair of glasses per year

*For more information about preauthorization, see www.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
vision care benefits are available at www.davisvision.com or call 1-800-999-5431.	Children's dental check-up	Not covered	Not covered	None

*For more information about preauthorization, see www.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements.

Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric Surgery (unless medically necessary)
- Cosmetic Surgery
- Dental care
- Hearing aids
- Long-term care
- Routine foot care (unless medically necessary)
- Weight loss programs

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

- Chiropractic Care
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: for health care coverage, contact Capital Blue Cross at 1-800-216-9741 or www.capbluecross.com; for prescription drug coverage, contact Express Scripts at 1-866-383-7420 or www.express-scripts.com; and for vision coverage, contact Davis Vision at 1-800-999-5431 or www.davisvision.com. or the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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

*For more information about preauthorization, see www.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements.

About these Coverage Examples:

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

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

The plan's overall deductible	$1350
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,350
Copayments	$0
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,910

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

The plan's overall deductible	$1350
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,350
Copayments	$0
Coinsurance	$1,370
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$2,780

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

The plan's overall deductible	$1350
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,350
Copayments	$0
Coinsurance	$390
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,740

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage: about health care coverage, contact Capital Blue Cross at 1-800-216-9741 or www.capbluecross.com; about prescription drug coverage, contact Express Scripts at 1-866-383-7420 or www.express-scripts.com; and about vision coverage, contact Davis Vision at 1-800-999-5431 or www.davisvision.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-888-428-2566 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$200/individual/$600/family participating providers; $500/individual non-participating providers.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Network preventive services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For participating providers $3,000 individual / $6,000 family; for non-participating providers $0 individual combined out-of-pocket limit for medical and prescription drug.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Pre-authorization penalties, premiums, balance billing charges, vision care costs, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of participating providers, see www.capbluecross.com or call 1-800-962-2242. See www.davisvision.com or call 1-800-999-5431 for vision care participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment/visit	30% coinsurance	None
	Specialist visit	$40 copayment/visit	30% coinsurance	None
	Preventive care/screening/ immunization	No charge	Mandated screening and immunizations 30% coinsurance; Routine Physical exams; Not covered	Deductible does not apply to services at participating providers. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance for lab and 20% coinsurance for tests. 20% coinsurance for outpatient radiology.	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com or call 1-866-383-7420.	Generic drugs	10% coinsurance (retail and mail order)	10% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Preferred brand drugs	20% coinsurance (retail and mail order)	20% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Non-preferred brand drugs	30% coinsurance (retail and mail order)	30% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Specialty drugs	20% coinsurance for preferred brand drugs and 30% coinsurance For non-preferred brand drugs	Not covered	Some drugs may require purchase through Accredo Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	Services at non-participating ambulatory surgical facilities 30% coinsurance.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% coinsurance	30% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
If you need immediate medical attention	Emergency room care	$100 copayment/visit	$100 copayment/visit	Deductible does not apply. Copayment waived if admitted inpatient.
	Emergency medical transportation	20% coinsurance	30% coinsurance	Deductible does not apply.
	Urgent care	$40 copayment/visit	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copayment/visit	30% coinsurance	None
	Inpatient services	20% coinsurance	30% coinsurance	None
If you are pregnant	Office visits	$40 copayment/visit	30% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	90 visit limit *See preauthorization schedule attached to your certificate of coverage.
	Rehabilitation services	20% coinsurance	30% coinsurance	None
	Habilitation services	20% coinsurance	30% coinsurance	None
	Skilled nursing care	20% coinsurance	30% coinsurance	100 day limit
	Durable medical equipment	20% coinsurance	30% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
	Hospice services	20% coinsurance	30% coinsurance	None
If your child needs dental or eye care -- More information about participating providers and vision care benefits are available at www.davisvision.com or call 1-800-999-5431.	Children's eye exam	No charge	Full cost less $32	Limited to one exam per year
	Children's glasses	No charge for standard lenses and select frames; Amount over $60 for provider frames	Full cost less $55 for standard lenses and any frame	Limited to one pair of glasses per year
	Children's dental check-up	Not covered	Not covered	None

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Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric Surgery (unless medically necessary)
- Cosmetic Surgery
- Dental care
- Hearing aids
- Long-term care
- Routine foot care (unless medically necessary)
- Weight loss programs

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

- Chiropractic Care
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
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If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

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

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About these Coverage Examples:

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

The plan's overall deductible	$200
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$50
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,810

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

The plan's overall deductible	$200
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$280
Coinsurance	$1,160
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,700

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

The plan's overall deductible	$200
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$120
Coinsurance	$330
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$650

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage: about health care coverage, contact Capital Blue Cross at 1-800-216-9741 or www.capbluecross.com; about prescription drug coverage, contact Express Scripts at 1-866-383-7420 or www.express-scripts.com; about mental/behavioral health or substance abuse, contact Integrated Behavioral Health at 1-800-395-1616 or www.ibhcorp.com; and about vision coverage, contact Davis Vision at 1-800-999-5431 or www.davisvision.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-888-428-2566 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0/individual participating providers; $500/individual non-participating providers.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency services or emergency medical transportation, and network preventive services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For participating providers $3,000 individual / $6,000 family; for non-participating providers $0 individual combined out-of-pocket limit for medical and prescription drug.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Pre-authorization penalties, premiums, balance billing charges, vision care costs, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of participating providers, see www.capbluecross.com or call 1-800-962-2242. Call IBH at 1-800-395-1616 for mental/behavioral health or substance abuse	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be

	providers. See www.davisvision.com or call 1-800-999-5431 for vision care participating providers.	aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment/visit	20% coinsurance	None
	Specialist visit	$40 copayment/visit	20% coinsurance	None
	Preventive care/screening/ immunization	No charge	Mandated screening and immunizations 20% coinsurance; Routine Physical exams; Not covered	Deductible does not apply to services at participating providers. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance for lab and 10% coinsurance for tests. 10% coinsurance for outpatient radiology.	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com or call 1-866-383-7420.	Generic drugs	10% coinsurance (retail and mail order)	10% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Preferred brand drugs	20% coinsurance (retail and mail order)	20% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Non-preferred brand drugs	30% coinsurance (retail and mail order)	30% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Specialty drugs	20% coinsurance for preferred brand drugs and 30% coinsurance For non-preferred brand drugs	Not covered	Some drugs may require purchase through Accredo Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	Services at non-participating ambulatory surgical facilities 30% coinsurance.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	10% coinsurance	20% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
If you need immediate medical attention	Emergency room care	$100 copayment/visit	$100 copayment/visit	Copayment waived if admitted inpatient.
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	$40 copayment/visit	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copayment/visit	20% coinsurance	Some services require pre-certification.
	Inpatient services	10% coinsurance	20% coinsurance	Pre-certification required. 50% co-insurance for services provided without pre-authorization.
If you are pregnant	Office visits	$40 copayment/visit	20% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	50 visit limit *See preauthorization schedule attached to your certificate of coverage.
	Rehabilitation services	10% coinsurance	20% coinsurance	30 visit limit
	Habilitation services	10% coinsurance	20% coinsurance	30 visit limit
	Skilled nursing care	10% coinsurance	20% coinsurance	100 day limit
	Durable medical equipment	10% coinsurance	20% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
	Hospice services	10% coinsurance	20% coinsurance	None
If your child needs dental or eye care -- More information about participating providers and vision care benefits are available at www.davisvision.com or call 1-800-999-5431.	Children's eye exam	No charge	Full cost less $32	Limited to one exam per year
	Children's glasses	No charge for standard lenses and select frames; Amount over $60 for provider frames	Full cost less $55 for standard lenses and any frame	Limited to one pair of glasses per year
	Children's dental check-up	Not covered	Not covered	None

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

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- Dental care
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- Long-term care
- Routine foot care (unless medically necessary)
- Weight loss programs

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

- Chiropractic Care
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- Private-duty nursing

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Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: for health care coverage, contact Capital Blue Cross at 1-800-216-9741 or www.capbluecross.com; for prescription drug coverage, contact Express Scripts at 1-866-383-7420 or www.express-scripts.com; for mental/behavioral health or substance abuse, contact Integrated Behavioral Health at 1-800-395-1616 or www.ibhcorp.com; and for vision coverage, contact Davis Vision at 1-800-999-5431 or www.davisvision.com. or the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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

*For more information about preauthorization, see www.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements.

About these Coverage Examples:

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

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

The plan's overall deductible	$0
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$50
Coinsurance	$1,250
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,360

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

The plan's overall deductible	$0
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$280
Coinsurance	$970
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,310

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

The plan's overall deductible	$0
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$120
Coinsurance	$160
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$280

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage: about health care coverage, contact Capital Blue Cross at 1-800-216-9741 or www.capbluecross.com; about prescription drug coverage, contact Express Scripts at 1-866-383-7420 or www.express-scripts.com; about mental/behavioral health or substance abuse, contact Integrated Behavioral Health at 1-800-395-1616 or www.ibhcorp.com; and about vision coverage, contact Davis Vision at 1-800-999-5431 or www.davisvision.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-888-428-2566 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Not applicable.	This plan does not have an overall deductible.
Are there services covered before you meet your deductible?	No.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,000 individual / $6,000 family combined out-of-pocket limit for network medical and prescription drug.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, vision care costs, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of participating providers, see www.capbluecross.com or call 1-800-962-2242. Call IBH at 1-800-395-1616 for mental/behavioral health or substance abuse providers. See www.davisvision.com or call 1-800-999-5431 for vision care participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment/visit	Not covered	Additional $10 copayment/visit required after hours.
	Specialist visit	$40 copayment/visit	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for lab or tests	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	*See preauthorization schedule attached to your certificate of coverage.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com or call 1-866-383-7420.	Generic drugs	10% coinsurance (retail and mail order)	10% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Preferred brand drugs	20% coinsurance (retail and mail order)	20% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Non-preferred brand drugs	30% coinsurance (retail and mail order)	30% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Specialty drugs	20% coinsurance for preferred brand drugs and 30% coinsurance For non-preferred brand drugs	Not covered	Some drugs may require purchase through Accredo Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	*See preauthorization schedule attached to

*For more information about preauthorization, see www.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				your certificate of coverage.
If you need immediate medical attention	Emergency room care	$100 copayment/visit	$100 copayment/visit	Copayment waived if admitted inpatient.
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$40 copayment/visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copayment/service	Not covered	*See preauthorization schedule attached to your certificate of coverage.
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copayment/visit	Not covered	Some services require pre-certification.
	Inpatient services	$200 copayment/service	Not covered	Pre-certification required. 50% co-insurance for services provided without pre-authorization.
If you are pregnant	Office visits	$40 copayment/visit	Not covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	100 visit limit *See preauthorization schedule attached to your certificate of coverage.
	Rehabilitation services	No charge	Not covered	30 visit limit
	Habilitation services	No charge	Not covered	30 visit limit
	Skilled nursing care	No charge	Not covered	60 day limit. Skilled nursing limit combined with acute inpatient rehabilitation limit.
	Durable medical equipment	No charge	Not covered	*See preauthorization schedule attached to your certificate of coverage.
	Hospice services	No charge	Not covered	None
If your child needs dental or eye care -- More information about participating providers and vision care benefits are available at www.davisvision.com	Children's eye exam	No charge	Full cost less $32	Limited to one exam per year
	Children's glasses	No charge for standard lenses and select frames; Amount over $60 for provider frames	Full cost less $55 for standard lenses and any frame	Limited to one pair of glasses per year
	Children's dental check-up	Not covered	Not covered	None

*For more information about preauthorization, see www.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
or call 1-800-999-5431.				

Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric Surgery (unless medically necessary)
- Cosmetic Surgery
- Dental care
- Hearing aids
- Long-term care
- Routine foot care (unless medically necessary)
- Weight loss programs

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

- Chiropractic Care
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: for health care coverage, contact Capital Blue Cross at 1-800-216-9741 or www.capbluecross.com; for prescription drug coverage, contact Express Scripts at 1-866-383-7420 or www.express-scripts.com; for mental/behavioral health or substance abuse, contact Integrated Behavioral Health at 1-800-395-1616 or www.ibhcorp.com; and for vision coverage, contact Davis Vision at 1-800-999-5431 or www.davisvision.com. or the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

*For more information about preauthorization, see www.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements.

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** [insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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

*For more information about preauthorization, see www.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements.

About these Coverage Examples:

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

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

The plan's overall deductible	$0
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$
Copayments	$250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$310

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

The plan's overall deductible	$0
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$280
Coinsurance	$780
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,120

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

The plan's overall deductible	$0
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$120
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$120

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

Plan Design Details
Appendix 2

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Benefit Highlights
PPO HDHP Plan
Lehigh University

THIS IS NOT A CONTRACT. This information highlights *some* of the benefits available through this program and is NOT intended to be a complete list or description of available services. Benefits are subject to the exclusions and limitations contained in your Certificate of Coverage (COC). Refer to your COC for benefit details.

SUMMARY OF COST-SHARING	Amounts *Members* Are Responsible For:	
	Participating Providers	***NonParticipating Providers***
Deductible (per benefit period) *Deductible is waived for PREVENTIVE SERVICES unless otherwise noted.* *Deductible is combined to include medical & prescription drug benefits.*	$1,350 single coverage $2,700 family coverage	$2,500 single coverage $5,000 family coverage
Copayments		
• **Office Visits** (*performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist, or participating Retail Clinic*)	Not Applicable	30% coinsurance
• **Specialist Office Visit**	Not Applicable	30% coinsurance
• **Emergency Room**	Not Applicable	
• **Urgent Care**	Not Applicable	30% coinsurance
• **Inpatient** (Per Admission)	Not Applicable	30% coinsurance
• **Outpatient Surgery Copayment** (facility)	Not Applicable	30% coinsurance
Coinsurance	20% coinsurance	30% coinsurance
Out-of-Pocket Maximum *Includes deductible, coinsurance and copayments for medical & prescription drug benefits.*	$6,650 single coverage $13,300 family coverage	Unlimited

SUMMARY OF BENEFITS	Limits and Maximums	Amounts *Members* Are Responsible For:	
		Participating Providers	***NonParticipating Providers***
PREVENTIVE CARE: *Administered in accordance with Preventive Health Guidelines and PA state mandates*			
Preventive Care Services			
• Pediatric Preventive Care		Covered in full, waive deductible	Not Covered
• Adult Preventive Care		Covered in full, waive deductible	Not Covered
Immunizations		Covered in full, waive deductible	30% coinsurance, waive deductible
Mammograms			
• Screening Mammogram	One per benefit period	Covered in full, waive deductible	30% coinsurance, waive deductible
• Diagnostic Mammogram		20% coinsurance after deductible	30% coinsurance after deductible
Gynecological Services			
• Screening Gynecological Exam & Pap Smear	One per benefit period	Covered in full, waive deductible	30% coinsurance, waive deductible
BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET			
Acute Care Hospital Room & Board		20% coinsurance after deductible	30% coinsurance, waive deductible
Acute Inpatient Rehabilitation	60 days/benefit period	20% coinsurance after deductible	30% coinsurance, waive deductible
Skilled Nursing Facility	100 days/benefit period	20% coinsurance after deductible	30% coinsurance, waive deductible
Surgery			
• Surgical Procedure & Anesthesia		20% coinsurance after deductible	30% coinsurance, waive deductible
Maternity Services and Newborn Care		20% coinsurance after deductible	30% coinsurance, waive deductible
Diagnostic Services			
• Radiology		20% coinsurance after deductible	30% coinsurance, waive deductible
• Laboratory		20% coinsurance after deductible	30% coinsurance, waive deductible
• Medical tests		20% coinsurance after deductible	30% coinsurance, waive deductible
Outpatient Surgery		20% coinsurance after deductible	30% coinsurance, waive deductible
Outpatient Therapy Services			
• Physical Medicine		20% coinsurance after deductible	30% coinsurance, waive deductible
• Occupational Therapy		20% coinsurance after deductible	30% coinsurance, waive deductible
• Speech Therapy		20% coinsurance after deductible	30% coinsurance, waive deductible
• Respiratory Therapy		20% coinsurance after deductible	30% coinsurance, waive deductible
• Manipulation Therapy		20% coinsurance after deductible	30% coinsurance, waive deductible
Emergency Services		20% coinsurance after deductible	
Mental Health Care Services • Inpatient Services		20% coinsurance after deductible	30% coinsurance, waive deductible
• Outpatient Services		20% coinsurance after deductible	30% coinsurance, waive deductible
Substance Abuse Services • Rehabilitation – Inpatient		20% coinsurance after deductible	30% coinsurance, waive deductible
• Rehabilitation – Outpatient		20% coinsurance after deductible	30% coinsurance, waive deductible
Home Health Care Services	90 visits/benefit period	20% coinsurance after deductible	30% coinsurance, waive deductible
Durable Medical Equipment (DME)		20% coinsurance after deductible	30% coinsurance, waive deductible
Prosthetic Appliances		20% coinsurance after deductible	30% coinsurance, waive deductible
Orthotic Devices		20% coinsurance after deductible	30% coinsurance, waive deductible

Benefits are underwritten by Capital Advantage Assurance Company®, a subsidiary of Capital BlueCross. Independent licensee of the BlueCross BlueShield Association. *Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.*

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Benefit Highlights
PPO Plan
Lehigh University

THIS IS NOT A CONTRACT. This information highlights *some* of the benefits available through this program and is NOT intended to be a complete list or description of available services. Benefits are subject to the exclusions and limitations contained in your Certificate of Coverage (COC). Refer to your COC for benefit details.

SUMMARY OF COST-SHARING	Amounts *Members* Are Responsible For:	
	Participating Providers	***NonParticipating Providers***
Deductible (per benefit period)	$200 per member $600 per family	$500 per member
Copayments		
• **Office Visits** (*performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist, or participating Retail Clinic*)	$25 copayment per visit	Coinsurance applies
• **Specialist Office Visit**	$40 copayment per visit	Coinsurance applies
• **Emergency Room**	$100 copayment per visit, waived if admitted	
• **Urgent Care**	$40 copayment per visit	Coinsurance applies
• **Inpatient** (Per Admission)	Coinsurance applies	Coinsurance applies
• **Outpatient Surgery Copayment** (facility)	Coinsurance applies	Coinsurance applies
Coinsurance	20% coinsurance	30% coinsurance
Out-of-Pocket Maximum *(includes Deductible, Copayments and Coinsurance for Medical (including ER,* Including Prescription Drug for Participating Providers only).	$3,000 per member $6,000 per family	Unlimited

SUMMARY OF BENEFITS	Limits and Maximums	Amounts *Members* Are Responsible For:	
		Participating Providers	***NonParticipating Providers***
PREVENTIVE CARE: *Administered in accordance with Preventive Health Guidelines and PA state mandates*			
Preventive Care Services			
• Pediatric Preventive Care		Covered in full, waive deductible	Not covered
• Adult Preventive Care		Covered in full, waive deductible	Not covered
Immunizations		Covered in full, waive deductible	30% coinsurance, waive deductible
Mammograms			
• Screening Mammogram	One per benefit period	Covered in full, waive deductible	30% coinsurance, waive deductible
• Diagnostic Mammogram		20% coinsurance after deductible	30% coinsurance after deductible
Gynecological Services			
• Screening Gynecological Exam & Pap Smear	One per benefit period	Covered in full, waive deductible	30% coinsurance, waive deductible
BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET			
Acute Care Hospital Room & Board		20% coinsurance	30% coinsurance
Acute Inpatient Rehabilitation		20% coinsurance	30% coinsurance
Skilled Nursing Facility	100 days/benefit period	20% coinsurance	30% coinsurance
Surgery			
• Surgical Procedure & Anesthesia		20% coinsurance	30% coinsurance
Maternity Services and Newborn Care		20% coinsurance	30% coinsurance
Diagnostic Services			
• Radiology		20% coinsurance	30% coinsurance
• Laboratory		20% coinsurance	30% coinsurance
• Medical tests		20% coinsurance	30% coinsurance
Outpatient Surgery		20% coinsurance	30% coinsurance
Outpatient Therapy Services			
• Physical Medicine		20% coinsurance	30% coinsurance
• Occupational Therapy		20% coinsurance	30% coinsurance
• Speech Therapy		20% coinsurance	30% coinsurance
• Respiratory Therapy		20% coinsurance	30% coinsurance
• Manipulation Therapy		20% coinsurance	30% coinsurance
Emergency Services		Covered in full, waive deductible Emergency room copayment applies, waived if admitted inpatient	
Mental Health Care Services • Inpatient Services		20% coinsurance	30% coinsurance
• Outpatient Services		$25 copayment per visit	30% coinsurance
Substance Abuse Services • Rehabilitation – Inpatient		20% coinsurance	30% coinsurance
• Rehabilitation – Outpatient		$25 copayment per visit	30% coinsurance
Home Health Care Services	90 visits/benefit period	20% coinsurance	30% coinsurance
Durable Medical Equipment (DME)		20% coinsurance	30% coinsurance
Prosthetic Appliances		20% coinsurance	30% coinsurance
Orthotic Devices		20% coinsurance	30% coinsurance

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Benefit Highlights
PPO Plus Plan
Lehigh University

THIS IS NOT A CONTRACT. This information highlights *some* of the benefits available through this program and is NOT intended to be a complete list or description of available services. Benefits are subject to the exclusions and limitations contained in your Certificate of Coverage (COC). Refer to your COC for benefit details.

SUMMARY OF COST-SHARING	Amounts *Members* Are Responsible For:	
	Participating Providers	***NonParticipating Providers***
Deductible (per benefit period)	Not Applicable	$500 per member
Copayments		
• **Office Visits** (*performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist, or participating Retail Clinic*)	$25 copayment per visit	Coinsurance applies
• **Specialist Office Visit**	$40 copayment per visit	Coinsurance applies
• **Emergency Room**	$100 copayment per visit, waived if admitted	
• **Urgent Care**	$40 copayment per visit	Coinsurance applies
• **Inpatient** (Per Admission)	Coinsurance applies	Coinsurance applies
• **Outpatient Surgery Copayment** (facility)	Coinsurance applies	Coinsurance applies
Coinsurance	10% coinsurance	20% coinsurance
Out-of-Pocket Maximum *(includes Deductible, Copayments and Coinsurance for Medical (including ER,* including Prescription Drug for Participating Providers only).	$3,000 per member $6,000 per family	Unlimited

SUMMARY OF BENEFITS	Limits and Maximums	Amounts *Members* Are Responsible For:	
		Participating Providers	***NonParticipating Providers***
PREVENTIVE CARE: *Administered in accordance with Preventive Health Guidelines and PA state mandates*			
Preventive Care Services			
• Pediatric Preventive Care		Covered in full	Not covered
• Adult Preventive Care		Covered in full	Not covered
Immunizations		Covered in full	20% coinsurance, waive deductible
Mammograms			
• Screening Mammogram	One per benefit period	Covered in full	20% coinsurance, waive deductible
• Diagnostic Mammogram		10% coinsurance	20% coinsurance after deductible
Gynecological Services			
• Screening Gynecological Exam & Pap Smear	One per benefit period	Covered in full	20% coinsurance, waive deductible
BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET			
Acute Care Hospital Room & Board		10% coinsurance	20% coinsurance
Acute Inpatient Rehabilitation	60 days/benefit period	10% coinsurance	20% coinsurance
Skilled Nursing Facility	100 days/benefit period	10% coinsurance	20% coinsurance
Surgery			
• Surgical Procedure & Anesthesia		10% coinsurance	20% coinsurance
Maternity Services and Newborn Care		10% coinsurance	20% coinsurance
Diagnostic Services			
• Radiology		10% coinsurance	20% coinsurance
• Laboratory		10% coinsurance	20% coinsurance
• Medical tests		10% coinsurance	20% coinsurance
Outpatient Surgery		10% coinsurance	20% coinsurance
Outpatient Therapy Services			
• Physical Medicine	30 visits/benefit period/condition	10% coinsurance	20% coinsurance
• Occupational Therapy	30 visits/benefit period	10% coinsurance	20% coinsurance
• Speech Therapy	30 visits/benefit period	10% coinsurance	20% coinsurance
• Respiratory Therapy		10% coinsurance	20% coinsurance
• Manipulation Therapy		10% coinsurance	20% coinsurance
Emergency Services		Covered in full, waive deductible Emergency room copayment applies, waived if admitted inpatient	
Mental Health Care Services • Inpatient Services		COVERAGE PROVIDED UNDER A SEPARATE BEHAVORIAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY	
• Outpatient Services		COVERAGE PROVIDED UNDER A SEPARATE BEHAVORIAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY	
Substance Abuse Services • Rehabilitation – Inpatient		COVERAGE PROVIDED UNDER A SEPARATE BEHAVORIAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY	
• Rehabilitation – Outpatient		COVERAGE PROVIDED UNDER A SEPARATE BEHAVORIAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY	
Home Health Care Services	50 visits/benefit period	10% coinsurance	20% coinsurance
Durable Medical Equipment (DME)		10% coinsurance	20% coinsurance
Prosthetic Appliances		10% coinsurance	20% coinsurance
Orthotic Devices		10% coinsurance	20% coinsurance

Keystone HEALTH PLAN® CENTRAL
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Benefit Highlights
HMO Plan
Lehigh University

THIS IS NOT A CONTRACT. This information highlights ***some*** of the benefits available through this program and is **NOT** intended to be a complete list or complete description of available services. Refer to your Certificate of Coverage for benefit details.

SUMMARY OF COST-SHARING	Amounts *Members* Are Responsible For:
Deductible (per benefit period)	Not Applicable
Copayments	
• **Office Visits - PCP** (*performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist, or participating Retail Clinic*)	$25 copayment per visit
• **Specialist Office Visit**	$40 copayment per visit
• **After Hours Office Visit** (in addition to the PCP office visit copayment)	$10 copayment per visit
• **Emergency Room**	$100 copayment per visit, waived if admitted
• **Urgent Care** – Outside service area	Covered in full, after $40 copayment (PCP or Emergency Room)
• **Urgent Care** – In service area	Covered in full after $40 copayment (additional $10 copayment for after hours visit)
• **Inpatient** (Per Admission)	$200 copayment/admission
• **Outpatient Surgery Copayment** (facility)	Not Applicable
Coinsurance	50% coinsurance, where applicable
Out-of-Pocket Maximum *(includes deductible, copayments and coinsurance for Medical (including ER) Including Prescription Drug for Participating Providers only)*	$3,000 per member $6,000 per family

SUMMARY OF BENEFITS	Limits and Maximums	Amounts *Members* Are Responsible For:
PREVENTIVE CARE: *Administered in accordance with Preventive Health Guidelines and PA state mandates*		
Preventive Care Services		
• Pediatric Preventive Care		Covered in full
• Adult Preventive Care		Covered in full
Immunizations		Covered in full
Mammograms		
• Screening Mammogram	One per benefit period	Covered in full (no referral necessary)
• Diagnostic Mammogram		Covered in full
Gynecological Services		
• Screening Gynecological Exam & Pap Smear	One per benefit period	Covered in full (no referral necessary)
BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET		
Acute Care Hospital Room & Board		$200 copayment/admission
Acute Inpatient Rehabilitation **Skilled Nursing Facility**	60 days/benefit period combined	$200 copayment/admission
Surgery		
• Surgical Procedure & Anesthesia		Covered in full
Maternity Services and Newborn Care		$200 copayment/admission
Diagnostic Services		
• Radiology		Covered in full
• Laboratory		Covered in full
• Medical tests		Covered in full
Outpatient Therapy Services		
• Physical Medicine • Occupational Therapy • Respiratory Therapy • Speech Therapy	30 (visits each type/benefit period)	Covered in full
Emergency Services		Emergency room copayment applies, waived if admitted inpatient
Mental Health Care Services		
• Inpatient Services		COVERAGE PROVIDED UNDER A SEPARATE BEHAVORIAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY
• Outpatient Services		COVERAGE PROVIDED UNDER A SEPARATE BEHAVORIAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY
Substance Abuse Services		
• Rehabilitation – Inpatient		COVERAGE PROVIDED UNDER A SEPARATE BEHAVORIAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY
• Rehabilitation – Outpatient		COVERAGE PROVIDED UNDER A SEPARATE BEHAVORIAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY
Home Health Care Services	100 visits/benefit period	Covered in full
Durable Medical Equipment (DME)		Covered in full
Prosthetic Appliances		Covered in full
Orthotic Devices		Covered in full

Benefits are underwritten by Capital Advantage Assurance Company®, a subsidiary of Capital BlueCross. Independent licensee of the BlueCross BlueShield Association. *Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.*

Capital BLUE

2018 Schedule of Preventive Care Services

This information highlights the preventive care services available under this *coverage* and lists items/services required under the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended. It is reviewed and updated periodically based on the recommendations of the U.S. Preventive Services Task Force (USPSTF); Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, and other applicable laws and regulations. Accordingly, the content of this schedule is subject to change.

Your specific needs for preventive services may vary according to your personal risk factors. It is not intended to be a complete list or complete description of available services. In-network preventive services are provided at no Member Cost-share. Additional diagnostic studies may be covered if *medically necessary* for a particular diagnosis or procedure; if applicable, these diagnostic services may be subject to cost-sharing. Members may refer to the benefit contract for specific information on available *benefits or contact Customer Service at the number listed on their ID card.*

Schedule for Adults: Age 19+

GENERAL HEALTH CARE*		
For Routine History and Physical Examination, including pertinent patient education. Adult counseling and patient education include:		
Women		
• Breast Cancer chemoprevention • Contraceptive methods/counseling[1]	• Folic Acid (childbearing age) • Hormone Replacement Therapy (HRT) – risk vs. benefits	At least annually
Men and Women		
• Aspirin prophylaxis (high risk) • Calcium/vitamin D intake • Drug use • Family Planning • Fall Prevention (age 65 and older)	• Physical Activity • Seat Belt use • Statin Medication (high risk) • Unintentional Injuries	At least annually

SCREENINGS/PROCEDURES*	
Women (Preventive care for pregnant women, see Maternity section.)	
Bone Mineral Density (BMD) test	Testing every 2 years for women age 19-64 at high risk for Osteoporosis. Once every 2 years for women over age 65 and older.
BRCA screening/genetic counseling/testing	Beginning at age 19 for high risk women, including those not previously diagnosed with BRCA-related cancer but who have a history of breast cancer, ovarian cancer or other cancer; reassess screening every 5-10 years or as determined by your health care provider.
Chlamydia and Gonorrhea test	Test all sexually active women from age 19-24 years; women at increased risk at age 25 years and older, as recommended by your health care provider. Suggested testing is every 1-3 years.
Domestic/Interpersonal/Partner Violence screening/counseling	Intervention services available at least annually for women age 19 and older.
HIV Screening/Counseling	Age 19 and older: Preventive education and risk-assessment for infection at least annually. More frequently for high risk women.
Mammogram (2D or 3D)	Beginning at age 40, every 1-2 years.
Pelvic Exam/Pap Smear/HPV DNA	Pelvic Exam/Pap Smear: Age 21-65: every 3 years; HPV DNA: age 30-65, every 5 years.
Men	
Abdominal Duplex Ultrasound	One-time screening for abdominal aortic aneurysm in men age 65-75 who have ever smoked.
Prostate Cancer screening	Every 1-4 years for men 19-49 years of age; Annually for men 50 years of age and older.
Prostate Specific Antigen	Annually for men 50 years of age and older.
Men and Women	
Alcohol misuse screening/counseling	Behavioral counseling interventions for adults age 19 and older who are engaged in risky or hazardous drinking.
CT Colonography[2]	Beginning at age 50, every 5 years
Colonoscopy[3]	Beginning at age 50, every 10 years.
Depression screening	Age 19 and older: annually or as determined by your health care provider.
Diabetes (type 2)/Abnormal Blood Glucose Screening	Test all adults age 40-70 who are overweight or obese; if normal, rescreen every 3 years. If abnormal, offer Intensive Behavioral Therapy (IBT) counseling to promote a healthful diet and physical activity.
Fasting Lipid Profile	Beginning at age 20, every 5 years.
Fecal Occult Blood test (gFOBT/FIT)[4]	Beginning at age 50, annually.
FIT-DNA/Cologuard Test	Beginning at age 50, every 3 years.
Flexible Sigmoidoscopy[3]	Beginning at age 50, every 5 years.
Hepatitis B test	For adults age 19 and older who have not been vaccinated for hepatitis B virus (HBV) infection and other high risk adults; Periodic repeat testing of adults with continued high risk for HBV infection.
Hepatitis C test	Offer one-time testing of adults born between 1945 and 1965. Periodic repeat testing of adults with continued high risk for HCV infection.

High Blood Pressure (HBP)	Every 3-5 years for adults age 19-39 with BP<130/85 who have no other risk factors. Annually for adults age 40 and older, and annually for all adults at increased risk for HBP.
HIV test	Routine one-time testing of adults age 19-65 at unknown risk for HIV infection. Periodic repeat testing (at least annually) of all high risk adults age 19 and older.
Latent Tuberculosis Infection Test	At least one-time testing of adults age 19 and older at high risk. Periodic repeat testing of adults with continued high risk for TB infection.
Low-dose CT Scan for Lung Cancer	Annual testing until smoke-free for 15 years for high risk adults 55-80 years of age.
Obesity	Age 19 and older: every visit (BMI of 30 or greater: Intensive Multicomponent Behavioral Therapy (IBT) counseling available).
Obesity/Overweight + Cardiovascular Risk Factor combination	Age 19 and older: (BMI of 25 or greater: Intensive Behavioral Therapy (IBT) counseling available to promote a healthful diet and physical activity).
STI counseling	Age 19 and older for high risk adults: Moderate and Intensive Behavioral Therapy (IBT) counseling available.
Sun/UV (ultraviolet) Radiation Skin Exposure; Skin Cancer counseling	Age 19-24 with fair skin: Counseling to minimize exposure to UV radiation.
Syphilis test	Test all high risk adults age 19 and older; suggested testing at 1-3 year intervals.
Tobacco use assessment/counseling and cessation interventions	Age 19 and older: 2 cessation attempts per year (each attempt includes a maximum of 4 counseling visits of at least 10 minutes per session); FDA-approved tobacco cessation medications[5]; individualize risk in pregnant women.
IMMUNIZATIONS**	
Hemophilus Influenza type b (Hib)	Age 19 and older Based on individual risk or health care provider recommendation: One or three doses
Hepatitis A (HepA)	Age 19 and older Based on individual risk or health care provider recommendation: Two or three doses
Hepatitis B (HepB)	Age 19 and older Based on individual risk or health care provider recommendation: Three doses
Human Papillomavirus (4vHPV/9vHPV - women)	For women age 19-26: Three doses, if not previously immunized.
Human papillomavirus (4vHPV/9vHPV - men)	For men age 19-21: Three doses, if not previously immunized. Age 22+, as determined by your health care provider.
Influenza[6]	Age 19 and older One dose annually during influenza season.
Measles/Mumps/Rubella (MMR)	Age 19-60: One or two doses, give as necessary based upon risk and past immunization history.
Meningococcal (conjugate) (MenACWY) or (polysaccharide) (MPSV4)	Age 19 and older Based on individual risk or health care provider recommendation: One or more doses
Meningococcal B (MenB)	Age 19 and older Based on individual risk or health care provider recommendation: Two or three doses
Pneumococcal (conjugate) (PCV13)	Age 19-64: One dose (high risk; serial administration with PPSV23 may be indicated). Beginning at 65: One dose (only if PCV13-naive; serial administration with PPSV23 may be indicated)
Pneumococcal (polysaccharide) (PPSV23)	Age 19-64: One or two doses (high risk; serial administration with PCV13 may be indicated). Beginning at 65: One dose at least 1 year after PCV13 (regardless of previous PCV13/PPSV23 immunization; serial administration with PCV13 may be indicated).
Tetanus/diphtheria/pertussis (Td/Tdap)	Age 19 and older Td every 10 years (substitute one dose of Tdap for Td, regardless of interval of last booster).
Varicella (Chickenpox)	Beginning at age 19; two doses, as necessary based upon past immunization or medical history.
Zoster (Shingles)	Beginning at age 50; one dose, regardless of prior zoster episodes.

[1] Coverage is provided without cost-share for all FDA-approved generic contraceptive methods and all FDA-approved contraceptives without a generic equivalent. See the Rx Preventive Coverage List at capbluecross.com for details. Coverage includes clinical services, including patient education and counseling, needed for provision of the contraceptive method. If an individual's provider recommends a particular service or FDA-approved item based on a determination of medical necessity with respect to that individual, the service or item is covered without cost-sharing.

[2] CT Colonography is listed as an alternative to a flexible sigmoidoscopy and colonoscopy, with the same schedule overlap prohibition as found in footnote #3.

[3] Only one endoscopic procedure is covered at a time, without overlap of the recommended schedules.

[4] For guaiac-based testing (gFOBT), six stool samples are obtained (2 samples on each of 3 consecutive stools, while on appropriate diet, collected at home). For immunoassay testing (FIT), specific manufacturer's instructions are followed.

[5] Refer to the most recent Formulary that is listed on the Capital BlueCross web site at [capbluecross.com].

[6] Capital BlueCross has extended coverage of influenza immunization to all individuals with the preventive benefit regardless of risk.

Schedule for Maternity

SCREENINGS/PROCEDURES*

The recommended services listed below are considered preventive care (including prenatal visits) for pregnant women. You may receive the following screenings and procedures at no member cost share:

- Anemia screening (CBC)
- Breastfeeding support/counseling/supplies
- Gestational Diabetes screening
- Hepatitis B screening at the first prenatal visit
- HIV screening
- Low-dose aspirin after 12 weeks of gestation for preeclampsia in high risk women
- Rh blood typing
- Rh antibody testing for Rh-negative women
- Syphilis Test
- Tobacco Use Assessment, Counseling and Cessation Interventions
- Urine culture and sensitivity
- Additional preventive services may be available as determined by your health care provider

* Services that need to be performed more frequently than stated due to specific health needs of the member and that would be considered medically necessary may be eligible for coverage when submitted with the appropriate diagnosis and procedure(s) and are covered under the core medical benefit. If a clinician determines that a patient requires more than one well-woman visit annually to obtain all necessary recommended preventive services, the additional visits will be provided without cost-sharing. Occupational, school and other "administrative" exams are not covered.

** Refer to the guidelines set forth by the Centers for Disease Control and Prevention (CDC) for additional immunization information.

Schedule for Children: Birth through the end of the month Child turns 19

GENERAL HEALTH CARE

Routine History and Physical Examination – Recommended Initial/Interval of Service:
Newborn, 3-5 days, by 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, and 30 months; and 3 years to 19 years [annually].

Exams may include:

- Blood pressure (risk assessment up to 2½ years)
- Body mass index (BMI; beginning at 2 years of age)
- Developmental milestones surveillance (except at time of developmental screening)
- Head circumference (up to 24 months)
- Height/length and weight
- Newborn evaluation (including gonorrhea prophylactic topical eye medication)
- Weight for length (up to 18 months)
- Anticipatory guidance for age-appropriate issues including:
  - Growth and development, breastfeeding/nutrition/support/counseling/supplies, obesity prevention, physical activity and psychosocial/behavioral health
  - Safety, unintentional injuries, firearms, poisoning, media access
  - Contraceptive methods/counseling
  - Tobacco products
  - Oral health risk assessment/dental care/fluoride supplementation (> 6 months)[1]
  - Fluoride varnish painting of primary teeth (to age 5 years)
  - Folic Acid (childbearing age)

	Newborn	9-12 months	1 year	2 years	3 years	4 years	5 years	6 years	7 years	8 years	9 years	10 years	11 years	12 years	13 years	14 years	15 years	16 years	17 years	18 years	19 years
SCREENINGS/PROCEDURES*																					
Alcohol, tobacco and drug use assessment (CRAFFT)													✔	✔	✔	✔	✔	✔	✔	✔	✔
Alcohol misuse screening/ counseling																				✔	✔
Autism screening	At 18 months			✔																	
Chlamydia test	For sexually active females: suggested testing interval is 1-3 years.																				
Depression screening (PHQ-2)														✔	✔	✔	✔	✔	✔	✔	✔
Developmental screening		✔	✔	✔	At 9 months, 18 months and 2½ years																
Domestic/Interpersonal/Intimate Partner Violence	Intervention services available at least annually for adolescents of childbearing age 11 years of age and older.																				
Fasting Lipid Profile	Between 9-11 years (younger if risk is assessed as high) and once between 17-19 years.																				
Gonorrhea test	For sexually active females: suggested testing interval is 1-3 years.																				
Hearing screening/risk assessment	Between 3-5 days through 3 years; repeat at 7and 9																				
Hearing test (objective method)	✔					✔	✔	✔		✔		✔	Once between ages 11-14, 15-17 and 18+								
Hemoglobin and Hematocrit			✔	Assess risk at all other well child visits																	
Hepatitis B test	Beginning at 11 years (children who have not been vaccinated for hepatitis B virus (HBV) infection/other high risk); Periodic repeat testing of children with continued high risk for HBV infection.																				
High blood pressure (HBP)					✔	Beginning at 3 years: at every well-child visit. Confirm HBP by measuring outside office setting utilizing Ambulatory Blood Pressure Monitoring (ABPM) before treating.															
HIV risk assessment													✔	✔	✔	✔					✔
HIV test	Routine one-time testing to occur between ages 15-18 years of age. Periodic repeat testing (at least annually) of all high risk children.																				
Lead screening test/risk assessment	Screening Test: 9-12 months (at risk)[2]; Risk Assessment at 6, 18, 24 months and 3-6 years.																				
Lipid screening/risk assessment				✔		✔		✔		✔				✔	✔	✔	✔	✔	✔		
Newborn blood screen *(as mandated by the PA Department of Health)*	✔																				

	Newborn	9-12 months	1 year	2 years	3 years	4 years	5 years	6 years	7 years	8 years	9 years	10 years	11 years	12 years	13 years	14 years	15 years	16 years	17 years	18 years	19 years
Obesity								✔	Beginning at 6 years: at every well-child visit. Offer/refer to intensive counseling and behavioral interventions.												
STI counseling	Beginning at 11 years (at risk, sexually active): offer Intensive Behavioral Therapy (IBT) counseling												✔								
STI screening													✔	✔	✔	✔	✔	✔	✔	✔	✔
Sun/UV (ultraviolet) radiation skin exposure; skin cancer counseling	Beginning at 10 years with children who have fair skin.											✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Syphilis test	For high risk children; suggested testing interval is 1-3 years.																				
Tobacco smoking screening and cessation	Beginning at age 18: two (2) cessation attempts per year (each attempt includes a maximum of 4 counseling visits); FDA-approved tobacco cessation medications[3]																			✔	✔
Tuberculin test	Assess risk at every well child visit.																				
Vision risk assessment	Up to 2½ years								✔		✔		✔		✔	✔		✔	✔	✔	✔
Vision test (objective method)					✔	✔	✔	✔		✔		✔		✔			✔				
	Optional annual instrument-based testing may be used between 1-5 years of age and between 6-19 years of age in uncooperative children.																				

IMMUNIZATIONS**	
Diphtheria/Tetanus/Pertussis (DTaP)	2 months, 4 months, 6 months, 15–18 months, 4–6 years
Hemophilus influenza type b (Hib)	2 months, 4 months, 6 months, 12–15 months (catch-up through age 5) for specific vaccines and 5–18 years for those at high risk
Hepatitis A (HepA)	12–23 months (2 doses) (catch-up through age 18) and 2–18 years for those at high risk
Hepatitis B (HepB)	Birth, 1–2 months, 6–18 months (catch-up through age 18)
Human papillomavirus (4vHPV/9vHPV)	11–12 years (2 doses) (catch-up through age 18: 2 or 3 doses) and 9–10 years for individuals at high risk or individualization for non high risk
Influenza[4]	6 months–18 years; annually during flu season
Measles/Mumps/Rubella (MMR)	12–15 months, 4-6 years (catch-up through age 18)
Meningococcal (MenACWY-D/MenACWY-CRM)	11–12 years, 16 years (catch-up through age 18); 2 months–18 years for those at high risk
Meningococcal B (MenB)	10–18 years for those at high risk; 16–18 years for individuals not at high risk
Pneumococcal conjugate (PCV13)	2 months, 4 months, 6 months, 12–15 months (catch up through age 5) and 5–18 years for those at high risk
Pneumococcal polysaccharide (PPSV23)	2–18 years (1 or 2 doses)
Polio (IPV)	2 months, 4 months, 6–18 months, 4–6 years (catch-up through age 17)
Rotavirus (RV)	2 months, 4 months or 6 months for specific vaccines
Tetanus/reduced Diphtheria/Pertussis (Tdap)	11–12 years (catch-up through age 18)
Varicella/Chickenpox (VAR)	12–15 months, 4–6 years (catch-up through age 18)

[1] Fluoride supplementation pertains only to children who reside in communities with inadequate water fluoride.
[2] Encourage all PA-CHIP Members to undergo blood lead level testing before age 2 years.
[3] Capital BlueCross providers should refer to the most recent Formulary that is listed on the Capital BlueCross web site at capbluecross.com.
[4] Children aged 6 months to 8 years who are receiving influenza vaccines for the first time should receive 2 separate doses (> 4 weeks apart), both of which are covered.

* Services that need to be performed more frequently than stated due to specific health needs of the member and that would be considered medically necessary may be eligible for coverage when submitted with the appropriate diagnosis and procedure(s) and are covered under the core medical benefit. If a clinician determines that a patient requires more than one well-woman visit annually to obtain all necessary recommended preventive services, the additional visits will be provided without cost-sharing. Occupational, school and other "administrative" exams are not covered.

** Refer to the guidelines set forth by the Centers for Disease Control and Prevention (CDC) for additional immunization information.

This preventive schedule is periodically updated to reflect current recommendations from the U.S. Preventive Services Task Force (USPSTF); Health Resources and Services Administration (HRSA), National Institutes of Health (NIH); NIH Consensus Development Conference Statement, March 27–29, 2000; Advisory Committee on Immunization Practices (ACIP); Centers for Disease Control and Prevention (CDC); American Diabetes Association (ADA); American Cancer Society (ACS); Eighth Joint National Committee (JNC 8); U.S. Food and Drug Administration (FDA), American Academy of Pediatrics (AAP), Women's Preventive Services Initiative (WPSI)

SERVICES REQUIRING PREAUTHORIZATION

Members should present their *identification card* to their health care *provider* when medical services or items are requested. When *members* use a *participating provider* (including a BlueCard facility *participating provider* providing ***inpatient* services**), the *participating provider* will be responsible for obtaining the *preauthorization*. If *members* use a *non-participating provider* or a BlueCard *participating provider* providing ***non-inpatient* services**, the *non-participating provider* or BlueCard *participating provider* may call for *preauthorization* on the *member's* behalf; however, it is ultimately the *member's* responsibility to obtain *preauthorization*. *Providers* and *members* should call *Capital's Utilization* Management Department toll-free at **1-800-471-2242** to obtain the necessary *preauthorization*.

Providers/Members should request Preauthorization of non-urgent admissions and services well in advance of the scheduled date of service (15 days). *Investigational* or experimental procedures are not usually covered benefits. *Members* should consult their *Certificate of Coverage or Contract, Capital BlueCross' Medical Policies,* or contact Customer Service at the number listed on the back of their health plan identification card to confirm *coverage*. *Participating providers* and *members* have full access to *Capital's* medical policies and may request *preauthorization* for experimental or *investigational* services/items if there are unique *member* circumstances.

Capital only pays for services and items that are considered *medically necessary*. *Providers* and *members* can reference *Capital's* medical policies for questions regarding *medical necessity*.

PREAUTHORIZATION OF MEDICAL SERVICES INVOLVING URGENT CARE

If the *member's* request for *preauthorization* involves *urgent care*, the *member* or the *member's provider* should advise *Capital* of the urgent medical circumstances when the *member* or the *member's provider* submits the request to *Capital's* Clinical Management Department. *Capital* will respond to the *member* and the *member's provider* no later than seventy-two (72) hours after *Capital's* Utilization Management Department receives the *preauthorization* request.

PREAUTHORIZATION PENALTY APPLICABILITY

Failure to obtain *preauthorization* for a service could result in a payment reduction or denial for the *provider* and *benefit* reduction or denial for the *member*, based on the *provider's* contract and the *member's* Certificate of Coverage or Contract. Services or items provided without *preauthorization* may also be subject to retrospective *medical necessity* review.

If the *member* presents his/her *ID card* to a *participating provider* in the 21-county area and the *participating provider* fails to obtain or follow *preauthorization* requirements, payment for services will be denied and the provider may not bill the *member*.

When *members* undergo a procedure requiring *preauthorization* and fail to obtain *preauthorization* (when responsible to do so as stated above), *benefits* will be provided for *medically necessary* covered services. However, in this instance, the *allowable amount* may be reduced by the dollar amount or the percentage established in the *Certificate of Coverage* or Contract.

The table that follows is a partial listing of the *preauthorization* requirements for services and procedures.

The attached list provides categories of services for which *preauthorization* is required, as well as specific examples of such services. This list is not all inclusive. For a listing of services currently requiring *preauthorization*, members and providers may consult capbluecross.com.

Category	Details	Comments
Inpatient **Admissions**	• Acute care • Long-term acute care • Non-routine maternity admissions and newborns requiring continued hospitalization after the mother is discharged • Skilled nursing facilities • Rehabilitation hospitals • Behavioral Health (mental health care/ substance abuse)	*Preauthorization* requirements do not apply to services provided by a *hospital* emergency room *provider*. If an *inpatient* admission results from an emergency room visit, notification must occur within two (2) business days of the admission. All such services will be reviewed and must meet *medical necessity* criteria from the first hour of admission. Failure to notify *Capital* of an admission may result in an administrative denial. Non-routine maternity admissions, including preterm labor and maternity complications, require notification within two (2) business days of the date of admission.
Observation Care Admissions	• Notification is required for all observation stays expected to exceed 48 hours. • All observation care must meet medical necessity criteria from the first hour of admission.	Admissions to observation status require notification within two (2) business days. Failure to notify *Capital* of an admission may result in an administrative denial.
Diagnostic Services	• Genetic disorder testing **except**: standard chromosomal tests, such as Down Syndrome, Trisomy, and Fragile X, and state mandated newborn genetic testing. • High tech imaging such as but not limited to: Cardiac nuclear medicine studies including nuclear cardiac stress tests, CT (computerized tomography) scans, MRA (magnetic resonance angiography), MRI (magnetic resonance imaging), PET (positron emission tomography) scans, and SPECT (single proton emission computerized tomography) scans.	Diagnostic services do not require *preauthorization* when emergently performed during an emergency room visit, observation stay, or *inpatient* admission.
Durable Medical Equipment (DME), Prosthetic, Appliances, Orthotic Devices, Implants	Purchases, repairs or rentals for DME regardless of price per unit *(Note: Capital BlueCross may require rental of a device for a designated time prior to purchase*)	*Members* and *providers* may view a listing of services currently requiring *preauthorization* at capbluecross.com.
Office Surgical Procedures When Performed in a Facility*	• Aspiration and/or injection of a joint • Colposcopy • Treatment of warts • Excision of a cyst of the eyelid (chalazion) • Excision of a nail (partial or complete) • Excision of external thrombosed hemorrhoids; • Injection of a ligament or tendon; • Eye injections (intraocular) • Oral Surgery • Pain management (including trigger point injections, stellate ganglion blocks, peripheral nerve blocks, and intercostal nerve blocks) • Proctosigmoidoscopy/flexible Sigmoidoscopy; • Removal of partial or complete bony impacted teeth (if a benefit);	*The items listed are examples of services considered safe to perform in a professional provider's office. Medical necessity review is required when office procedures are performed in a facility setting. Members and providers may view a listing of services currently requiring preauthorization when performed in a facility at* capbluecross.com.

Category	Details	Comments
Office Surgical Procedures When Performed in a Facility* (continued)	• Repair of lacerations, including suturing (2.5 cm or less); • Vasectomy • Wound care and dressings (including outpatient burn care)	
Outpatient Procedures/ Surgery	• Weight loss surgery (Bariatric) • Meniscal transplants, allografts and collagen meniscus implants (knee) • Ovarian and Iliac Vein Embolization • Photodynamic therapy • Radioembolization for primary and metastatic tumors of the liver • Radiofrequency ablation of tumors • Transcatheter aortic valve replacement • Valvuloplasty	The items listed are examples of outpatient procedures that may be reviewed for *medical necessity* and or place of service. *Members* and *providers* may view a listing of services currently requiring *preauthorization* at capbluecross.com.
Therapy Services	• Hyperbaric oxygen therapy (non-emergency) • Manipulation therapy (chiropractic and osteopathic) • Occupational therapy • Physical therapy • Pulmonary rehabilitation programs	*Preauthorization* requirements for manipulation therapy may vary based upon the *provider* of the services. The specific requirements for *preauthorization* of manipulation therapy may be found in the Preauthorization Policy at capbluecross.com.
Transplant Surgeries	Evaluation and services related to transplants	*Preauthorization* will include referral assistance to the Blue Distinction Centers for Transplant network if appropriate.

Reconstructive or Cosmetic Services and Items	• Removal of excess fat tissue (Abdominoplasty/Panniculectomy and other removal of fat tissue such as Suction Assisted Lipectomy)
	• Breast Procedures
	  ◆ Breast Enhancement (Augmentation)
	  ◆ Breast Reduction
	  ◆ Mastectomy (Breast removal or reduction) for Gynecomastia
	  ◆ Breast Lift (Mastopexy)
	  ◆ Removal of Breast implants
	• Correction of protruding ears (Otoplasty)
	• Repair of nasal/septal defects (Rhinoplasty/Septoplasty)
	• Skin related procedures
	  ◆ Acne surgery
	  ◆ Dermabrasion
	  ◆ Hair removal (Electrolysis/Epilation)
	  ◆ Face Lift (Rhytidectomy)
	  ◆ Removal of excess tissue around the eyes (Blepharoplasty/Brow Ptosis Repair)
	  ◆ Mohs Surgery when performed on two separate dates of service by the same provider
	• Treatment of Varicose Veins and Venous Insufficiency	

Medical Injectables		*Members and providers may view a listing of services currently requiring preauthorization at* capbluecross.com.

Category	Details	Comments
Investigational and Experimental procedures, devices, therapies, and pharmaceuticals		*Investigational* or experimental procedures are not usually covered benefits. *Members* and *providers* may request *preauthorization* for experimental or *investigational* services/items if there are unique *member* circumstances.
New to market procedures, devices, therapies, and pharmaceuticals		*Preauthorization* is required during the first two (2) years after a procedure, device, therapy or pharmaceutical enters the market. *Members* and *providers* may view a listing of services currently requiring *preauthorization* at capbluecross.com.
Select Outpatient Behavioral Health Services	• Transcranial Magnetic Stimulation (TMS) • Partial Hospitalization • Intensive Outpatient Programs	
Other Services	• Bio-engineered skin or biological wound care products • Category IDE trials (Investigational Device Exemption) • Clinical trials (including cancer related trials) • Enhanced external counterpulsation (EECP) • Home health care • Home infusion therapy • Eye injections (Intravitreal angiogenesis inhibitors) • Laser treatment of skin lesions • Non-emergency air and ground ambulance transports • Radiofrequency ablation for pain management • Facility based sleep studies for diagnosis and medical Management of obstructive sleep apnea • Enteral feeding supplies and services	
Pain Management	Interventional Pain Management • Joint injections	Members and providers may view a listing of services currently requiring preauthorization at capbluecross.com.
Oncology Services	Radiation therapy and related treatment planning and procedures performed for planning (such as but not limited to IMRT, proton beam, neutron beam, brachytherapy, 3D conform, SRS, SBRT, gamma knife, EBRT, IORT, IGRT, and hyperthermia treatments.)	Members and providers may view a listing of services currently requiring preauthorization at capbluecross.com.
Select Cardiac Services		Members and providers may view a listing of services currently requiring preauthorization at capbluecross.com.

PLEASE NOTE: This listing identifies those services that require *preauthorization* only as of the date it was printed. This listing is subject to change. *Members* should call *Capital* at 1-800-962-2242 (TTY: 711) with questions regarding the *preauthorization* of a particular service.

For HMO and Gatekeeper PPO *members*, all care rendered by *nonparticipating providers* requires *preauthorization*. This includes care that falls under the Continuity of Care provision of the Certificate of Coverage or Contract.

This information highlights the standard Preauthorization Program. *Members* should refer to their *Certificate of Coverage* or Contract for the specific terms, conditions, exclusions and limitations relating to their *coverage*.

Managed Behavioral Health in PPO Plus and Keystone

Benefit Plan Summary for PPO Plus

Service	IBH Network	Non-Network	Pre-Certification
Inpatient Psychiatric Care	**IBH pays 90% of allowable charge**	▪ 80% of IBH allowable after $500 deductible (combined MH, CD, and medical) .	**Required through IBH for both network and non-network** 50% penalty for services provided by non-network providers w/o pre-authorization.
Mental Health (MH)- Outpatient Office Visits –Individual, Family, Group Counseling	**$25 co-pay**	▪ 80% of IBH allowable after $500 deductible (combined MH, CD, and medical) .	**Some services require Pre-Certification.**
Inpatient Chemical Dependence (CD)/Substance Abuse	**IBH pays 90% of allowable charge**	▪ 80% of IBH allowable after $500 deductible (combined MH, CD, and medical) .	**Required through IBH for both network and non-network** 50% penalty for services provided by non-network providers w/o pre-authorization.
Chemical Dependence (CD)/ Substance Abuse - Outpatient Office Visits – Individual, Family, Group Counseling	**$25 co-pay**	▪ 80% of IBH allowable after $500 deductible (combined MH, CD, and medical) .	**Some services require Pre-Certification.**

- **Treatment must be provided by a psychiatrist, psychologist, therapist or clinical social worker who is licensed to practice independently at the master's level or above.**
- **Laboratory work must be prescribed by a psychiatrist.**
- **Treatment must be delivered in a goal-oriented manner that produces observable and measurable improvement in the patient's condition.**

Benefit Plan Summary for Keystone Health Plan

Service	IBH Network	Non-Network	Pre-Certification
Inpatient Psychiatric Care	**100%, after $200 deductible per admission**	No benefit	**Required through IBH**
Mental Health (MH)- Outpatient Office Visits –Individual, Family, Group Counseling	**$25 co-pay**	No benefit	**Some services require Pre-Certification.**
Inpatient Chemical Dependence (CD)/Substance Abuse	**100%, after $200 deductible per admission**	No benefit	**Required through IBH**
Chemical Dependence (CD)/Substance Abuse - Outpatient Office Visits – Individual, Family, Group Counseling	**$25 co-pay**	No benefit	**Some services require Pre-Certification.**

- **Only inpatient services pre-certified by IBH and provided by network providers are covered. There is no benefit for non-network providers or for services not pre-certified.**
- **Treatment must be provided by a psychiatrist, psychologist, therapist or clinical social worker who is licensed to practice independently at the master's level or above.**
- **Laboratory work must be prescribed by a psychiatrist.**
- **Treatment must be delivered in a goal-oriented manner that produces observable and measurable improvement in the patient's condition.**

A Managed Behavioral Health Plan includes mental health and substance abuse treatment benefits. The behavioral health benefit included for this plan is provided by Integrated Behavioral Health (IBH). This plan is compliant with the Mental Health Parity and Equity Act of 2008 (MHPAEA) and Final Rules of 2013.

Plan features include:

- Use of IBH network providers results in lower copays, coinsurance and patient financial responsibility.
- National network of quality providers and facilities selected and credentialed by IBH.
- No need for patient submission of claim forms when IBH network providers are used.
- IBH network providers accept the plan payment as payment in full after the applicable copayment or deductible.
- All mental health services are subject to evidentiary standards of care and medical necessity.
- Some services require prior authorization, call IBH for care coordination.
- If treatment is needed call 800-395-1616 and IBH will provide referrals, case management, care coordination, and benefit questions for your behavioral health plan.

Certain services are still required to be pre-authorized; contact IBH with any questions.

Pre-authorization of all behavioral health services including initial outpatient care with a psychiatrist, psychologist or therapist is highly recommended. Pre-authorization of behavioral health services will insure medical necessity criteria are met and retrospective review will be limited. All care is subject to eligibility, plan definitions, limitations, exclusions, and are payable when determined by IBH as medically necessary and appropriate.

Inpatient and Program based Mental Health Benefits:

To find an in-network facility, contact Integrated Behavioral Health at 800-395-1616. The benefit may allow you to choose services through an out-of-network facility, but you may have to pay a larger portion of the costs, and subject to prior authorization and concurrent review.

Pre-authorization is required for all inpatient, partial hospitalization, residential, and any program based care. You or your provider may call an IBH care manager at 800-395-1616 to obtain preauthorization prior to starting any intensive treatment program.

Outpatient Mental Health Benefits:

All outpatient care falling within outlier categories, requires the provider to submit documentation for review of medical necessity, evidentiary based treatment, and appropriateness of care.

The following outpatient evaluations or treatments require authorization before commencing:

- Psychological testing
- Group therapy

- Outpatient Electroconvulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Or any service determined as an outlier.

The benefit may allow you to choose services through either an IBH network provider or a non-network provider. Non-network providers must be independently licensed and still must follow plan requirements of submitting documentation of evidentiary standards and medically necessary care. Call IBH to determine if a non-network provider is eligible for coverage under your plan.

While there are no treatment visit or hospital day limits in the benefit plan, all claims for treatment (including those delivered before any pre-authorization) are subject to review for medical necessity and appropriateness of care by IBH.

All claims are subject to benefit eligibility as well as plan exclusions and limitations at time of service.

Services Not Included in the Managed Behavioral Health Plan in PPO Plus or Keystone HMO:

1. Services performed by the patient on him/herself or performed by immediate family, or an individual residing in the same household, including but not limited to a spouse, child, brother, sister, parent, or the spouse's parent, even if that individual is a qualified provider.
2. Services provided by someone not licensed by the state to treat the condition for which the claim is made and to independently bill fee for service and/or not trained or experienced to treat a specific condition under review.
3. Extended hospital, residential or program related stays that are unrelated to medically necessary and approved treatment.
4. Services furnished by or for the U.S. government, Federal and state funded agency or foreign government, unless payment is legally required.
5. Treatment that is of an experimental or educational nature. Procedures which are experimental, investigational, or unproven. Therapies and technologies whose long-term efficacy or effect is undetermined, or whose efficacy is no greater than that of traditionally accepted standard treatment.
6. Services applied under any government or publicly funded program or law under which the individual is covered.
7. Services for which a third-party is liable.
8. New procedures, services, and medication until they are reviewed for safety and efficacy, through accepted evidentiary review.
9. Services that are primarily to assess or address neurodevelopmental disorders are to be considered as medical conditions and as such not covered under the mental health benefits. With the exception of Attention Deficit/ Hyperactivity disorder, and Tic disorders which are covered by the mental health portion of the plan.
10. Custodial care or supportive counseling, including care for conditions not typically resolved by treatment.
11. Alternative treatment methods that do not meet national standards for behavioral

health practice, including but not limited to: regressive therapy, aversion therapy, neurofeedback or neuro-biofeedback, hypnotherapy, acupuncture, acupressure, aromatherapy, massage therapy, reiki, thought-field energy, art or dance therapy.

12. Services not medically necessary. All services must be medically necessary. The fact that a physician or other provider may prescribe, order, recommended, or approve a service or supply does not, in itself, make it medically necessary, even though it is not specifically listed as an exclusion or limitation.

13. Court-ordered treatment. If a participant is currently in a course of treatment that is confirmed as being required by a court, the treatment may be considered only as long as it is medically necessary.

14. Psychological or neuropsychological testing, unless specifically pre-certified by IBH.

15. Inpatient treatment for co-dependency, gambling and sexual addiction.

16. Treatment primarily for chronic pain management or neuropsychological rehabilitation.

17. Treatment primarily for the convenience of the patient or provider.

18. Treatment provided primarily for medical or other research.

19. Charges for services, supplies or treatments which are primarily educational in nature; charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.

20. Charges primarily for marriage, career, or legal counseling, mediation, or custody related services.

21. Treatment of sexual dysfunction not related to organic disease. Sex therapy.

22. Services provided if covered individual would not legally have to pay for them if the covered individual were not covered by the Plan or any other medical plan, to the extent that exclusion of charges for such services is not prohibited by law or regulation.

23. Evaluation or services not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.

24. Charges for obtaining medical records or completing a treatment report, and late payment charges.

25. Methadone maintenance.

26. Speech and language evaluations or speech therapy.

27. Charges for failure to keep a scheduled visit, charges for completion of a claim form.

28. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance.

30. Expenses for pastoral counseling, marriage therapy, music or art therapy, assertiveness training, social skills training, recreational therapy, stress management, or other supportive therapies.

31. Long-term treatment at a residential treatment facility, or long term rehabilitation therapy.

32. Smoking cessation programs not covered under the medical plan.

33. Therapeutic foster care, group home, halfway or three-quarter houses, residential/therapeutic schools, camps.

34. Any treatment or condition excluded by the medical Plan.

How Managed Behavioral Health Plan Claims Are Paid:

Network services require no claim forms. IBH will pay your provider directly. You are responsible for paying coinsurance, copay, or deductible that may apply.

If you use a nono network provider, either you or the provider must submit a claim form and you are responsible for paying the balance of the provider's outpatient or inpatient mental health or substance abuse charges, after the IBH payment of the nono network benefit based on the IBH allowable rate. The IBH allowable rate is the rate for the IBH fee schedule for specific network services. Remember if you use nono network providers, your financial responsibility, the amount you pay, for nono network mental health or substance abuse care is higher and is based on the IBH allowable rate. Claims may be mailed to:

Integrated Behavioral Health
Claims Department
P.O. 30018
Laguna Niguel, CA 92607-0018

How to File a Managed Behavioral Health Plan Appeal:

For purposes of the appeal procedure, a mental health or substance abuse claim appeal includes any request for benefits or authorization that is denied either in part or in whole. You or your provider may appeal a claim or other adverse benefit decision directly to IBH. The appeal must be submitted to:

Integrated Behavioral Health
Quality Management—Appeals
P.O. Box 30018
Laguna Niguel, CA 92607-0018

Appeals Process:

Policy: Integrated Behavioral Health shall offer an appeals process for both members and providers. Such policy shall include reasonable efforts to resolve concerns and disagreements prior to a formal appeal process through collegial and non-adversarial means. The appeals process is consistent with ERISA guidelines.

Procedures: IBH provides an appeal process for members, providers and employers/health plans hereinafter referred to as claimant. This appeal process is available for any adverse benefit decision and/or when disagreements occur regarding decisions or potential decisions about authorizations for proposed treatment, claims payments, or treatment reviews. When such adverse benefit decisions or disagreements occur, the member, provider or employer/health plan may request reconsideration by phone or mail. A Senior Care Manager or supervisor

responds to this Request for Reconsideration immediately. The response is communicated by phone and mail. Facsimile is used when issues are urgent.

Should this reconsideration process fail to satisfy the issue, the claimant may submit a formal appeal for review. This Level 1 Appeal may be a written request or telephonic. It is responded to within the timeframes outlined below for the particular type of claim. A clinical person, with appropriate expertise, and other than the care manager who effected the denial must conduct the appeal review. Such clinician may not be supervised by the initial reviewer. The response is communicated by phone and mail. Facsimile is used when issues are urgent.

External Review Option: If the appealing party continues to be dissatisfied, a second level appeal can be requested in writing or telephonically and is conducted by an external clinical person with appropriate expertise. This decision is also provided within the timeframes outlined below for the particular type of claim. The providers and members are informed by mail or facsimile, depending on the urgency.

All protected health information shall be managed within HIPAA regulations and within other federal law and regulations specific to confidentiality of behavioral health medical data.

Timeframes:

Expedited/Urgent Care Claims

Initial Claim Response Timeframe:	48 Hours
Request Missing Info from Claimant:	24 Hours
Claimant to Provide Missing Info:	48 Hours
Claimant to Request Appeal:	180 days
Appeal Response Timeframe:	72 Hours

Pre-Service Health Care Claims

Initial Claim Response Timeframe:	15 Days
Extension (Proper Notice/Delay Beyond Plan Control):	15 Days
Request Missing Info from Claimant:	5 Days
Claimant to Provide Missing Info:	50 Days
Claimant to Request Appeal:	180 Days
Appeal Response Timeframe:	30 Days

Post-Service Health Care Claim

Initial Claim Response Timeframe:	30 Days
Extension (Proper Notice/Delay Beyond Plan Control):	15 Days
Request Missing Info from Claimant:	30 Days
Claimant to Provide Missing Info:	50 Days
Claimant to Request Appeal:	180 Days

Appeal Response Timeframe: 60 Days

Additional Claimant Rights:

The claimant is entitled to receive, free of charge, and have access to all relevant documents and information relied upon in making the claim determination.

Once you have completed all mandatory appeals, you and your plan may have other voluntary alternative dispute resolution options. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Under ERISA Section 502(a)(I)(B), you have the right to bring a civil action. This right can be exercised when all required reviews of your claims, including the appeal process, have been completed, your claim was not approved, in whole or in part, and you disagree with the outcome.

The above-described Appeal Process is subject to all applicable State and Federal laws and regulations.