

## Flex Benefits Updates for 2017

This is your annual Flex Benefits Open Enrollment quick-reference guide. It contains information and links you should review to select your flexible benefits for the 2017 benefit plan year, which runs from January 1 to December 31, 2017. This year, the online Open Enrollment process runs November 7 through 28, 2016. Your benefits choices take effect January 1, 2017. For complete information, consult the the 2017 Flexible Benefits Enrollment and Reference Guide on the Benefitfocus portal.

### WHAT'S NEW?

2017 is Year One of a multi-year plan to revise Lehigh's healthcare coverage. Here's what's on tap:

#### Plan Changes

- Dental coverage premiums are increasing.
- The Comprehensive Major Medical insurance plan has been eliminated.
- A new High Deductible Health Plan with Health Savings Account joins the PPOs and Keystone HMO as the fourth plan option for staff and faculty. See page 8 to learn more.
- Gender confirmation surgery is now covered under all four plans.
- New voluntary critical illness and accident insurance products are being introduced. See page 8 for more information.
- Total Out of Pocket Maximums have been reduced and will be managed as a single maximum, including healthcare and pharmacy.

#### Claims Processing and Enrollment Changes

**This year, Open Enrollment is mandatory for all benefits eligible employees.**

- Flexible Spending and Health Savings Account holders will now be able to use a special debit card to pay for services.
- Benefitfocus is our new enrollment system and benefits service center. This portal replaces Banner in the enrollment process and offers features like a tool to help you make the best medical insurance choice for you and your family. It will also meet your year-round benefits service needs. You can access information about all of your benefits both on the web and via a call center. The call center can be reached at 844-342-4002 and is available Monday through Friday from 8:00 a.m. to 8:00 p.m. eastern time.

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# Medical Plan Benefit Comparison Chart

Plan Structure	High Deductible Health Plan (HDHP)		Preferred Provider Organization 80 (PPO 80)		Preferred Provider Organization 100 (PPO 100)		Keystone Health Plan Health Maintenance Organization (HMO)
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	
Network	National		National		National		Local
Deductible [D]	\$1300/person \$2600/family	\$2500/person \$5000/family	\$200/person \$600/family	\$500/person		\$500/person	
Coinsurance [CI] (After deductible is met)	20%	30%	20% up to \$800/person \$2400/family	30%		20%	
Annual deductible, copayment and coinsurance limits	\$6550/person \$13100/family	Unlimited	\$1000/person \$3000/family	Unlimited		Unlimited	
Annual Out of Pocket Maximum: medical and pharmacy combined	\$6550/person \$13100/family	No Maximum	\$6550/person \$13100/family	No Maximum	\$6550/person \$13100/family	No Maximum	\$6550/person \$13100/family
Copayment [CP]			\$20/doctor visit		\$20/doctor visit		\$20/doctor visit
Preventive Care [L]	No Cost	Mandated care: 30% coinsurance All other: no benefit	No Cost		No Cost		No Cost
Doctor's Office Visit	D/CI	D/CI	CP	D/CI	CP	D/CI	CP
Inpatient Hospital	D/CI [P]	D/CI	D/CI [P]	D/CI [P]	No Cost [P]	D/CI [P]	No Cost [P]
Outpatient Hospital	D/CI [P]	D/CI [P]	D/CI [P]	D/CI [P]	No Cost [P]	D/CI [P]	No Cost [P]
Surgical Charges, Tests, Procedures	D/CI [P]	D/CI [P]	D/CI [P]	D/CI [P]	No Cost [P]	D/CI [P]	No Cost [P]
Mental Health/ Substance Abuse Outpatient [P]	D/CI [A] [P]	D/CI [A] [P]	CP [A] [P]	D/CI [A] [P]	CP [M] [P]	D/CI [M] [P]	CP [M] [P]
Mental Health/ Substance Abuse Inpatient [P]	D/CI [A] [P]	D/CI [A] [P]	D/CI [A] [P]	D/CI [A] [P]	No Cost [M] [P]	D/CI [M] [P]	No Cost [M] [P]
Prescription Drugs	Administered by Express Scripts: 10% Generic; 20% Brand. More information on page 4. [G]						
Vision Care	Davis Vision Program. More information on page 4.						

[A] Preauthorization required from Magellan Behavioral Health, Contact Magellan directly to coordinate services.  
 [CI] Coinsurance: Portion of a covered charge paid by both the insured and the plan.  
 [CP] Copayment: Flat dollar amount paid to provider by the insured for a covered service or supply at the time service or supply is received.  
 [D] Deductible: Total amount of covered charges the insured must pay in full during plan year before any payment is made by plan. **HDHP SPECIAL NOTE:** It's important to note that if you cover any dependents with this plan, the family deductible must be met before your coverage begins paying benefits for anyone in the family.  
 [G] \$25 generic prescription maximum per prescription, per month; \$50 brand prescription maximum per prescription, per month.  
 [L] With limitations defined by the plan or provided in the Affordable Care Act (see <https://www.healthcare.gov/preventive-care-benefits/>).  
 [M] Managed by Integrated Behavior Health (IBH). Contact IBH directly to coordinate services.  
 [P] Preauthorization required: 50 percent coinsurance out-of-network in HDHP, PP080 and PPO 100; failure to preauthorize with KHP results in no benefit.

# Understanding Medical Coverage Plan Language

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

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

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

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

**Copayment [CP]:** A flat dollar amount paid to the provider by the insured for a covered service or supply at the time it is received. An example would be paying the physician \$20 at the time of an office visit. Copayments do not affect the deductible and coinsurance maximum but do contribute to the out-of-pocket maximum that includes applicable physician copayments.

**Covered Charge:** An allowed charge for service that the plan is designed to accept and for which the plan will pay, if all other conditions (like deductibles and coinsurance)

have been met. Charges that are not covered (like Balance Billing) do not affect deductibles, coinsurance, or out-of-pocket maximums.

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

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

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

## 2017 Monthly Medical Insurance Prices

	University Contribution	Employee Premiums			
		HDHP Plan	PPO 80	PPO 100	HMO
Individual	\$511	\$28	\$190	\$242	\$92
Employee + Spouse/Partner	\$1,058	\$107	\$471	\$584	\$257
Employee + Child(ren)	\$962	\$91	\$419	\$521	\$226
Employee + Family	\$1,525	\$158	\$684	\$847	\$374

# Vision and Prescription Drug Plan Information

Davis Vision Program		
Service/Product	Your In-Network Cost	Out-of-Network Reimbursement to You
Eye Exam	\$0	\$32
Eyeglass Lenses		
Standard Single vision	\$0	\$25
Bifocal	\$0	\$36
Trifocal	\$0	\$46
Post Cataract	\$0	\$72
Non-standard (i.e. no line bifocals, tints, coatings)	Fixed Costs	No Additional Benefit
Frames		
Frames	\$0 for Davis fashion selection frames. Amount over \$110 for non-Davis frames at Visionworks; amount over \$60 at all other providers.	\$30
Contact Lenses		
Prescription and Fitting	\$0	Daily Wear: \$20 Extended Wear: \$30
Standard Contact Lenses	\$0	\$48
Specialty Contact Lenses	Amount over \$75	\$75
<p>1-877-923-2847 (prior to initial enrollment)                      1-800-999-5431 (once enrolled) or <a href="http://www.davisvision.com">www.davisvision.com</a></p>		

## Express Scripts Preferred Drug Step Therapy Program

Lehigh's prescription drug program is based on a two-tiered formulary that determines the amount of coverage you will receive for your drugs. Those tiers are Generic and Name Brand medications. There are, however, twelve classes of medications in which there are preferred and non-preferred drugs:

- PPIs (proton pump inhibitors): used to reduce stomach acid
- SSRIs (selective serotonin re-uptake inhibitors): used to treat depression, anxiety, and some personality disorders
- Osteoporosis: used to strengthen fragile bones
- ARBs (angiotension II receptor blockers): used to reduce blood pressure
- INS (intranasal steroids): used to treat nasal allergies
- Hypnotics (insomnia medications): used to treat sleep disorders
- Triptans: used to treat migraines
- Glaucoma: used to treat increased pressure in the fluid inside the eye.
- Combination Beta2 Agonists/corticosteroids inhalers: used to treat asthma
- Estrogen Replacement Therapy: used to treat menopausal symptoms and potential calcium deficiency
- Insulin: used to control diabetes.

When you are prescribed a drug in one of these twelve classes, Express Scripts will use its Preferred Drug Step Therapy Program (PDST) to determine coverage. In general, Express Scripts considers all ingredients in the medications in each class to be equivalent. Preferred drugs are then selected based on their cost.

## Coordination of Benefits

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

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

# Concordia Flex Dental Benefit Summary

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

Semi-annual cleaning, polishing and examination  
 Annual bitewing X-rays  
 Complete X-ray series (every five years)  
 Fluoride treatment (under age 19)  
 Sealant: One sealant per tooth in three-year period for members under age 16  
 Emergency treatment: Palliative (to alleviate pain), not restorative

**Basic Service Benefits - Paid at 80% of MAC\***

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

**Major Service Benefits - Paid at 50% of MAC\***

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

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

Orthodontic lifetime benefit maximum of \$1,000 per person

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

## The Preventive Incentive

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

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

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

### 2017 Monthly Dental Prices

#### United Concordia Dental

Employee Only	\$33.27
Employee + One	\$66.54
Employee + Two or More	\$86.04

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

## A Note About International Travel

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

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

If you plan to travel outside the US, you can find information about the program and its services - including the process for locating a doctor or hospital - by calling 1-800-810-BLUE. Outside the US call collect at 1-804-673-1177.

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

# Need Help?

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

Provider	Phone	Web Address
AFLAC	800-433-3036	<a href="http://www.aflacgroupinsuranc.com">www.aflacgroupinsuranc.com</a>
American Well Telehealth	855-818-DOCS	<a href="http://www.capbluecross.com/telehealth">www.capbluecross.com/telehealth</a>
Benefitfocus	844-342-4002	<a href="#">Log In Via Connect Lehigh</a>
Capital BlueCross and Keystone Health Plan	800-216-9741	<a href="http://www.capbluecross.com">www.capbluecross.com</a>
Health Equity (HSA administration)	866-346-5800	<a href="http://www.healthequity.com">www.healthequity.com</a>
Integrated Behavioral Health (mental health/substance abuse benefits in Keystone Health Plan and PPO100)	800-395-1616	<a href="http://www.ibhcorp.com">www.ibhcorp.com</a> To access EAP/WorkLife: user id: lehigh password: univ03
Magellan (mental health/substance abuse benefits in HDHP and PPO80)	866-322-1657	<a href="http://www.magellanhealth.com">www.magellanhealth.com</a>
Express Scripts	866-383-7420	<a href="http://www.express-scripts.com">www.express-scripts.com</a>
Davis Vision	877-923-2847 or 800-999-5431	<a href="http://www.davisvision.com">www.davisvision.com</a> control code: 4100
United Concordia Dental	800-332-0366	<a href="http://www.ucci.com">www.ucci.com</a>

## Campus Visits By Insurance Vendors

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

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

Monday, November 14  
and  
Tuesday, November 15

11:30 a.m. to 1:30 p.m.

University Center (Faculty Lounge)  
and  
Iacocca Hall (Wood Dining Room Foyer)

## Notice of Privacy Practices

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

Lehigh University Human Resources  
428 Brodhead Avenue  
Bethlehem, PA 18015

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

# Frequently Asked Questions

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**Q: What is the last date to file Capital BlueCross claims for the HDHP, PPO80 or PPO100 medical plans?**

A: Claims must be filed within twelve (12) months of the date of service for any of the Capital BlueCross medical plans.

**Q: How often may I change from one health insurance plan to another within our medical plans?**

A: The only time you can change to another carrier is during the annual open enrollment period, held this year from November 7 - 28. If you are dissatisfied with your current coverage, please contact Human Resources. It is important to tell us about any problems you encounter.

**Q: I am getting married soon. Can I add my new spouse and/or stepchild(ren) to my coverage or do I have to wait until there is an open enrollment period?**

A: You have thirty one (31) days from the date of your marriage to add your spouse and/or stepchild(ren) to your health and/or dental coverage, purchase dependent life insurance, and/or increase your supplemental life insurance. After thirty one days, you must wait for the next open enrollment period. If your spouse has access to health insurance through his or her employer, keep the spousal surcharge in mind when considering adding him or her to your medical plan. See the full Flexible Benefits Enrollment and Reference Guide online on the **Benefitfocus Benefits Portal**. To enroll your new spouse and stepchild(ren) go to the Qualifying Life Events section of the Benefitfocus Portal. There, you will request the change and upload the required documentation.

**Q: I am expecting a baby/adopting a child soon. Can I add my new child to my coverage?**

A: You have thirty one (31) days from the date of birth or adoption placement to add a child (under age 26) to your medical and/or dental coverage. To enroll your new child, go to the Qualifying Life Events section of the Benefitfocus Portal. There, you will request the change to your benefits and upload the required documentation.

**Q: My child just turned age 26 and has no health insurance plan. Can he or she stay on my medical plan?**

A: No. Your dependent or adult children can only remain covered under a university medical, dental, life insurance, or FSA program until the end of the month in which they reach age 26. He or she will be offered COBRA continuation medical and dental coverage at that time. He or she can also visit [www.healthcare.gov](http://www.healthcare.gov) to see options for purchasing individual medical insurance. If your child is disabled, special rules may apply. Please contact HR for more information.

**Q: I am helping my 25-year old pay for major dental work. Can I be reimbursed through my Flexible Spending Account (FSA)?**

A: Yes. As a result of The Affordable Care Act, qualifying medical expenses incurred by your adult child (under 26 years old) are eligible for reimbursement through your FSA. The same documentation requirements apply.

**Q: What is the difference between “pre-tax” and “post-tax” long-term disability (LTD) plans?**

A: If you purchase LTD coverage on a **pre-tax** basis, this means you pay federal income tax on the benefit if you become disabled, but you pay no federal income tax on the premium. If you choose the **post-tax** option, you pay federal income tax on the premium, but no federal income tax on the benefit (the income you would receive if you became disabled). Please note that it is necessary to pay the premium on a post-tax basis for a period of at least 36 months before the benefit is 100% free of federal taxation. If you have paid the premium on a post-tax basis for less than 36 months, you will receive pro-rated tax savings.

**Q: I enrolled my non-working spouse/partner on my insurance plan. How do I avoid being charged the Spouse/Partner Surcharge?**

A: The Spouse/Partner Surcharge of \$100 per month is assessed when an employee’s spouse/partner has access to medical insurance via an employer or former employer but still chooses to be enrolled in Lehigh’s plan. If your spouse/partner does not have such access, you must complete the online Spouse/Partner Surcharge Waiver Request form to avoid being charged. If you do not complete the spousal surcharge waiver request prior to November 28, 2016, you will be charged the surcharge starting in January 2017. You will continue to be charged \$100 monthly if you do not submit the waiver request. Please note that if your waiver request is accepted, the surcharge will stop, but prior months’ charges will not be refunded.

*For more Frequently Asked Questions, refer to the 2017 Flexible Benefits Enrollment and Reference Guide posted online on the Benefitfocus Benefits Portal.*

# New Offerings: HDHP/HSA and More

## About the New HDHP Plan and HSA Accounts

The HDHP gives you more control over how you spend - or save - your health care dollars. If you enroll in the HDHP, you can open a tax-advantaged Health Savings Account (HSA) that includes a contribution from Lehigh. You can also contribute to the HSA to save towards medical expenses for today or tomorrow.

Like our PPO plans, with the HDHP plan you will have the freedom to see in-network and out-of-network providers. You will typically pay more for services from out-of-network providers and those expenses won't count toward your out of pocket maximum.

The HDHP has a higher annual deductible than the PPO plans in exchange for a much lower monthly premium. It's important to note that if you cover any dependents with this plan, the family deductible must be met before your coverage begins paying benefits for anyone in the family.

Visit the Benefitfocus portal to find out more about the HDHP Plan and about Health Savings Accounts. There you'll find a Quick Links section with many resources.

## Voluntary Critical Illness and Accident Insurance

New this year, Lehigh will offer employees voluntary critical illness and accident insurance products through AFLAC.

### Accident Insurance

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

### Critical Illness Insurance

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

There are two coverage options: \$10,000 and \$20,000.

## YOUR ENROLLMENT CHECKLIST

1. Log in to "Connect Lehigh" from the upper left corner of the Inside Lehigh homepage.
2. Select the "Employee" tab.
3. Select "Lehigh Benefits" from the list of applications.
4. Select your To Do List and complete required actions.
5. Select Enroll Now!
6. Review each of the benefits available to you.
7. Accept each option that is automatically provided to you.
8. Accept or decline each optional benefit.
9. Update your life insurance beneficiary information.
10. Print a copy of your elections for your records.