

FLEXIBLE BENEFITS ENROLLMENT & REFERENCE GUIDE

2014

*This booklet contains all of the information needed
to understand your Flexible Benefits for 2014.*

WHERE TO GO FOR HELP

PROVIDER/GROUP #	TELEPHONE NUMBER	WEB ADDRESS
<i>Capital BlueCross and Keystone Health Plan Central Group# 00515044</i>	800-216-9741	www.capbluecross.com
<i>Integrated Behavioral Health</i> (Mental Health/Substance Abuse benefits in <i>Keystone Health Plan</i> and <i>PPO 100</i>)	800-395-1616	www.ibhcorp.com/ User ID: lehigh Password: univ03
<i>Magellan Health Services</i> (Mental Health/Substance Abuse benefits in <i>CMM</i> and <i>PPO 80</i>)	866-322-1657	www.magellanhealth.com/MBH
<i>Express Scripts</i> (Prescription plan) Group# LEHIGHU	866-383-7420	www.express-scripts.com
<i>Davis Vision</i> Group# LHU	877-923-2847 or 800-999-5431	www.davisvision.com/ Control Code: 4100
<i>United Concordia Dental</i> Group# 250021021	800-332-0366	www.ucci.com
<i>Ceridian</i> (Flexible Spending Account Administration) Group# L00805	877-799-8820	www.ceridian-benefits.com
Human Resources 428 Brodhead Avenue Bethlehem, PA 18015	610-758-3900 610-758-6226 (fax)	hr.lehigh.edu

Flexible Benefits — 2014

Table of Contents

Where to go for help	2
Flexible Benefits for 2014	4
Changing your benefit elections	7
Medical coverage	9
Medical coverage plans offered by Lehigh.....	10
Notices Required by <i>The Affordable Care Act</i>	11
Understanding medical coverage plan language.....	56
Plan Feature Comparison Chart	58
Plan Benefit Comparison Chart	59
Narrative Plan Descriptions	60
Comprehensive Plan Description.....	62
PPO80 Plan Description	64
PPO100 Plan Description	66
Keystone Plan Description.....	68
Managed Behavioral Health in PPO and HMO Plans	70
CBC Preventive Care Program	76
CMM and PPO Preauthorization Program	77
Keystone Preauthorization Program	79
Finding a Provider.....	81
Cost of Medical Coverage for 2014.....	81
Coverages the four medical plans have in common	82
Prescription drug benefit.....	82
Vision care benefit	84
Dental insurance.....	86
Life insurance.....	89
Buying life insurance for your dependents	91
Long-term disability insurance	92
Flexible spending accounts	94
Frequently asked questions	101
Special rules	106
Creditable Coverage Disclosure Notice.....	111
Notice of Privacy Practices	114
Checklist for open enrollment.....	119

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 page 112 for more details.

Flexible Benefits for 2014

We all have different benefit needs, so instead of giving everyone the same benefits, *Flexible Benefits* offer a variety of options. And, because your benefit needs may change from year to year, you can always choose what's best for your personal situation. *Flexible Benefits (Flex)* let you make new benefit selections each year so your coverage can keep up with your life.

Although **Human Resources (HR)** cannot directly advise you or provide individual counseling on the benefit plans you select, we provide as much information as possible to ensure that you can make an informed decision. Feel free to call HR at **extension 83900** with general questions about benefit plans.

Information and details about every benefit program in *Flex* is contained in this guide — in multiple formats for some programs, like medical coverage. You can also visit any benefit vendor Website (see page 2) or contact carriers by telephone for additional information or to discuss specific, detailed coverage issues.

Benefits Included in the Flexible Benefits Plan

You have the ability to choose from four different medical coverage plans under which you can cover yourself and any eligible dependents you wish — spouse/partner and/or children. All University medical plans include prescription drug coverage and coverage for vision exams and corrective lenses. Lehigh also offers an indemnity dental insurance plan for you and your eligible dependents.

The University provides you with group term life insurance equal to one times your *Flexible Benefits Salary* and offers the ability to purchase up to four times more coverage if you wish to do so. In addition, you can purchase group term life insurance on your eligible spouse/partner and/or eligible dependent children.

Lehigh provides — and pays the full premium for — long-term disability (LTD) insurance coverage that pays up to 66-2/3 percent of your pre-disability flexible benefits salary in the event you become totally disabled. However, you must decide how to treat federal taxation of the premium for that coverage. Your decision has implications for the taxability of any LTD benefit you might receive if you qualify for it in the future.

You can use flexible spending accounts (FSAs) to save federal and/or state tax dollars on income you spend for qualified medical, dental, vision, and dependent care costs. You must, of course, file charges with any insurance coverage that might pay them first. But after that you are able to use FSAs to pay for the balances with income that is not taxed for federal tax purposes, and in the case of medical FSA expenses, that is also free from Pennsylvania state income tax.

If you live in another state, you should contact your own tax advisor to learn of any state tax exemption for FSA deposits.

Salary for Benefit Levels

Your Flexible Benefits Salary is your base salary as budgeted at the start of the plan year. It is used to determine the coverage you have for life insurance and long-term disability

(LTD) insurance. While the Flexible Benefits Salary used for life insurance is fixed for the plan year, your LTD benefit coverage amount is recalculated mid-year:

- For the period January 1 through June 30, your LTD Base Salary is your Flexible Benefits 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.

If you decide to spend some of your salary as pre-tax dollars to pay for the benefits you elect, your taxable income will be reduced by that amount (salary reduction). Your benefit coverage, however, will be based on your full, unreduced pay as will any future pay increase.

Eligibility to Participate

You are eligible to participate in Flexible Benefits if you are a full-time (at least 75 percent of a full work schedule) salaried member of Lehigh's faculty or staff employed in a benefits-eligible position.

You can enter Flexible Benefits only once during the plan year. If, for any reason, you voluntarily cease to participate in a given year, IRS rules will not allow us to enroll you again until the next plan year.

When Benefits Begin or Change/Default Benefit Coverage

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 the day that completed enrollment forms are received in Human Resources.

Basic life and long-term disability insurances are effective on your first work day for faculty and the first of the month for staff members. Active enrollment is required for participation in a medical plan, dental coverage, supplemental life insurance, dependent life insurance, and flexible spending accounts. Coverage for faculty members in these benefits is effective on the date completed enrollment materials are received by Human Resources, provided they are received within thirty (30) days of your first work day. Coverage for staff members in these benefits is effective on the first of the month following your start date, provided completed enrollment materials are received within thirty (30) days of your first work day.

If you miss this enrollment deadline, you will be assigned **default benefit coverage** that consists of individual enrollment in the *CMM Plan* medical coverage, university-provided basic life insurance, and pre-tax long-term disability coverage. 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.

Benefit elections you make during an annual Flexible Benefits re-enrollment (changes to medical plan, dental coverage, supplemental life insurance, dependent life insurance, and the taxation of the long-term disability insurance premium; or decisions about flexible spending accounts for the next plan year) will be effective on January 1 of the new Flexible Benefits year.

Only a qualifying life event (see page 7) or the next open enrollment period will permit you to make changes to default coverage or to the coverage with which you begin a new Flexible Benefits year.

Plan Documents

Each benefit plan is governed by specific and detailed plan documents. In any discrepancy between plan descriptions you may receive and the official plan documents, the plan documents will govern.

Changing Your Benefit Elections

You can make benefit elections when you start benefits-eligible employment at the University. In addition, you can make new benefit elections each fall for the next plan year. You have the flexibility to re-evaluate your benefit needs each year, allowing you to change your coverages as you wish. The Flexible Benefit elections you make during the annual open enrollment period are effective throughout the next plan year (January 1 through December 31).

After your initial flexible benefits enrollment — and between annual enrollments — you can change your benefit coverage decisions only if you have a “**qualifying life event**” (QLE). Qualifying life events include:

- Birth or adoption of a child;
- Change in marital status;
- Change in dependent’s status;
- Death of a dependent or spouse/partner; and/or
- Loss or gain of coverage for yourself or your dependents under another program (i.e., your spouse/partner had coverage with his or her employer and s/he ends employment).

Please note: Under IRS regulations, the change must be requested within thirty (30) days of the event and must be consistent with the QLE that took place. For example, increasing your life insurance option when you get married would be consistent with the QLE. Decreasing your life insurance would normally not be consistent with the QLE of getting married.

It is your responsibility to notify Human Resources 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.

If your child no longer qualifies as a dependent for benefit purposes, you must submit a *Request to Change Flexible Benefit Elections* form to Human Resources. This will allow us to change your election and the related premium cost.

If you fail to file a QLE change request within thirty (30) 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 Human Resources in a timely fashion.

If you don't submit a benefit change request that meets the IRS regulations, you need to wait until the next annual enrollment. Any additional limitations on the types of changes that are allowed are described within each benefit area.

To make a change because of a qualifying life event, submit a *Request to Change Flexible Benefit Elections* form within thirty (30) days following the date the event occurs. The form is available in the HR office or on the web at <https://hr.lehigh.edu/sites/hr.lehigh.edu/files/RequesttoChangeFlexibleBenefitElections-2010.pdf> Don't forget to complete a medical and/or dental enrollment change form when making changes to these benefits (i.e., adding or removing dependents, stopping coverage, etc.):

- *Medical Enrollment Form:* <https://hr.lehigh.edu/sites/hr.lehigh.edu/files/MedEnroll.pdf>
- *Dental Enrollment Form:* <https://hr.lehigh.edu/sites/hr.lehigh.edu/files/DentalEnrollForm.pdf>

Medical Coverage

Eligibility for Coverage in Medical Plans

If you elect medical coverage, you must decide whom you want to cover:

- You alone;
- You and your spouse/partner;
- You and your child(ren); or
- You and your family, which includes your spouse/partner and child(ren).

You can cover your children until the end of the month in which they become age 26. A disabled child dependent on you for support may be covered without age limitation and coverage and its continuation is subject to required certification with the carrier.

Coverage of Working Spouses/Partners

Lehigh's medical plans will be the primary coverage for your spouse/partner **only** if one of the following is true:

- Your spouse/partner does not have access to another employer-sponsored medical benefit in which the employer pays at least 50 percent of the premium cost, or
- You elect to pay an additional monthly cost of \$100 to enroll a working spouse/partner who could otherwise have enrolled in an employer-sponsored medical benefit with his or her employer.

In all other cases, our carriers will process claims as if your spouse/partner has primary coverage with an employer and will coordinate benefits under the standard "non-duplication of benefits" provision. This means that Lehigh's plan will assume another carrier has processed the claim first and at the level the Lehigh plan would have paid. Since Lehigh plans will not make additional payments on claims that have already been paid at the Lehigh plan level of benefits (i.e., non-duplication of benefits), no additional claim payment will be possible.

If you elect medical coverage for a domestic partner and/or the child(ren) of that partner, you will incur a tax liability equal to the value of the benefits provided unless your partner and his/her child(ren) are tax qualified dependents pursuant to section 152 of the *Internal Revenue Code*. Please see *Tax Information on Health Benefits for Domestic Partners* on the Human Resources website at: <https://hr.lehigh.edu/sites/hr.lehigh.edu/files/TaxInfoDomesticPartners.pdf>. You are also urged to consult with your personal tax advisor or attorney.

Coverage For Your Children

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 spouse/partner also has coverage for your dependents on a plan from his or her employer. In general, 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.

Changing Medical Coverage Elections

As is true of the other benefits included in *Flexible Benefits*, you can change your medical coverage election during the plan year only if you have a QLE. Otherwise, you will have to wait until the start of the next plan year (during the Open Enrollment period) to make a change. If a QLE occurs, you can add or drop individuals from coverage, but you cannot change your medical coverage option (see QLE information on page 7).

The changes you make to any of these coverages are effective on the first of the month following the QLE provided that Human Resources receives all necessary forms, accurately completed, including a *Request to Change Benefit Elections* form and — for medical and dental coverage — these additional forms:

- Medical Coverage — The *Medical Enrollment/Change Application* form, including selection of primary care physician for Keystone Health Plan
- Dental Coverage — The *Dental Plan Enrollment* form.

It is your responsibility to complete all required forms. No one else can assume this responsibility for you, **nor can coverage be extended retroactively for any reason**. All qualifying life event guidelines (see page 7) apply to enrollment changes.

Medical Coverage Plans Offered by Lehigh

Medical coverage is one of the most important benefits employees choose. Lehigh offers three different types of medical coverage plans to meet your needs, and, if applicable, the needs of your family. Having that range of choices makes the decision a complex one as well. Selecting the medical coverage plan that's best for you requires some study and thought.

To help you, we have organized information about the University's medical plans into several types of summaries. The first compares plan features or structures. The second compares plan benefit costs and coverage levels. The third provides brief narrative descriptions of each plan. Benefit Highlight Sheets are provided by Capital BlueCross. These are accompanied by a Schedule of Preventive Care Services and a description of their Preauthorization Program. Finally, there are summaries and details of the managed behavioral health care plans associated with our medical insurance. The combination of these summaries may make it easier for you to feel comfortable that you've chosen the best plan for 2014.

No Preexisting Conditions Clauses

None of Lehigh's medical plans has a preexisting conditions clause. Each University-sponsored medical plan will begin to offer benefits for all covered services and supplies from the first day of coverage.

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 30 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.

AVAILABILITY OF SUMMARY HEALTH INFORMATION

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is available beginning on page 15 of this document, as well as on the web at: <https://hr.lehigh.edu/Open-Enrollment-Central>. A paper copy is also available, free of charge, by calling 610-758-3900.

The following notice is required by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

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 are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the states on the following page, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2013. You should contact your State for further information on eligibility –To see if any more States have added a premium assistance program since July 31, 2013, or for more information on special enrollment rights, you can contact either:

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

or

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

OMB Control Number 1210-0137 (expires 09/30/2013)

The following list of states offering low- or no-cost medical assistance to eligible residents is current as of July 31, 2012. You should contact your state for further information on eligibility.

<p>ALABAMA—Medicaid Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447</p>	<p>MASSACHUSETTS—Medicaid and CHIP web: http://www.mass.gov/MassHealth phone: 1-800-462-1120</p>	<p>PENNSYLVANIA—Medicaid Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462</p>
<p>ALASKA—Medicaid Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529</p>	<p>MINNESOTA—Medicaid Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629</p>	<p>RHODE ISLAND—Medicaid Web: www.ohhs.ri.gov Phone: 401-462-5300</p>
<p>ARIZONA—CHIP Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437</p>	<p>MISSOURI—Medicaid Web: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>	<p>SOUTH CAROLINA—Medicaid web: http://www.scdhhs.gov phone: 1-888-549-0820</p>
<p>COLORADO—Medicaid Medicaid web: http://www.colorado.gov/ Medicaid phone: 1-800-866-3513 Medicaid phone (out of state): 1-800-221-3943</p>	<p>MONTANA—Medicaid Web: http://www.medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084</p>	<p>SOUTH DAKOTA—Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059</p>
<p>FLORIDA—Medicaid Web: https://www.flmedicaidprecovery.com/ Phone: 1-877-357-3268</p>	<p>NEBRASKA—Medicaid Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278</p>	<p>TEXAS—Medicaid web: https://www.gethipptexas.com phone: 1-800-440-0493</p>
<p>GEORGIA—Medicaid Web: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150</p>	<p>NEVADA—Medicaid Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900</p>	<p>UTAH—Medicaid Web: http://health.utah.gov/upp Phone: 1-866-435-7414</p>
<p>IDAHO—Medicaid and CHIP Medicaid web: www.accesshealthinsurance.idaho.gov Medicaid phone: 1-800-926-2588 CHIP web: www.medicaid.idaho.gov CHIP phone: 1-800-926-2588</p>	<p>NEW HAMPSHIRE—Medicaid Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218</p>	<p>VERMONT—Medicaid Web: http://www.greenmountaincare.org Phone: 1-800-250-8427</p>
<p>INDIANA—Medicaid Web: http://www.in.gov/fssa phone: 1-800-889-9949</p>	<p>NEW JERSEY—Medicaid and CHIP 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</p>	<p>VIRGINIA—Medicaid and CHIP Medicaid web: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid phone: 1-800-432-5924 CHIP web: http://www.famis.org CHIP phone: 1-866-873-2647</p>
<p>IOWA—Medicaid web: http://www.dhs.state.ia.us/hipp phone: 1-888-346-9562</p>	<p>NEW YORK—Medicaid web: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>	<p>WASHINGTON—Medicaid web: http://hrs.dshs.wa.gov/premiumpymt/Apply.stm phone: 1-800-562-3022 ext. 15473</p>
<p>KANSAS—Medicaid Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884</p>	<p>NORTH CAROLINA—Medicaid Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100</p>	<p>WEST VIRGINIA—Medicaid Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability</p>
<p>KENTUCKY—Medicaid web: http://chfs.ky.gov/dms/default.htm phone: 1-800-635-2570</p>	<p>NORTH DAKOTA—Medicaid Web: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-888-755-2604</p>	<p>WISCONSIN—Medicaid web: http://www.badgercareplus.org/pubs/p-10095.htm phone: 1-800-362-3002</p>
<p>LOUISIANA—Medicaid Web: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447</p>	<p>OKLAHOMA—Medicaid web: http://www.insureoklahoma.org phone: 1-888-365-3742</p>	<p>WYOMING—Medicaid Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531</p>
<p>MAINE—Medicaid Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741</p>	<p>OREGON—Medicaid and CHIP web: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov phone: 1-800-699-9075</p>	



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan documents at www.capbluecross.com; www.ihcorp.com; and www.davisvision.com. See phone numbers on bottom of this page.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$600 /person \$1,800 /family. Does not apply to network preventive services, prescription drugs, or vision costs.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$6,350 /person \$12,700 /family for services from participating providers. No limit for care from non-participating providers.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Pre-authorization penalties, premiums, balance-billed charges, pharmacy coinsurance, vision care costs, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.capbluecross.com or call 1-800-962-2242 for a list of participating providers. See www.davisvision.com or call 1-800-999-5431 for vision care participating providers.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: About health care coverage: 1-800-216-9741 or www.capbluecross.com; about prescription drug coverage: 1-866-383-7420 or www.express-scripts.com; and about vision care coverage: 1-800-999-5431 or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	20% coinsurance	_____none_____
	Specialist visit	20% coinsurance	20% coinsurance	_____none_____
	Other practitioner office visit	20% coinsurance for chiropractic	20% coinsurance for chiropractic	Acupuncture not covered.
	Preventive care/screening/immunization	No charge	Mandated screenings and immunizations: 20% coinsurance; Routine physical exams: Not covered	Deductible does not apply to services at participating providers.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance for lab, tests, and outpatient radiology.	20% coinsurance for lab, tests, and outpatient radiology.	_____none_____
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	_____none_____

Lehigh University Comprehensive Major Medical Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 – 12/31/2014
Coverage for: All | Plan Type: CMM

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.express-scripts.com or call 1-866-383-7420.</p>	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	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.
	Specialty drugs	20% coinsurance	Not covered	Some drugs may require purchase through Accredo Specialty pharmacy
		Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance
<p>If you have outpatient surgery</p>	Physician/surgeon fees	20% coinsurance	20% coinsurance	Preauthorization is required.
	Emergency room services	20% coinsurance	20% coinsurance	Deductible does not apply to services at in-network participating providers.
<p>If you need immediate medical attention</p>	Emergency medical transportation	20% coinsurance	20% coinsurance	_____none_____
	Urgent care	20% coinsurance	20% coinsurance	Deductible does not apply for services at in-network providers.
<p>If you have a hospital stay</p>	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	Preauthorization is required.
	Physician/surgeon fee	20% coinsurance	20% coinsurance	_____none_____

Questions: About health care coverage: 1-800-216-9741 or www.capbluecross.com; about prescription drug coverage: 1-866-383-7420 or www.express-scripts.com; and about vision care coverage: 1-800-999-5431 or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.

Lehigh University Comprehensive Major Medical Plan Coverage Period: 01/01/2014 – 12/31/2014
Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: All | Plan Type: CMM

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	20% coinsurance	_____none_____
	Mental/Behavioral health inpatient services	20% coinsurance	20% coinsurance	_____none_____
	Substance use disorder outpatient services	20% coinsurance	20% coinsurance	_____none_____
	Substance use disorder inpatient services	20% coinsurance	20% coinsurance	_____none_____
If you are pregnant	Prenatal and postnatal care	20% coinsurance	20% coinsurance	_____none_____
	Delivery and all inpatient services	20% coinsurance	20% coinsurance	_____none_____
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	After 120 visits, not covered. Preauthorization is required.
	Rehabilitation services	20% coinsurance	20% coinsurance	_____none_____
	Habilitation services	Not covered	Not covered	_____none_____
	Skilled nursing care	20% coinsurance	20% coinsurance	After 120 days, not covered.
	Durable medical equipment	20% coinsurance	20% coinsurance	Preauthorization is required on items greater than or equal to \$500.
	Hospice service	20% coinsurance	20% coinsurance	_____none_____
If your child needs dental or eye care	Eye exam	No charge	Full cost less \$32	Limited to one exam per year
	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
More information about participating providers and vision care benefits are available at www.davisvision.com or call 1-800-999-5431.	Dental check-up	Not Covered	Not Covered	_____none_____

Questions: About health care coverage: **1-800-216-9741** or www.capbluecross.com; about prescription drug coverage: **1-866-383-7420** or www.express-scripts.com; and about vision care coverage: **1-800-999-5431** or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Infertility treatment (\$2,500 benefit lifetime maximum/subscriber and spouse each)
- Non-emergency care when traveling outside the U.S. - Most coverage provided outside the United States. See www.bcbs.com/shop-for-health-insurance/coverage-home-and-away.html
- Private-duty nursing
- Routine eye care

Questions: About health care coverage: **1-800-216-9741** or www.capbluecross.com; about prescription drug coverage: **1-866-383-7420** or www.express-scripts.com; and about vision care coverage: **1-800-999-5431** or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-216-9741. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cms.gov.

Your Grievance and Appeals Rights:

²⁰If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- Regarding medical claims: Capital Blue Cross at 1-800-962-2242.
- Regarding drug coverage, call the number on the back of your prescription benefit card or visit www.express-scripts.com.
- Regarding your vision care coverage, call 1-800-999-5432 or visit www.davisvision.com.

You may also contact the Pennsylvania Insurance Department at 1-877-881-6388 or www.insurance.pa.gov or the U.S. Department of Labor Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. For additional assistance, you may contact the Pennsylvania consumer assistance line at 1-877-881-6388 or ra-in-consumer@pa.gov.

Questions: About health care coverage: **1-800-216-9741** or www.capbluecross.com; about prescription drug coverage: **1-866-383-7420** or www.express-scripts.com; and about vision care coverage: **1-800-999-5431** or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,900
- Patient pays \$1,640

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$600
Copays	\$0
Coinsurance	\$1,040
Limits or exclusions	\$0
Total	\$1,640

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,860
- Patient pays \$1,540

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$600
Copays	\$0
Coinsurance	\$940
Limits or exclusions	\$0
Total	\$1,540

Questions and answers about the Coverage Examples:

Questions: About health care coverage: [1-800-216-9741](tel:1-800-216-9741) or www.capbluecross.com; about prescription drug coverage: [1-866-383-7420](tel:1-866-383-7420) or www.express-scripts.com; and about vision care coverage: [1-800-999-5431](tel:1-800-999-5431) or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✘ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✘ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✔ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✔ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HIRAs) that help you pay out-of-pocket expenses.



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan documents at www.capbluecross.com; www.express-scripts.com; www.ibhcorp.com; and www.davisvision.com. See phone numbers on bottom of this page.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$200 /person \$600 /family for participating providers. \$500 /person for non-participating providers. Does not apply to professional services with co-pays, network preventive services, prescription drugs, or vision costs.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$6,350 /person \$12,700 /family for in-network care. No limit for out-of-network care.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Pre-authorization penalties, premiums, balance-billed charges, pharmacy coinsurance, vision care costs, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.capbluecross.com or call 1-800-962-2242 for a list of participating providers. See www.davisvision.com or call 1-800-999-5431 for vision care participating providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

Questions: About health care coverage: 1-800-216-9741 or www.capbluecross.com; about prescription drug coverage: 1-866-383-7420 or www.express-scripts.com; and about vision care coverage: 1-800-999-5431 or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay/visit	30% coinsurance	_____none_____
	Specialist visit	\$20 copay/visit	30% coinsurance	_____none_____
	Other practitioner office visit	20% coinsurance for chiropractic	30% coinsurance for chiropractic	Acupuncture not covered.
If you have a test	Preventive care/screening/immunization	No charge	Mandated screenings and immunizations: 30% coinsurance; Routine physical exams: Not covered	Deductible does not apply to services at participating in-network providers.
	Diagnostic test (x-ray, blood work)	20% coinsurance for lab, tests, and outpatient radiology.	30% coinsurance for lab, tests, and outpatient radiology.	_____none_____
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	_____none_____

Lehigh University PPO-80 Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 – 12/31/2014
Coverage for: All | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.express-scripts.com or call 1-866-383-7420.</p>	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	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.
	Specialty drugs	20% coinsurance	Not covered	Some drugs may require purchase through Accredo Specialty pharmacy
		Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance
<p>If you have outpatient surgery</p>	Physician/surgeon fees	20% coinsurance	30% coinsurance	Preauthorization is required.
	Emergency room services	\$35 copay/service	30% coinsurance	Deductible does not apply to services at in-network participating providers.
<p>If you need immediate medical attention</p>	Emergency medical transportation	20% coinsurance	30% coinsurance	_____none_____
	Urgent care	\$20 copay/service	30% coinsurance	Deductible does not apply for services at in-network providers.
<p>If you have a hospital stay</p>	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Preauthorization is required.
	Physician/surgeon fee	20% coinsurance	30% coinsurance	_____none_____

Questions: About health care coverage: 1-800-216-9741 or www.capbluecross.com; about prescription drug coverage: 1-866-383-7420 or www.express-scripts.com; and about vision care coverage: 1-800-999-5431 or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.

Lehigh University PPO-80 Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 – 12/31/2014
Coverage for: All | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20 copay/visit	30% coinsurance	_____none_____
	Mental/Behavioral health inpatient services	20% coinsurance	30% coinsurance	_____none_____
	Substance use disorder outpatient services	\$20 copay/visit	30% coinsurance	_____none_____
	Substance use disorder inpatient services	20% coinsurance	30% coinsurance	_____none_____
If you are pregnant	Prenatal and postnatal care	20% coinsurance	30% coinsurance	_____none_____
	Delivery and all inpatient services	20% coinsurance	30% coinsurance	_____none_____
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	After 90 visits, not covered. Preauthorization is required.
	Rehabilitation services	20% coinsurance	30% coinsurance	_____none_____
	Habilitation services	Not covered	Not covered	_____none_____
	Skilled nursing care	20% coinsurance	30% coinsurance	After 100 days, not covered.
	Durable medical equipment	20% coinsurance	30% coinsurance	Preauthorization is required on items greater than or equal to \$500.
	Hospice service	20% coinsurance	30% coinsurance	_____none_____
If your child needs dental or eye care	Eye exam	No charge	Full cost less \$32	Limited to one exam per year
	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
More information about participating providers and vision care benefits are available at www.davisvision.com or call 1-800-999-5431.	Dental check-up	Not Covered	Not Covered	_____none_____

Questions: About health care coverage: [1-800-216-9741](tel:1-800-216-9741) or www.capbluecross.com; about prescription drug coverage: [1-866-383-7420](tel:1-866-383-7420) or www.express-scripts.com; and about vision care coverage: [1-800-999-5431](tel:1-800-999-5431) or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u>.)	
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery (unless medically necessary) • Cosmetic surgery 	<ul style="list-style-type: none"> • Dental care • Habilitation services • Hearing aids • Long term care • Routine foot care (unless medically necessary) • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
<ul style="list-style-type: none"> • Chiropractic care • Infertility treatment (\$2,500 benefit lifetime maximum/subscriber and spouse each) 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. - Most coverage provided outside the United States. See www.bcbs.com/shop-for-health-insurance/coverage-home-and-away.html • Private-duty nursing • Routine eye care

Questions: About health care coverage: **1-800-216-9741** or www.capbluecross.com; about prescription drug coverage: **1-866-383-7420** or www.express-scripts.com; and about vision care coverage: **1-800-999-5431** or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-216-9741. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- Regarding medical claims: Capital Blue Cross at 1-800-962-2242.
- Regarding drug coverage, call the number on the back of your prescription benefit card or visit www.express-scripts.com.
- Regarding your vision care coverage, call 1-800-999-5432 or visit www.davisvision.com.

You may also contact the Pennsylvania Insurance Department at 1-877-881-6388 or www.insurance.pa.gov or the U.S. Department of Labor Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. For additional assistance, you may contact the Pennsylvania consumer assistance line at 1-877-881-6388 or ra-in-consumer@pa.gov.

Questions: About health care coverage: **1-800-216-9741** or www.capbluecross.com; about prescription drug coverage: **1-866-383-7420** or www.express-scripts.com; and about vision care coverage: **1-800-999-5431** or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$6,380
- **Patient pays** \$1,160

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$200
Copays	\$120
Coinsurance	\$840
Limits or exclusions	\$0
Total	\$1,160

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$4,200
- **Patient pays** \$1,200

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$200
Copays	\$120
Coinsurance	\$880
Limits or exclusions	\$0
Total	\$1,200

Questions and answers about the Coverage Examples:

Questions: About health care coverage: [1-800-216-9741](tel:1-800-216-9741) or www.capbluecross.com; about prescription drug coverage: [1-866-383-7420](tel:1-866-383-7420) or www.express-scripts.com; and about vision care coverage: [1-800-999-5431](tel:1-800-999-5431) or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✘ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✔ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✔ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HIRAs) that help you pay out-of-pocket expenses.



This is only a summary.

If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan documents at www.capbluecross.com; www.express-scripts.com; www.ibhcorp.com; and www.davisvision.com. See phone numbers on bottom of this page.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<p>\$0/person for participating providers. \$500/person for non-participating providers. Does not apply to professional services with co-pays, prescription drugs, or vision costs.</p>	<p>You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.</p>
Are there other <u>deductibles</u> for specific services?	No.	<p>You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</p>
Is there an <u>out-of-pocket limit</u> on my expenses?	<p>Yes. \$6,350/person \$12,700/family for in-network care. No limit for out-of-network care.</p>	<p>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of covered services. This limit helps you plan for health care expenses.</p>
What is not included in the <u>out-of-pocket limit</u> ?	<p>Pre-authorization penalties, premiums, balance-billed charges, pharmacy coinsurance, vision care costs, and health care this plan does not cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
Is there an overall annual limit on what the plan pays?	No.	<p>The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.</p>
Does this plan use a <u>network of providers</u> ?	<p>Yes. See www.capbluecross.com or call 1-800-962-2242 for a list of participating providers. Call IBH at 1-800-395-1616 for Mental/Behavioral Health and Substance Abuse participating providers. See www.davisvision.com or call 1-800-999-5431 for vision care participating providers.</p>	<p>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.</p>
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a written referral to see a specialist.	<p>You can see the <u>specialist</u> you choose without permission from this plan.</p>
Are there services this plan doesn't cover?	Yes.	<p>Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.</p>

Questions: About health care coverage: **1-800-216-9741** or www.capbluecross.com; about prescription drug coverage: **1-866-383-7420** or www.express-scripts.com; about mental/behavioral health or substance abuse: **1-800-395-1616** or www.ibhcorp.com; and about vision care coverage: **1-800-999-5431** or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay/visit	20% coinsurance	_____none_____
	Specialist visit	\$20 copay/visit	20% coinsurance	_____none_____
	Other practitioner office visit	No charge for chiropractic	20% coinsurance for chiropractic	Acupuncture not covered.
If you have a test	Preventive care/ screening/immunization	No charge	Mandated screenings and immunizations: 20% coinsurance; Routine physical exams: Not covered	_____none_____
	Diagnostic test (x-ray, blood work)	No charge for lab or tests.	20% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	No charge.	20% coinsurance	_____none_____

Lehigh University PPO-100 Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 – 12/31/2014
 Coverage for: All | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
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	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.
	Specialty drugs	20% coinsurance	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	20% coinsurance	Services at out-of-network ambulatory surgical facilities: 20% coinsurance.
	Physician/surgeon fees	No charge	20% coinsurance	Preauthorization is required.
	Emergency room services	\$35 copay/service	20% coinsurance	_____none_____
	Emergency medical transportation	No charge	20% coinsurance	_____none_____
If you need immediate medical attention	Urgent care	\$20 copay/service	20% coinsurance	_____none_____
	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Preauthorization is required.
	Physician/surgeon fee	No charge	20% coinsurance	_____none_____

Questions: About health care coverage: **1-800-216-9741** or www.capbluecross.com; about prescription drug coverage: **1-866-383-7420** or www.express-scripts.com; about mental/behavioral health or substance abuse: 1-800-395-1616 or www.ibhcorp.com; and about vision care coverage: **1-800-999-5431** or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.

Lehigh University PPO-100 Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 – 12/31/2014
Coverage for: All | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
<p>If you have mental health, behavioral health, or substance abuse needs</p> <p>More information is available at www.ibhcorp.com or 1-800-395-1616.</p>	Mental/Behavioral health outpatient services	\$20 copay/visit	20% coinsurance	Some services require pre-certification.
	Mental/Behavioral health inpatient services	No charge	20% coinsurance	Pre-certification required. 50% co-insurance for services provided without pre-authorization.
<p>If you are pregnant</p>	Substance use disorder outpatient services	\$20 copay/visit	20% coinsurance	Some services require pre-certification.
	Substance use disorder inpatient services	No charge	20% coinsurance	Pre-certification required. 50% co-insurance for services provided without pre-authorization.
<p>If you need help recovering or have other special health needs</p>	Prenatal and postnatal care	No charge	20% coinsurance	_____none_____
	Delivery and all inpatient services	No charge	20% coinsurance	_____none_____
	Home health care	No charge	20% coinsurance	After 50 visits, not covered. Preauthorization is required.
	Rehabilitation services	No charge	20% coinsurance	Therapy visit limit: Physical 30, speech 30, and occupational 30.
	Habilitation services	Not covered	Not covered	_____none_____
	Skilled nursing care	No charge	20% coinsurance	After 100 days, not covered.
	Durable medical equipment	No charge	20% coinsurance	Preauthorization is required on items greater than or equal to \$500.
	Hospice service	No charge	20% coinsurance	_____none_____
	Eye exam	No charge	Full cost less \$32	Limited to one exam per year
	Glasses	No charge -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
<p>If your child needs dental or eye care</p> <p>-More information about participating providers and vision care benefits are available at www.davisvision.com or call 1-800-999-5431</p>	Dental check-up	Not Covered	Not Covered	_____none_____

Questions: About health care coverage: [1-800-216-9741](tel:1-800-216-9741) or www.capbluecross.com; about prescription drug coverage: [1-866-383-7420](tel:1-866-383-7420) or www.express-scripts.com; about mental/behavioral health or substance abuse: [1-800-395-1616](tel:1-800-395-1616) or www.ibhcorp.com; and about vision care coverage: [1-800-999-5431](tel:1-800-999-5431) or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)	
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery (unless medically necessary) • Cosmetic surgery 	<ul style="list-style-type: none"> • Dental care • Habilitation services • Hearing aids • Long term care • Routine foot care (unless medically necessary) • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
<ul style="list-style-type: none"> • Chiropractic care • Infertility treatment (\$2,500 benefit lifetime maximum/subscriber and spouse each) 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. - Most coverage provided outside the United States. See www.bcbs.com/shop-for-health-insurance/coverage-home-and-away.html • Private-duty nursing • Routine eye care

Questions: About health care coverage: **1-800-216-9741** or www.capbluecross.com; about prescription drug coverage: **1-866-383-7420** or www.express-scripts.com; about mental/behavioral health or substance abuse: 1-800-395-1616 or www.ibhcorp.com; and about vision care coverage: **1-800-999-5431** or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-216-9741. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cms.gov.

Your Grievance and Appeals Rights:

³⁸ If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- Regarding medical claims: Capital Blue Cross at 1-800-962-2242.
- Regarding drug coverage, call the number on the back of your prescription benefit card or visit www.express-scripts.com.
- Regarding mental/behavioral health and substance abuse coverage, call 1-800-395-1616 or visit www.ibhcorp.com.
- Regarding your vision care coverage, call 1-800-999-5432 or visit www.davisvision.com.

You may also contact the Pennsylvania Insurance Department at 1-877-881-6388 or www.insurance.pa.gov or the U.S. Department of Labor Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. For additional assistance, you may contact the Pennsylvania consumer assistance line at 1-877-881-6388 or ra-in-consumer@pa.gov.

Questions: About health care coverage: **1-800-216-9741** or www.capbluecross.com; about prescription drug coverage: **1-866-383-7420** or www.express-scripts.com; about mental/behavioral health or substance abuse: 1-800-395-1616 or www.ibhcorp.com; and about vision care coverage: **1-800-999-5431** or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,380
- Patient pays \$160

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Copays	\$120
Coinsurance	\$40
Limits or exclusions	\$0
Total	\$160

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,700
- Patient pays \$700

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Copays	\$120
Coinsurance	\$580
Limits or exclusions	\$0
Total	\$700

Questions: About health care coverage: [1-800-216-9741](tel:1-800-216-9741) or www.capbluecross.com; about prescription drug coverage: [1-866-383-7420](tel:1-866-383-7420) or www.express-scripts.com; about mental/behavioral health or substance abuse: [1-800-395-1616](tel:1-800-395-1616) or www.ibhcorp.com; and about vision care coverage: [1-800-999-5431](tel:1-800-999-5431) or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✘ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✘ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✔ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✔ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HIRAs) that help you pay out-of-pocket expenses.

Questions: About health care coverage: [1-800-216-9741](tel:1-800-216-9741) or www.capbluecross.com; about prescription drug coverage: [1-866-383-7420](tel:1-866-383-7420) or www.express-scripts.com; about mental/behavioral health or substance abuse: [1-800-395-1616](tel:1-800-395-1616) or www.ibhcorp.com; and about vision care coverage: [1-800-999-5431](tel:1-800-999-5431) or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan documents at www.capbluecross.com; www.express-scripts.com; www.ibhcorp.com; and www.davisvision.com. See phone numbers on bottom of this page.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$6,350 /person \$12,700 /family for in-network care. No limit for out-of-network care.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Pre-authorization penalties, premiums, balance-billed charges, pharmacy coinsurance, vision care costs, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.capbluecross.com or call 1-800-962-2242 for a list of participating providers. Call IBH at 1-800-395-1616 for Mental/Behavioral Health and Substance Abuse participating providers. See www.davisvision.com or call 1-800-999-5431 for vision care participating providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	Yes. You need a written referral to see a specialist.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist .
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

Questions: About health care coverage: **1-800-216-9741** or www.capbluecross.com; about prescription drug coverage: **1-866-383-7420** or www.express-scripts.com; about mental/behavioral health or substance abuse: **1-800-395-1616** or www.ibhcorp.com; and about vision care coverage: **1-800-999-5431** or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay/visit	Not covered.	Additional \$10 copay required after hours.
	Specialist visit	\$20 copay/visit	Not covered.	_____none_____
	Other practitioner office visit	No charge for chiropractic	Not covered for chiropractic	Acupuncture not covered. 2 weeks (14 consecutive days) for chiropractic. Preauthorization is required for manipulation therapy.
If you have a test	Preventive care/screening/immunization	No charge	Not covered.	_____none_____
	Diagnostic test (x-ray, blood work)	No charge for lab or tests.	Not covered.	_____none_____
	Imaging (CT/PET scans, MRIs)	No charge.	Not covered.	Preauthorization is required.

Lehigh University HMO Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 – 12/31/2014
Coverage for: All | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.express-scripts.com or call 1-866-383-7420.</p>	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	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.
<p>If you have outpatient surgery</p>	Specialty drugs	20% coinsurance	Not covered	Some drugs may require purchase through Accredo Specialty pharmacy
	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	_____none_____
	Physician/surgeon fees	No charge	Not covered	Preauthorization is required.
<p>If you need immediate medical attention</p>	Emergency room services	\$25 copay/service	\$25 copay/service	Copay waived if admitted.
	Emergency medical transportation	No charge	No charge	_____none_____
	Urgent care	\$20 copay/service	Not covered	_____none_____
<p>If you have a hospital stay</p>	Facility fee (e.g., hospital room)	No charge	Not covered	Preauthorization is required.
	Physician/surgeon fee	No charge	Not covered	_____none_____

Questions: About health care coverage: 1-800-216-9741 or www.capbluecross.com; about prescription drug coverage: 1-866-383-7420 or www.express-scripts.com; about mental/behavioral health or substance abuse: 1-800-395-1616 or www.ibhcorp.com; and about vision care coverage: 1-800-999-5431 or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.

Lehigh University HMO Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 – 12/31/2014
Coverage for: All | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
<p>If you have mental health, behavioral health, or substance abuse needs</p> <p>More information is available at www.ibhcorp.com or 1-800-395-1616.</p>	Mental/Behavioral health outpatient services	\$20 copay/visit	Not covered	Some services require pre-certification.
	Mental/Behavioral health inpatient services	No charge	Not covered	Pre-certification required. 50% co-insurance for services provided without pre-authorization.
	Substance use disorder outpatient services	\$20 copay/visit	Not covered	Some services require pre-certification.
	Substance use disorder inpatient services	No charge	Not covered	Pre-certification required. 50% co-insurance for services provided without pre-authorization.
<p>If you are pregnant</p>	Prenatal and postnatal care	No charge	Not covered	_____none_____
	Delivery and all inpatient services	No charge	Not covered	_____none_____
<p>If you need help recovering or have other special health needs</p>	Home health care	No charge	Not covered	After 100 visits, not covered. Preauthorization is required.
	Rehabilitation services	No charge	Not covered	Therapy limited to 30 visits
	Habilitation services	Not covered	Not covered	_____none_____
	Skilled nursing care	No charge	Not covered	After 60 days, not covered. Skilled nursing limit combined with acute inpatient rehabilitation limit.
	Durable medical equipment	No charge	Not covered	Preauthorization is required on items greater than or equal to \$500.
	Hospice service	No charge	Not covered	_____none_____

Questions: About health care coverage: 1-800-216-9741 or www.capbluecross.com; about prescription drug coverage: 1-866-383-7420 or www.express-scripts.com; about mental/behavioral health or substance abuse: 1-800-395-1616 or www.ibhcorp.com; and about vision care coverage: 1-800-999-5431 or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.

Lehigh University HMO Plan

Coverage Period: 01/01/2014 – 12/31/2014
 Coverage for: All | Plan Type: HMO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
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	Eye exam	No charge	Full cost less \$32	Limited to one exam per year
	Glasses	No charge -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
	Dental check-up	Not Covered	Not Covered	_____none_____

Questions: About health care coverage: [1-800-216-9741](tel:1-800-216-9741) or www.capbluecross.com; about prescription drug coverage: [1-866-383-7420](tel:1-866-383-7420) or www.express-scripts.com; about mental/behavioral health or substance abuse: [1-800-395-1616](tel:1-800-395-1616) or www.ibhcorp.com; and about vision care coverage: [1-800-999-5431](tel:1-800-999-5431) or www.davisvision.com.
 If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.

Excluded Services & Other Covered Services:**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery (unless medically necessary) • Cosmetic surgery • Dental care 	<ul style="list-style-type: none"> • Habilitation services • Hearing aids • Long term care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Routine foot care (unless medically necessary) • Weight loss programs
--	---	--

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

<ul style="list-style-type: none"> • Chiropractic care (with plan limitations) 	<ul style="list-style-type: none"> • Infertility treatment (\$2,500 benefit lifetime maximum/subscriber and spouse each) 	<ul style="list-style-type: none"> • Private-duty nursing • Routine eye care
---	---	--

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-216-9741. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cms.gov.

Your Grievance and Appeals Rights:

⁴⁸ If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- Regarding medical claims: Capital Blue Cross at 1-800-962-2242.
- Regarding drug coverage, call the number on the back of your prescription benefit card or visit www.express-scripts.com.
- Regarding mental/behavioral health and substance abuse coverage, call 1-800-395-1616 or visit www.ibhcorp.com.
- Regarding your vision care coverage, call 1-800-999-5432 or visit www.davisvision.com.

You may also contact the Pennsylvania Insurance Department at 1-877-881-6388 or www.insurance.pa.gov or the U.S. Department of Labor Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. For additional assistance, you may contact the Pennsylvania consumer assistance line at 1-877-881-6388 or ra-in-consumer@pa.gov.

Questions: About health care coverage: **1-800-216-9741** or www.capbluecross.com; about prescription drug coverage: **1-866-383-7420** or www.express-scripts.com; about mental/behavioral health or substance abuse: 1-800-395-1616 or www.ibhcorp.com; and about vision care coverage: **1-800-999-5431** or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$7,380
- **Patient pays** \$160

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Copays	\$120
Coinsurance	\$40
Limits or exclusions	\$0
Total	\$160

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$4,700
- **Patient pays** \$700

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Copays	\$120
Coinsurance	\$580
Limits or exclusions	\$0
Total	\$700

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HIRAs) that help you pay out-of-pocket expenses.

Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

Appeal

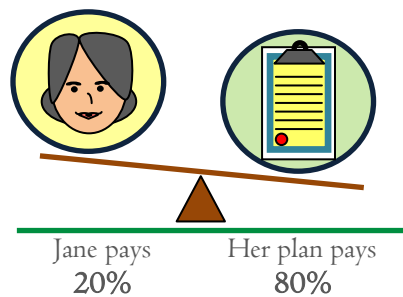
A request for your health insurer or **plan** to review a decision or a **grievance** again.

Balance Billing

When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A **preferred provider** may **not** balance bill you for covered services.

Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay co-insurance **plus** any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is \$100 and you've met your deductible, your co-insurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.



(See page 4 for a detailed example.)

Complications of Pregnancy

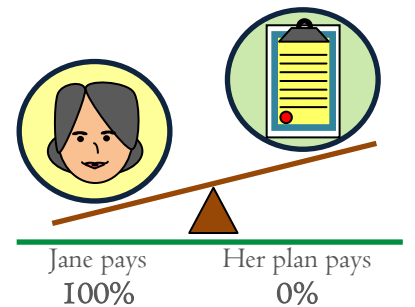
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment

A fixed amount (for example, \$15) 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.

Deductible

The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



(See page 4 for a detailed example.)

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an **emergency medical condition**.

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

Excluded Services

Health care services that your **health insurance** or **plan** doesn't pay for or cover.

Grievance

A complaint that you communicate to your health insurer or **plan**.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

Home Health Care

Health care services a person receives at home.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance

The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance**.

In-network Co-payment

A fixed amount (for example, \$15) you pay for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments**.

Medically Necessary

Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network

The facilities, **providers** and suppliers your health insurer or **plan** has contracted with to provide health care services.

Non-Preferred Provider

A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or plan, or if your health insurance or plan has a "tiered" **network** and you must pay extra to see some providers.

Out-of-network Co-insurance

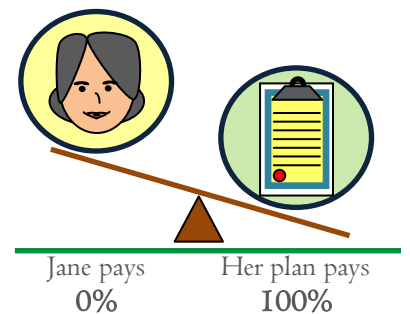
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

Out-of-network Co-payment

A fixed amount (for example, \$30) you pay for covered health care services from providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

Out-of-Pocket Limit

The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your **co-payments**, **deductibles**, **co-insurance** payments, out-of-network payments or other expenses toward this limit.



(See page 4 for a detailed example.)

Physician Services

Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan

A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization

A decision by your health insurer or **plan** that a health care service, treatment plan, **prescription drug** or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval or precertification. Your **health insurance** or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider

A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium

The amount that must be paid for your **health insurance** or **plan**. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage

Health insurance or **plan** that helps pay for **prescription drugs** and medications.

Prescription Drugs

Drugs and medications that by law require a prescription.

Primary Care Physician

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services

Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist

A physician 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. A non-physician specialist is a **provider** who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what **providers** in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount**.

Urgent Care

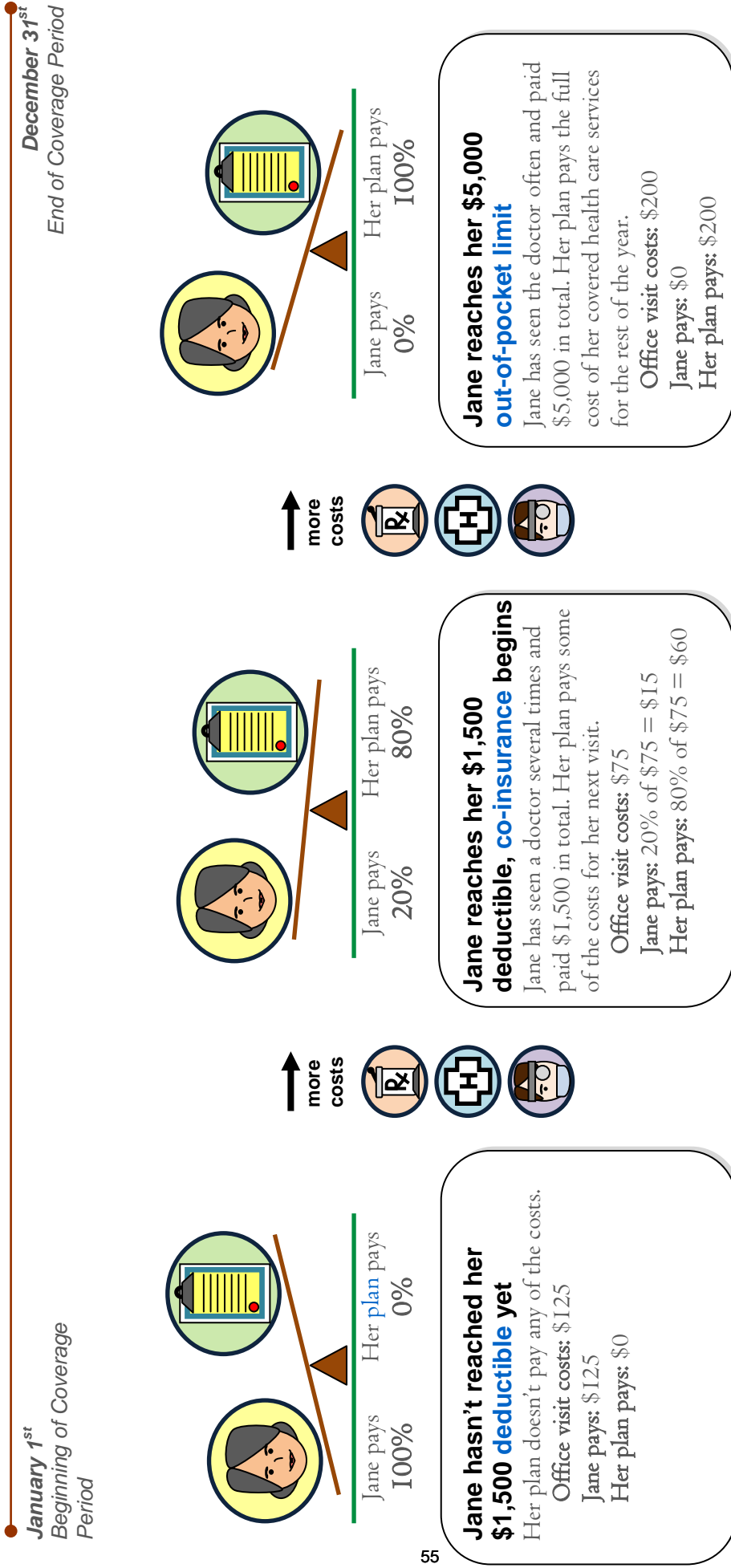
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require **emergency room care**.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: \$1,500

Co-insurance: 20%

Out-of-Pocket Limit: \$5,000



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 refuses 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.

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 do not affect deductibles, coinsurance, or out-of-pocket maximums.

Deductible [D]: The total amount of covered charges 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 and coinsurance. The amount does not include plan copayments, charges for services that are not covered, and charges that are in excess of plan allowable amounts (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 ser-

vices 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 wellness 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/what-are-my-preventive-care-benefits>.

1. Plan Feature Comparison Chart						
Plan Name	<i>CMM Plan</i>	<i>PPO 80</i>		<i>PPO 100</i>		Keystone HMO
Plan Type	Comprehensive Major Medical Fee for Service	Preferred Provider Organization		Preferred Provider Organization		Health Maintenance Organization
		In Network	Out of Network	In Network	Out of Network	
Network Type						
Local Network						✓
National Network	✓	✓		✓		
Primary Care Physician						
Primary Care Physician						✓
Referral Required						
Referral Required						✓
IBH Manages Mental Health/Substance Abuse Benefits						
IBH Manages Mental Health/Substance Abuse Benefits				✓	✓	✓
Magellan Pre-authorizes Mental Health/Substance Abuse Benefits						
Magellan Pre-authorizes Mental Health/Substance Abuse Benefits	✓	✓	✓			
What you pay						
Deductible	✓	✓	✓		✓	
Coinsurance	✓	✓	✓		✓	
Copayment		✓		✓		✓
Out of Network						
Higher Deductible and Coinsurance			✓		✓	
Balance Billing	✓		✓		✓	
Coverage out of network						
Routine care	✓		✓		✓	
Emergency/Urgent Care	✓		✓		✓	✓
Wellness Care						
Limited Preventive Testing	✓		✓		✓	
Broad Wellness Care		✓		✓		✓

2. Plan Benefit Comparison Chart Your Out-Of-Pocket Costs

Plan Structure	CMM Plan	PPO 80		PPO 100		Keystone HMO
		In Network	Out of Network	In Network	Out of Network	
Network	National	National		National		Local
Deductible [D]	\$600/person \$1800/family	\$200/person \$600/family	\$500/person		\$500/person	
Coinsurance [CI]	20% up to \$1000/person \$3000/family	20% up to \$800/person \$2400/family	30%		20%	
Annual deductible and coinsurance limits	\$1600/person \$4800/family	\$1000/person \$3000/family	Unlimited		Unlimited	
Annual Out of Pocket maximum including applicable physician copayments	\$6350/person \$12700/family	\$6350/person \$12700/family	Unlimited	\$6350/person \$12700/family	Unlimited	\$6350/person \$12700/family
Copayment [CP]		\$20/doctor visit		\$20/doctor visit		\$20/doctor visit
Preventive Care [L]	No Cost	No Cost		No Cost		No Cost
Doctor's Office Visit	D/CI	CP	D/CI	CP	D/CI	CP
Inpatient Hospital	D/CI [P]	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]	No Cost [P]	D/CI [P]	No Cost [P]
Surgical Charges, Tests, Procedures	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]	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]	No Cost [M] [P]	D/CI [M] [P]	No Cost [M] [P]
Prescription Drugs	Administered by Express Scripts 10% Generic; 20% Brand [G]					
Vision Care	Davis Vision Program (see page 84 for details)					

- [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.
[G] \$25 generic prescription maximum per month per script; \$50 brand prescription maximum per month per script.
[L] With limitations defined by the plan or provided in the Affordable Care Act (see <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>).
[M] Managed by IBH. Contact IBH directly to coordinate services.
[P] Preauthorization required: 30 percent coinsurance if **Capital BlueCross** procedures not followed in the *CMM Plan*; 50 percent coinsurance out-of-network in *PPO 80* and *PPO 100*; failure to preauthorize with **IBH** results in 50% benefit.

3. Narrative Plan Descriptions

No Coverage is an option only for individuals who have coverage through another source. All other faculty and staff are required to select and pay for one of the medical plans made available by the University.

CMM Plan is a **Capital BlueCross (CBC)** traditional fee-for-service comprehensive major medical plan that allows you to see any health care provider you choose. Charges for services are submitted to the plan and the plan determines what it will pay based on defined coverage levels. Unpaid balances are your responsibility. The plan is designed to pay the cost of treating and caring for participants when they are ill. It does *not* cover wellness care, except for a limited number of items listed below. This plan provides you with the greatest freedom of choice but also exposes you to the greatest out-of-pocket cost, including deductibles, coinsurance, and balance billing from physicians who do not participate with the CBC network.

- Preauthorization is required for hospital stays and many elective surgeries.
- Covered wellness testing is limited to annual gynecological exams, annual pap smears, screening mammograms, sigmoidoscopies, colonoscopies, and PSA tests — the availability of which is governed by generally accepted medical protocols — as well as preventive care benefits defined by The Affordable Care Act.
- To speak to a plan representative to ask coverage questions or identify participating doctors or hospitals, call 800-216-9741. To find a provider online, see the *Finding a Participating Provider* box on page 81.
- Magellan Behavioral Health will preauthorize behavioral inpatient care and partial hospitalization benefits. To receive reimbursement, services must be preauthorized.
- Prescription drug (through **Express Scripts**) and vision care benefits (through **Davis Vision**) are also provided under the *CMM Plan* (see pages 82 through 85).

PPO 80 is a CBC preferred provider organization (PPO) medical plan with an extensive network of physicians and hospitals across the United States. You may see any provider in the network, including specialists, without selecting a primary care physician or having a referral. Wellness care is covered if it is received from a network provider.

- You pay a small copayment for each doctor visit. Deductibles, coinsurance payments, and out-of-pocket limits similar to those in a fee-for-service plan apply to other in-network services such as tests and hospitalization. The plan is designed to give you access to flat dollar copayments for doctor visits, provide coverage for wellness care, and give you the freedom to receive care without the paperwork hassle of referrals.
- You may also receive services from providers who are not part of the network. However, charges for out-of-network services, if covered, are subject to higher deductibles, higher coinsurance payments, and balance billing by the provider.
- To speak to a plan representative to ask coverage questions or identify participating doctors or hospitals, call 800-216-9741. To find a provider online, see the *Finding a Participating Provider* box on page 81.
- Magellan Behavioral Health will preauthorize behavioral inpatient care and partial hospitalization benefits. To receive reimbursement, services must be preauthorized.

Services received out of the plan's network will be subject to higher deductibles, higher co-insurance payments, and are likely to result in balance billing, as well.

- Prescription drug (through **Express Scripts**) and vision care benefits (through **Davis Vision**) are also provided under PPO80 (see pages 82 through 85).

PPO 100 is a CBC preferred provider organization (PPO) medical plan with an extensive network of physicians and hospitals across the United States. You may see any provider in the network, including specialists, without selecting a primary care physician or having a referral. Wellness care is covered if it is received from a network provider.

- You pay a small copayment for each doctor visit. Other covered in-network services, such as tests and hospitalization, are paid in full. The plan is designed to give you access to flat dollar copayments for doctor visits, provide coverage for wellness care, and give you the freedom to receive care without the paperwork hassle of referrals.
- You may also receive services from providers who are not part of the network. However, charges for out-of-network services, if covered, are subject to deductible and coinsurance payments, as well as balance billing by the provider.
- To speak to a plan representative — to ask coverage questions or identify participating doctors or hospitals — call 800-216-9741. To find a provider online, see the *Finding a Participating Provider* box on page 81.
- Behavioral health care benefits for PPO 100 participants are managed by Integrated Behavioral Health (IBH). In network, IBH manages the benefits through assessment, referral, case management, and claims payment. IBH uses its nationwide network of behavioral health professionals and treatment programs and facilities. Services received out of network must be preauthorized by IBH. Such out of network services will be subject to deductibles, coinsurance payments, and are likely to result in balance billing, as well.
- Prescription drug (through **Express Scripts**) and vision care benefits (through **Davis Vision**) are also provided under *PPO 100* (see pages 82 through 85).

Keystone Health Plan Central (Keystone) is a CBC health maintenance organization or HMO. To receive benefits through the plan you are required to select a primary care physician (PCP). All services are received from the PCP or by referral from the PCP to another provider. The HMO is not obligated to pay for any care that is not initiated through the PCP.

- With Keystone, you must work within the network, use your PCP, and get referrals to see other doctors. In exchange, you enjoy the lowest premiums and highest coverage levels of the four plans available.
- To speak to a plan representative to ask coverage questions, identify participating doctors or hospitals, or to change your existing PCP, call 800-216-9741. To find a provider online, see the *Finding a Participating Provider* box on page 81.
- Keystone participants receive behavioral health care benefits through **Integrated Behavioral Health (IBH)**. IBH manages the benefits through assessment, referral, case management, and claims payment. IBH uses its nationwide network of behavioral health professionals and treatment programs and facilities. To use this benefit, all services must be preauthorized and received within the network. There are no out-of-network benefits available.
- Prescription drug (through **Express Scripts**) and vision care benefits (through **Davis Vision**) are also provided under Keystone (see pages 82 through 85).

SUMMARY OF COST-SHARING	Amounts Members Are Responsible For:	
	Participating Providers	Non-Participating Providers
Deductible (per benefit period) <i>Deductible applies to all services unless a Copayment is applied or otherwise noted</i>	\$600 per member \$1,800 per family	
Copayments		
• Office Visits (Family Practitioner, General Practitioner, Internist, Pediatrician)	Coinsurance applies	Coinsurance applies
• Specialist Office Visit	Coinsurance applies	Coinsurance applies
• Emergency Room	Coinsurance applies	Coinsurance applies
• Urgent Care	Coinsurance applies	Coinsurance applies
• Inpatient (Per Admission)	Coinsurance applies	Coinsurance applies
• Outpatient Surgery Copayment (facility)	Coinsurance applies	Coinsurance applies
Coinsurance	Coinsurance applies	Coinsurance applies
Out-of-Pocket Maximum (includes Deductible and Coinsurance for all services) When the out-of-pocket maximum is reached, benefits are paid at 100% of the allowable amount until the benefit period ends.	\$6,350 per member \$12,700 per family	
Coverage Lifetime Maximum	None	

SUMMARY OF BENEFITS	Limits and Maximums	Amounts Members Are Responsible For:	
		Participating Providers	Non-Participating 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
• Sigmoidoscopy and PSA tests		Covered in full, waive deductible	20% coinsurance after deductible
Immunizations		Covered in full, waive deductible	20% coinsurance after deductible
Mammograms			
• Screening Mammogram	One per benefit period	Covered in full, waive deductible	20% coinsurance after deductible
Gynecological Services			
• Screening Gynecological Exam	One per benefit period	Covered in full, waive deductible	20% coinsurance after deductible
• Screening Pap Smear	One per benefit period		20% coinsurance after deductible
BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET			
Acute Care Hospital Room & Board		20% coinsurance after deductible	20% coinsurance after deductible
• Transplant Services		20% coinsurance after deductible	20% coinsurance after deductible
Skilled Nursing Facility	120 days/benefit period	20% coinsurance after deductible	20% coinsurance after deductible
Surgery			
• Surgical Procedure		20% coinsurance after deductible	20% coinsurance after deductible
• Anesthesia		20% coinsurance after deductible	20% coinsurance after deductible
Maternity Services and Newborn Care		20% coinsurance after deductible	20% coinsurance after deductible
Diagnostic Services			
• Radiology		20% coinsurance after deductible	20% coinsurance after deductible
• Laboratory		20% coinsurance after deductible	20% coinsurance after deductible
• Medical tests		20% coinsurance after deductible	20% coinsurance after deductible
Outpatient Therapy Services			
• Physical Medicine		20% coinsurance after deductible	20% coinsurance after deductible
• Occupational Therapy		20% coinsurance after deductible	20% coinsurance after deductible
• Speech Therapy		20% coinsurance after deductible	20% coinsurance after deductible
• Respiratory Therapy		20% coinsurance after deductible	20% coinsurance after deductible
• Manipulation Therapy		20% coinsurance after deductible	20% coinsurance after deductible
Emergency Services		20% coinsurance after deductible	20% coinsurance after deductible
Medical Transport			
• Emergency Ambulance		20% coinsurance after deductible	
• Medically Necessary Ambulance		20% coinsurance after deductible	20% coinsurance after deductible

Benefits are underwritten by Capital Advantage Assurance Company or by Capital Advantage Insurance Company, subsidiaries of Capital BlueCross and independent licensees of the BlueCross BlueShield Association.

CMPS1 01/2014

SUMMARY OF BENEFITS (CONTINUED)	Limits and Maximums	Amounts Members Are Responsible For:	
		Participating Providers	Non-Participating Providers
Mental Health Care Services • Inpatient Services		20% coinsurance after deductible	20% coinsurance after deductible
• Outpatient Services		20% coinsurance after deductible	20% coinsurance after deductible
Substance Abuse Services • Rehabilitation - Inpatient		20% coinsurance after deductible	20% coinsurance after deductible
• Rehabilitation – Outpatient		20% coinsurance after deductible	20% coinsurance after deductible
Home Health Care Services	120 visits/benefit period	20% coinsurance after deductible	20% coinsurance after deductible
Hospice Care		20% coinsurance after deductible	20% coinsurance after deductible
Private Duty Nursing	240 hours/benefit period	20% coinsurance after deductible	20% coinsurance after deductible
Durable Medical Equipment (DME)		20% coinsurance after deductible	20% coinsurance after deductible
Prosthetic Appliances and Orthotic Devices		20% coinsurance after deductible	20% coinsurance after deductible
Diabetic Supplies and Education		20% coinsurance after deductible	20% coinsurance after deductible
Infertility Services	\$2,500 benefit lifetime max/subscriber & spouse each	50% coinsurance after deductible	50% coinsurance after deductible
Assisted Fertilization		Not Covered	Not Covered

OTHER STANDARD PLAN FEATURES	
Preauthorization	Preauthorization is a clinical program in which our nurses work with physicians to approve and monitor certain health care services prior to the delivery of services. The purpose of Preauthorization is to ensure all members receive medically appropriate treatment to meet their individual needs.
Disease Management	Disease Management Programs are a collaborative process that assesses the health needs of a member with a chronic condition and provides education, counseling and on-demand information designed to increase a member's self-management of his/her diabetes, asthma, heart disease, and/or depression.
Nurse Line	Nurse Line is staffed 24 hours a day, 7 days a week by experienced Registered Nurses to provide information and support for any health-related concern. Call 800-452-BLUE.
Better Health WorksSM Personal Profile	Answer questions about yourself and the way you live and, based on the answers you provide, you will receive customized recommendations for your health situation. Support is available to follow through on these recommendations and to make positive health changes.
mycapbluecross.com	Members register for on-line access to their personal account to check claim status, compare hospital quality and treatment costs, print temporary proof of coverage, read the SimplyWell SM member newsletter, view explanations of benefits, and much more.

STANDARD BENEFIT EXCLUSIONS. The following list highlights **some** standard benefit exclusions. It is **NOT** intended to be a complete list or a complete description of all categories of benefit exclusions.

Cosmetic procedures – Acupuncture – Routine foot care; or support devices of the feet – Eyeglasses, contact lenses, or vision examinations for prescribing or fitting eyeglasses or contact lenses – Corneal surgery and other procedures to correct refractive errors – Prescription and over-the-counter drugs dispensed by a pharmacy or home health care agency provider – Hearing aids or examinations for the prescription or fitting of hearing aids – All dental services rendered after stabilization of a member in an emergency following an accidental injury – Treatment of obesity, except for surgical treatment of morbid obesity – Any treatment leading or relating to or in connection with assisted fertilization, including donor services – Certain non-neonatal circumcisions – Procedures to reverse sterilization.

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.

Inpatient admissions as well as certain other services and equipment may require preauthorization.

Participating providers agree to accept our allowance as payment in full—often less than their normal charge.

If you visit a non-participating provider, you are responsible for paying the deductible, coinsurance and the difference between the non-participating provider's charges and the allowable amount. Non-Participating Providers may balance bill the member. Some non-participating facility providers are not covered.

For more information or to locate a participating provider, visit www.capbluecross.com.

Refer to your Certificate of Coverage for the applicable benefit period.

Autism Spectrum Disorders are covered as mandated by Pennsylvania state law for groups size >51.

SUMMARY OF COST-SHARING	Amounts Members Are Responsible For:	
	Participating Providers	Non-Participating Providers
Deductible (per benefit period) <i>Deductible applies to all services unless a Copayment is applied or otherwise noted</i>	\$200 per member \$600 per family	\$500 per member
Copayments		
• Office Visits (Family Practitioner, General Practitioner, Internist, Pediatrician)	\$ 20 copayment per visit	Coinsurance applies
• Specialist Office Visit	\$ 20 copayment per visit	Coinsurance applies
• Emergency Room	\$ 35 copayment per visit	Coinsurance applies
• Urgent Care	\$ 20 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 Copayments for all services) When the out-of-pocket maximum is reached, benefits are paid at 100% of the allowable amount until the benefit period ends.	\$6,350 per member \$12,700 per family	Unlimited
Coverage Lifetime Maximum	Unlimited	Unlimited

SUMMARY OF BENEFITS	Limits and Maximums	Amounts Members Are Responsible For:	
		Participating Providers	Non-Participating 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	One per benefit period	Covered in full, waive deductible	30% coinsurance, waive deductible
• Screening 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
• Transplant Services		20% coinsurance	30% coinsurance
Skilled Nursing Facility	100 days/benefit period	20% coinsurance	30% coinsurance
Surgery			
• Surgical Procedure		20% coinsurance	30% coinsurance
• 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 Therapy Services			
• Physical Medicine		20% coinsurance	30% coinsurance
• Occupational Therapy		20% coinsurance	30% coinsurance
• Speech Therapy		20% coinsurance	30% coinsurance
• Respiratory & Infusion Therapy		20% coinsurance	30% coinsurance
• Manipulation Therapy		20% coinsurance	30% coinsurance
Emergency Services		\$35 copayment waived if admitted	30% coinsurance
Medical Transport			
• Emergency Ambulance		20% coinsurance	30% coinsurance
• Medically Necessary Ambulance		20% coinsurance	30% coinsurance

Benefits are underwritten by Capital Advantage Assurance Company or by Capital Advantage Insurance Company, subsidiaries of Capital BlueCross and independent licensees of the BlueCross BlueShield Association.

SUMMARY OF BENEFITS (CONTINUED)	Limits and Maximums	Amounts Members Are Responsible For:	
		Participating Providers	Non-Participating Providers
Mental Health Care Services			
• Inpatient Services		20% coinsurance	30% coinsurance
• Outpatient Services		Copayment applies	30% coinsurance
Substance Abuse Services			
• Rehabilitation – Inpatient		20% coinsurance	30% coinsurance
• Rehabilitation – Outpatient		Copayment applies	30% coinsurance
Home Health Care Services	90 visits/benefit period	20% coinsurance	30% coinsurance
Hospice Care		20% coinsurance	30% coinsurance
Private Duty Nursing	240 hours/benefit period	20% coinsurance	30% coinsurance
Durable Medical Equipment (DME)		20% coinsurance	30% coinsurance
Prosthetic Appliances and Orthotic Devices		20% coinsurance	30% coinsurance
Diabetic Supplies and Education		20% coinsurance	30% coinsurance
Infertility Services	\$2,500 benefit lifetime max/subscriber & spouse each	50% coinsurance	Not covered
Assisted Fertilization		Not Covered	Not Covered

OTHER STANDARD PLAN FEATURES	
Preauthorization	Preauthorization is a clinical program in which our nurses work with physicians to approve and monitor certain health care services prior to the delivery of services. The purpose of Preauthorization is to ensure all members receive medically appropriate treatment to meet their individual needs.
Disease Management	Disease Management Programs are a collaborative process that assesses the health needs of a member with a chronic condition and provides education, counseling and on-demand information designed to increase a member's self-management of his/her diabetes, asthma, heart disease, and/or depression.
Nurse Line	Nurse Line is staffed 24 hours a day, 7 days a week by experienced Registered Nurses to provide information and support for any health-related concern. Call 800-452-BLUE.
Better Health WorksSM Personal Profile	Answer questions about yourself and the way you live and, based on the answers you provide, you will receive customized recommendations for your health situation. Support is available to follow through on these recommendations and to make positive health changes.
mycapbluecross.com	Members register for on-line access to their personal account to check claim status, compare hospital quality and treatment costs, print temporary proof of coverage, read the SimplyWell SM member newsletter, view explanations of benefits, and much more.

STANDARD BENEFIT EXCLUSIONS. The following list highlights *some* standard benefit exclusions. It is **NOT** intended to be a complete list or a complete description of all categories of benefit exclusions.

Cosmetic procedures – Acupuncture – Routine foot care; or support devices of the feet – Eyeglasses, contact lenses, or vision examinations for prescribing or fitting eyeglasses or contact lenses – Corneal surgery and other procedures to correct refractive errors – Prescription and over-the-counter drugs dispensed by a pharmacy or home health care agency provider – Hearing aids or examinations for the prescription or fitting of hearing aids – All dental services rendered after stabilization of a member in an emergency following an accidental injury – Treatment of obesity, except for surgical treatment of morbid obesity – Any treatment leading or relating to or in connection with assisted fertilization, including donor services – Certain non-neonatal circumcisions – Procedures to reverse sterilization

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.

Inpatient admissions as well as certain other services and equipment may require preauthorization.

Participating providers agree to accept our allowance as payment in full—often less than their normal charge.

If you visit a non-participating provider, you are responsible for paying the deductible, coinsurance and the difference between the non-participating provider's charges and the allowable amount. Non-Participating Providers may balance bill the member. Some non-participating facility providers are not covered.

For more information or to locate a participating provider, visit www.capbluecross.com.

Refer to your Certificate of Coverage for the applicable benefit period.

Autism Spectrum Disorders are covered as mandated by Pennsylvania state law for group size > 51.

SUMMARY OF COST-SHARING	Amounts Members Are Responsible For:	
	Participating Providers	Non-Participating Providers
Deductible (per benefit period) <i>Deductible applies to all services unless a Copayment is applied or otherwise noted</i>	Not applicable	\$500 per member
Copayments		
• Office Visits (Family Practitioner, General Practitioner, Internist, Pediatrician)	\$ 20 copayment per visit	Coinsurance applies
• Specialist Office Visit	\$ 20 copayment per visit	Coinsurance applies
• Emergency Room	\$ 35 copayment per visit	Coinsurance applies
• Urgent Care	\$ 20 copayment per visit	Coinsurance applies
• Inpatient (Per Admission)	Covered in full	Coinsurance applies
• Outpatient Surgery Copayment (facility)	Covered in full	Coinsurance applies
Coinsurance	Not Applicable	20% coinsurance
Out-of-Pocket Maximum (includes Copayments for all services) When the out-of-pocket maximum is reached, benefits are paid at 100% of the allowable amount until the benefit period ends.	\$6,350 per member \$12,700 per family	Unlimited
Coverage Lifetime Maximum	Unlimited	Unlimited

SUMMARY OF BENEFITS	Limits and Maximums	Amounts Members Are Responsible For:	
		Participating Providers	Non-Participating 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		Covered in full	20% coinsurance after deductible
Gynecological Services			
• Screening Gynecological Exam	One per benefit period	Covered in full	20% coinsurance, waive deductible
• Screening 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		Covered in full	20% coinsurance
• Transplant services		Covered in full	20% coinsurance
Skilled Nursing Facility	100 days/benefit period	Covered in full	20% coinsurance
Surgery			
• Surgical Procedure		Covered in full	20% coinsurance
• Anesthesia		Covered in full	20% coinsurance
Maternity Services and Newborn Care		Covered in full	20% coinsurance
Diagnostic Services			
• Radiology		Covered in full	20% coinsurance
• Laboratory		Covered in full	20% coinsurance
• Medical tests		Covered in full	20% coinsurance
Outpatient Therapy Services			
• Physical Medicine	30 visits/benefit period/condition	Covered in full	20% coinsurance
• Occupational Therapy	30 visits/benefit period	Covered in full	20% coinsurance
• Speech Therapy	30 visits/benefit period	Covered in full	20% coinsurance
• Respiratory & Infusion Therapy		Covered in full	20% coinsurance
• Manipulation Therapy		Covered in full	20% coinsurance
Emergency Services		\$35 copayment, waived if admitted	20% coinsurance
Medical Transport			
• Emergency Ambulance		Covered in full	20% coinsurance
• Medically Necessary Ambulance		Covered in full	20% coinsurance

Benefits are underwritten by Capital Advantage Assurance Company or by Capital Advantage Insurance Company, subsidiaries of Capital BlueCross and independent licensees of the BlueCross BlueShield Association.

SUMMARY OF BENEFITS (CONTINUED)	Limits and Maximums	Amounts Members Are Responsible For:	
		Participating Providers	Non-Participating Providers
Mental Health Care Services • Inpatient Services		COVERAGE PROVIDED UNDER A SEPARATE BEHAVIORAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY	
• Outpatient Services		COVERAGE PROVIDED UNDER A SEPARATE BEHAVIORAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY	
Substance Abuse Services • Rehabilitation – Inpatient		COVERAGE PROVIDED UNDER A SEPARATE BEHAVIORAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY	
• Rehabilitation – Outpatient		COVERAGE PROVIDED UNDER A SEPARATE BEHAVIORAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY	
Home Health Care Services	50 visits/benefit period	Covered in full	20% coinsurance
Hospice Care		Covered in full	20% coinsurance
Private Duty Nursing	240 hours/benefit period	Covered in full	20% coinsurance
Durable Medical Equipment (DME)		Covered in full	20% coinsurance
Prosthetic Appliances and Orthotic Devices		Covered in full	20% coinsurance
Diabetic Supplies and Education		Covered in full	20% coinsurance
Infertility Services	\$2,500 benefit lifetime max/subscriber & spouse each	50% coinsurance	Not covered
Assisted Fertilization		Not Covered	Not Covered

OTHER STANDARD PLAN FEATURES	
Preauthorization	Preauthorization is a clinical program in which our nurses work with physicians to approve and monitor certain health care services prior to the delivery of services. The purpose of Preauthorization is to ensure all members receive medically appropriate treatment to meet their individual needs.
Disease Management	Disease Management Programs are a collaborative process that assesses the health needs of a member with a chronic condition and provides education, counseling and on-demand information designed to increase a member's self-management of his/her diabetes, asthma, heart disease, and/or depression.
Nurse Line	Nurse Line is staffed 24 hours a day, 7 days a week by experienced Registered Nurses to provide information and support for any health-related concern. Call 800-452-BLUE.
Better Health WorksSM Personal Profile	Answer questions about yourself and the way you live and, based on the answers you provide, you will receive customized recommendations for your health situation. Support is available to follow through on these recommendations and to make positive health changes.
mycapbluecross.com	Members register for on-line access to their personal account to check claim status, compare hospital quality and treatment costs, print temporary proof of coverage, read the SimplyWell SM member newsletter, view explanations of benefits, and much more.

STANDARD BENEFIT EXCLUSIONS. The following list highlights *some* standard benefit exclusions. It is **NOT** intended to be a complete list or a complete description of all categories of benefit exclusions.

Cosmetic procedures – Acupuncture – Routine foot care; or support devices of the feet – Eyeglasses, contact lenses, or vision examinations for prescribing or fitting eyeglasses or contact lenses – Corneal surgery and other procedures to correct refractive errors – Prescription and over-the-counter drugs dispensed by a pharmacy or home health care agency provider – Hearing aids or examinations for the prescription or fitting of hearing aids – All dental services rendered after stabilization of a member in an emergency following an accidental injury – Treatment of obesity, except for surgical treatment of morbid obesity – Any treatment leading or relating to or in connection with assisted fertilization, including donor services – Certain non-neonatal circumcisions – Procedures to reverse sterilization

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.

Inpatient admissions as well as certain other services and equipment may require preauthorization.

Participating providers agree to accept our allowance as payment in full—often less than their normal charge.

If you visit a non-participating provider, you are responsible for paying the deductible, coinsurance and the difference between the non-participating provider's charges and the allowable amount. Non-Participating Providers may balance bill the member. Some non-participating facility providers are not covered.

For more information or to locate a participating provider, visit www.capbluecross.com.

Refer to your Certificate of Coverage for the applicable benefit period.

Autism Spectrum Disorders are covered as mandated by Pennsylvania state law for group size > 51.



SUMMARY OF COST-SHARING	Amounts Members Are Responsible For:
Deductible (per benefit period) Deductible applies to all services unless a Copayment is applied or otherwise noted	Not applicable
Copayments	
• Office Visits - PCP (Family Practitioner, General Practitioner, Internist, Pediatrician)	\$20 copayment per visit
• Specialist Office Visit	\$20 copayment per visit
• After Hours Office Visit (in addition to the PCP office visit copayment)	\$10 copayment per visit
• Emergency Room	\$25 copayment per visit, waived if admitted
• Urgent Care – Outside service area	Covered in full, after \$25 copayment (PCP or Emergency Room)
• Urgent Care – In service area	Covered in full after \$25 copayment (additional \$10 copayment for after hours visit)
• Inpatient (Per Admission)	Covered in full
• Outpatient Surgery Copayment (facility)	Not Applicable
Coinsurance	50% coinsurance, where applicable
Out-of-Pocket Maximum (includes Copayments for all services) When the out-of-pocket maximum is reached, benefits are paid at 100% of the allowable amount until the benefit period ends.	\$6,350 per member \$12,700 per family
Coverage Lifetime Maximum	None

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
• Newborn Circumcisions		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	One per benefit period	Covered in full (no referral necessary)
• Screening 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		Covered in full
Acute Inpatient Rehabilitation Skilled Nursing Facility	60 days/benefit period combined	Covered in full
Surgery		
• Surgical Procedure		Covered in full
• Anesthesia		Covered in full
• Removal of boney impacted teeth		Covered in full
Maternity Services and Newborn Care		Covered in full
Diagnostic Services		
• Radiology		Covered in full
• Laboratory		Covered in full
• Medical tests		Covered in full
Outpatient Therapy Services		
• Physical Medicine and occupational, respiratory, speech, cardiac, orthoptic and urinary incontinence therapy	30 visits/condition per calendar year	Covered in full
Emergency Services		Covered in full Emergency room copayment applies, waived if admitted inpatient
Urgent Medical Care		
• In Service Area		Covered in full after payment (additional copayment for AH visit)
• Outside Service Area		Covered in full after PCP or Emergency Room copayment
Medical Transport		
• Emergency Ambulance		Covered in full
• Medically Necessary Ambulance		Covered in full (between facility providers)

SUMMARY OF BENEFITS (CONTINUED)	Limits and Maximums	Amounts Members Are Responsible For:
Mental Health Care Services		
• Inpatient Services		COVERAGE PROVIDED UNDER A SEPARATE BEHAVIORAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY
• Outpatient Services		COVERAGE PROVIDED UNDER A SEPARATE BEHAVIORAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY
Substance Abuse Services		
• Rehabilitation – Inpatient		COVERAGE PROVIDED UNDER A SEPARATE BEHAVIORAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY
• Rehabilitation – Outpatient		COVERAGE PROVIDED UNDER A SEPARATE BEHAVIORAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY
Home Health Care Services	100 visits/benefit period	Covered in full
Hospice Care		Covered in full
Durable Medical Equipment (DME)		Covered in full
Prosthetic Appliances and Orthotic Devices		Covered in full
Diabetic Supplies and Education		Covered in full when obtained at Participating (DME) Provider 50% coinsurance when obtained at a Participating Pharmacy
Infertility Services	\$2,500 benefit lifetime max/subscriber & spouse each	50% coinsurance (artificial insemination)
Assisted Fertilization		Not Covered (invitro fertilization)

OTHER STANDARD PLAN FEATURES	
Preauthorization	Preauthorization is a clinical program in which our nurses work with physicians to approve and monitor certain health care services prior to the delivery of services. The purpose of Preauthorization is to ensure all members receive medically appropriate treatment to meet their individual needs.
Disease Management	Disease Management Programs are a collaborative process that assesses the health needs of a member with a chronic condition and provides education, counseling and on-demand information designed to increase a member's self-management of his/her diabetes, asthma, heart disease, and/or depression.
Nurse Line	Nurse Line is staffed 24 hours a day, 7 days a week by experienced Registered Nurses to provide information and support for any health-related concern. Call 800-452-BLUE.
Better Health WorksSM Personal Profile	Answer questions about yourself and the way you live and, based on the answers you provide, you will receive customized recommendations for your health situation. Support is available to follow through on these recommendations and to make positive health changes.
mycapbluecross.com	Members register for on-line access to their personal account to check claim status, compare hospital quality and treatment costs, print temporary proof of coverage, read the SimplyWell SM member newsletter, view explanations of benefits, and much more.

STANDARD BENEFIT EXCLUSIONS. The following list highlights *some* standard benefit exclusions. It is **NOT** intended to be a complete list or a complete description of all categories of benefit exclusions.

Cosmetic procedures – Acupuncture – Routine foot care; or support devices of the feet – Eyeglasses, contact lenses, or vision examinations for prescribing or fitting eyeglasses or contact lenses – Corneal surgery and other procedures to correct refractive errors – Prescription and over-the-counter drugs dispensed by a pharmacy or home health care agency provider – Hearing aids or examinations for the prescription or fitting of hearing aids – All dental services rendered after stabilization of a member in an emergency following an accidental injury – Treatment of obesity and/or morbid obesity, except to correct morbid obesity – Any treatment leading or relating to or in connection with assisted fertilization, including donor services – Certain non-neonatal circumcision – In vitro fertilization and/or embryo transplants – Private duty nursing services – Procedures to reverse sterilization –

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.

Inpatient admissions as well as certain other services and equipment may require preauthorization.

Participating providers agree to accept our allowance as payment in full—often less than their normal charge.

If you visit a non-participating provider, you are responsible for paying the deductible, coinsurance and the difference between the non-participating provider's charges and the allowable amount. Non-Participating Providers may balance bill the member. Some non-participating facility providers are not covered.

For more information or to locate a participating provider, visit www.capbluecross.com.

Refer to your Certificate of Coverage for the applicable benefit period.

Autism Spectrum Disorders are covered as mandated by Pennsylvania state law for group size > 51.

Managed Behavioral Health in PPO100 and Keystone

Benefit Plan Summary for PPO100

Service	IBH Network	Non-Network	Pre-Certification
Inpatient Psychiatric Care	100%	<ul style="list-style-type: none"> ▪ 80% of IBH allowable after \$500 deductible (combined MH, CD, and medical) 	Required through IBH for both network and non-network 50% co-insurance for services provided by non-network providers w/o pre-authorization.
Mental Health (MH)- Outpatient Office Visits –Individual, Family, Group Counseling	\$20 co-pay	<ul style="list-style-type: none"> ▪ 80% of IBH allowable after \$500 deductible (combined MH, CD, and medical) 	Some services require Pre-Certification.
Inpatient Chemical Dependence (CD)/Substance Abuse	100%	<ul style="list-style-type: none"> ▪ 80% of IBH allowable after \$500 deductible (combined MH, CD, and medical) 	Required through IBH for both network and non-network 50% co-insurance for services provided by non-network providers w/o pre-authorization.
Chemical Dependence (CD)/ Substance Abuse - Outpatient Office Visits – Individual, Family, Group Counseling	\$20 co-pay	<ul style="list-style-type: none"> ▪ 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%	No benefit	Required through IBH
Mental Health (MH)- Outpatient Office Visits –Individual, Family, Group Counseling	\$20 co-pay	No benefit	Some services require Pre-Certification.
Inpatient Chemical Dependence (CD)/Substance Abuse	100%	No benefit	Required through IBH
Chemical Dependence (CD)/Substance Abuse - Outpatient Office Visits – Individual, Family, Group Counseling	\$20 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 (MHPAE) and Interim Final Rules (IFR) of 2010.

Plan features include:

- Enhanced mental health benefits available when network providers are used.
- National network of quality providers and facilities that have been selected and credentialed by IBH.
- No need for patient submission of claim forms when network providers are used.
- Network providers accept the plan payment as payment in full after the applicable copayment or deductible.
- All mental health services subject to medical necessity and appropriateness of care.
- 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 answer benefit questions for your behavioral health plan.

To assure your behavioral health services will be covered it is recommended that you obtain prior authorization by an IBH care manager at **800-395-1616**. Services not pre-authorized by IBH are subject to retrospective review before payment determination. Without pre-authorization, your claims will be subject to a retrospective review and in some instances may not be covered. Certain services are still required to be pre-authorized, contact IBH with any questions. Your provider may be required to submit a treatment plan and documentation to establish medical necessity and appropriateness of care.

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. Services not pre-authorized by IBH are subject to retrospective review, and in some instances may not be covered. Certain behavioral health services require prior authorization. Contact IBH with any questions. Your provider may be required to submit a treatment plan and documentation to establish medical necessity and appropriateness of care. All care is subject to eligibility, plan definitions, limitations, exclusions, and is payable when determined by IBH as medically necessary and appropriate. Expenses determined not clinically necessary will not be covered.

Inpatient Mental Health Benefits:

To find an in-network facility, contact Integrated Behavioral Health at **800-395-1616**. Some benefit options 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 all services are subject to prior authorization and concurrent review. See included Benefit Table to determine if out of network benefits are available.

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

Outpatient Mental Health Benefits:

All treatment services are subject to medical necessity and appropriateness of care review. All outpatient care beyond the initial 8 visits per year, or falling within additional outlier categories, requires the provider to submit a treatment plan for review of medical necessity, appropriateness of care, and pre-authorization of continued care.

The following outpatient evaluations or treatments require authorization before commencing:

- Psychological testing
- Group therapy
- Outpatient Electroconvulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Specialized services

- Any service other than the initial 8 sessions with a licensed psychologist, licensed therapist or licensed psychiatrist.

Some benefit options may allow you to choose services through either an IBH network provider or a non-network provider. See included Benefit Table to determine if out-of-network benefits are available. Non-network providers must be independently licensed and must follow plan requirements of submitting documentation of 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 100 or Keystone

- ❖ Services performed by the patient on him/herself or performed by immediate family, including but not limited to a spouse, child, brother, sister, parent, or the spouse's parent, even if that individual is a qualified provider.
- ❖ 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.
- ❖ Extended hospital stays that are unrelated to medically necessary and approved treatment.
- ❖ Services furnished by or for the U.S. government, Federal and state funded agency or foreign government, unless payment is legally required.
- ❖ 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 unproven whose efficacy is no greater than that of traditionally accepted standard treatment.
- ❖ Services applied under any government program or law under which the individual is covered.
- ❖ Services for which a third-party is liable.
- ❖ New procedures, services, and medication until they are reviewed for safety, efficacy, and cost effectiveness.
- ❖ Services that are primarily to assess or address remedial educational disorders, including but not limited to: materials, devices and equipment to diagnose or treat learning disabilities.
- ❖ 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.
- ❖ Non-psychiatric therapy or education for mental retardation, learning disabilities/disorders or developmental disorders, including social skills training.
- ❖ Custodial care or supportive counseling, including care for conditions not typically resolved by treatment.
- ❖ Services not medically necessary. All services must be medically necessary. The fact that a physician or other provider may prescribe, order, recommend, 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.
- ❖ Court-ordered treatment, unless determined to be medically necessary and appropriate.
- ❖ Psychological or neuropsychological testing, unless specifically pre-certified by IBH.
- ❖ Inpatient treatment for co-dependency, gambling and sexual addiction.
- ❖ Treatment primarily for chronic pain management or neuropsychological rehabilitation.
- ❖ Treatment primarily for the convenience of the patient or provider.
- ❖ Treatment provided primarily for medical or other research.
- ❖ Charges primarily for marriage, career, or legal counseling.
- ❖ Biofeedback, unless pre-approved by IBH.

Services Not Included in the Managed Behavioral Health Plan (Cont.)

- ❖ 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.
- ❖ 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.
- ❖ Assessment or treatment related to sex change procedures.
- ❖ 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.
- ❖ Treatment of sexual dysfunction not related to organic disease. Sex therapy.
- ❖ Telephone consultations, charges for failure to keep a scheduled visit, charges for completion of a claim form, charges for obtaining medical records or completing a treatment report, and late payment charges.
- ❖ Methadone maintenance.
- ❖ Speech and language evaluations or speech therapy.
- ❖ Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance.
- ❖ Telephone, email and internet consultations in the absence of a specific benefit.
- ❖ Expenses for pastoral counseling, marriage therapy, music or art therapy, assertiveness training, social skills training, recreational therapy, stress management, or other supportive therapies.
- ❖ Long-term treatment at a residential treatment facility, or long term rehabilitation therapy.
- ❖ Smoking cessation programs not covered under the medical plan.
- ❖ Therapeutic foster care, group home, half-way or three-quarter houses, residential/therapeutic schools, camps.
- ❖ Any treatment or condition excluded by the medical plan.

How PPO 100 and Keystone 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 your benefit plan permits use of a *non-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 non-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 non-network providers, your financial responsibility, *the amount you pay*, for *non-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

Appeals Process

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. 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 will respond to the 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. The formal appeals process is consistent with federal ERISA and Patient Protection Act guidelines.

For purposes of the appeal procedure, a mental health or substance abuse claim appeal includes any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit or for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary, including any such denial, reduction, termination of, or a failure to provide or make payment that is based on a determination of a member's eligibility to participate under the group contract, or a failure to provide or make payment. For initial appeals dealing with eligibility determinations, terminations, and rescissions as defined under Patient Protection and Affordable Care Act, please contact your plan administrator for the applicable appeal procedures.

Internal Appeal Process: Whenever a *member* disagrees with IBHs' adverse benefit determination, the *member* may seek internal review of that determination by submitting a written request or a telephonic appeal. The appeal must include the reason(s) the *member* disagrees with the adverse benefit determination. . 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.

The *member's* appeal must be sent to:

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

An appeal is responded to within the timeframes noted below for the particular type of claim. At any time during either the internal or external appeal process, the *member* may appoint a representative to act on his or her behalf. The *member* may contact IBH at 1-800-395-1616 to receive information on the internal review process and to receive additional information including copies, free of charge, of any internal policy rule, guideline criteria, or protocol which IBH relied upon in making the adverse benefit determination. 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.

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. External reviews are limited to specific reason as defined by the Patient Protection and Affordable Care Act (PPACA) and any subsequent amendments or regulations to such Act. This decision is also provided within the timeframes noted below for the particular type of claim. The providers and members are informed by mail or facsimile, depending on the urgency.

Timeframes:

Expedited/Urgent Care Claims

Initial Claim Response Timeframe: 72 Hours

Request Missing Info from Claimant: 24 Hours

Claimant to Provide Missing Info: 48 Hours

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: 45 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: 45 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)(1)(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.

The greatest advantage of preventive care services is detecting potential problems early. To help members avoid serious illness, our group health plans include coverage for the pediatric and adult preventive care services listed below.

PEDIATRIC CARE (Birth through age 18)*

Service	Preventive Benefit Coverage
Routine History and Physical Exam Exams may include: newborn screening; height, weight and blood pressure measurements; body mass index (BMI); developmental milestones; sensory screening for vision and hearing.	21 exams between the ages of 0-10, which typically occur as follows: <ul style="list-style-type: none"> – As a newborn and at 2 to 4 weeks; – At months 1, 2, 4, 6, 9, 12, 15, 18, 24 and 30; and – At 3, 4, 5, 6, 7, 8, 9 and 10 years of age. – One exam annually, between 11 and 18 years of age
Screenings Includes, but is not limited to: newborn screenings for PKU; sickle cell; hemoglobinopathies and hypothyroidism; lead screening; hemoglobin and hematocrit; urinalysis; lipid screening; tuberculin test; Pap test and screening for sexually transmitted disease (when indicated).	Administered in accordance with age and frequency guidelines recommended by the American Academy of Pediatrics, U.S. Preventive Services Task Force, and the Centers for Disease Control and Prevention.
Immunizations Includes: Rotavirus; Polio; Diphtheria-Tetanus-Pertussis (DTaP); Tetanus-reduced Diphtheria/Pertussis (Tdap); Measles-Mumps-Rubella (MMR); Haemophilus influenzae type b (Hib); Hepatitis B; Chickenpox (VZV); Hepatitis A; Influenza*; Pneumococcal (PCV); Meningococcal (MCV4); Human Papillomavirus (HPV) for males and females.	Administered in accordance with age and frequency guidelines as required by state law and/or as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention. Mandated childhood immunizations are covered through age 20, in accordance with state law.
Nutritional Counseling for Children Diagnosed With Obesity Includes two sessions for anticipatory guidance for age-appropriate issues such as growth and development, breastfeeding/nutrition and obesity prevention.	Administered in accordance with guidelines recommended by the American Academy of Pediatrics and the U.S. Preventive Services Task Force.

ADULT CARE (Ages 19 and over)

Service	Preventive Benefit Coverage
Routine History and Physical Exam Includes pertinent patient education and counseling.	Nine exams between the ages of 19-49, which typically occur as follows: <ul style="list-style-type: none"> – Ages 19-29, once; – Ages 30-49, every four years; and – Age 50+, annually.
Screenings Includes, but may not be limited to: Pap smear/pelvic exam; chlamydia/gonorrhea tests (women); HIV tests (men/women); fasting lipid profile; fasting glucose; fecal occult blood test; flexible sigmoidoscopy; colonoscopy; barium enema; prostate specific antigen (PSA); bone mineral density (women); mammogram; abdominal ultrasound (men; screen for abdominal aortic aneurysm).	Administered in accordance with age and frequency guidelines as required by state law and/or as recommended by the U.S. Preventive Services Task Force, National Institutes of Health, Centers for Disease Control and Prevention, American Diabetes Association, and the American Cancer Society.
Prenatal screenings include, but may not be limited to: Bacteriuria; Hepatitis; Iron Deficiency Anemia; Rh (D) blood typing and antibody testing; and sexually transmitted diseases.	
Immunizations Includes: Tetanus/Diphtheria (Td); Hepatitis A; Hepatitis B; Meningococcal (MCV4/MPSV4); Measles/Mumps/Rubella (MMR); Chickenpox (VZV); Influenza*; Pneumococcal (PPV); Human Papillomavirus (HPV), Zoster	Administered in accordance with age and frequency guidelines as required by state law and/or as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.
Women's Services Includes well-women visits, screening and counseling (i.e., interpersonal and domestic violence, sexually transmitted infections, gestational diabetes, HIV).	Administered in accordance with guidelines as required by federal law and as recommended by the U.S. Department of Health and Human Services (HHS).
Nutritional Counseling for Adults Diagnosed With Obesity Includes two sessions for obesity screening and health diet counseling.	Administered in accordance with guidelines as required by state law and/or as recommended by the U.S. Preventive Services Task Force.

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

This information highlights the preventive care services available under this coverage. It is not intended to be a complete list or complete description of available services. Services may be subject to copayment, deductible and/or coinsurance. Additional diagnostic studies may be covered if medically necessary for a particular diagnosis or procedure. Refer to the Certificate of Coverage for specific information on available benefits. This schedule is periodically updated to reflect current recommendations from the American Academy of Pediatrics, National Institutes of Health, U.S. Preventive Services Task Force, American Cancer Society, Advisory Committee on Immunization Practices and Centers for Disease Control and Prevention.

This preventive schedule includes the services deemed to be mandated under the federal Patient Protection and Affordable Care Act (PPACA). As changes are communicated, Capital BlueCross will adjust the preventive schedule as required.

Health care benefit programs issued or administered by Capital BlueCross and/or its subsidiaries, Capital Advantage Insurance Company® and Keystone Health Plan® Central. Independent licensees of the Blue Cross and Blue Shield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.

To receive the highest level of benefits it is sometimes necessary to obtain preauthorization for services.

SERVICES REQUIRING PREAUTHORIZATION

The following services, regardless of whether they are performed as an inpatient or outpatient, require preauthorization:

- All non-emergency inpatient admissions including acute care, long-term acute care, skilled nursing facilities, rehabilitation hospitals and mental health care and substance abuse treatment facilities, including partial hospitalization. Emergent admissions require notification within 48 hours;
- Non-emergent air and ground ambulance transports;
- Behavioral health (mental health care/substance abuse) - intensive outpatient programs (Behavioral health phone numbers are listed on the member's ID card);
- Diagnostic assessment and treatment for autism spectrum disorder;
- Bio-engineered or biological wound care products.
- Category IDE Trials;
- Clinical Trials (including cancer related trials);
- Durable medical equipment (DME), orthotic devices and prosthetic appliances for all purchases and repairs greater than or equal to \$500 dollars. All DME rental items that are on the preauthorization list, regardless of price per unit, require preauthorization;
- Enhanced external counterpulsation (EECP)
- All testing for genetic disorders except; standard chromosomal tests, such as Down Syndrome, Trisomy, and Fragile X, and state mandated newborn genetic testing;
- Home health care;
- Home infusion therapy;
- Hyperbaric Oxygen Therapy (non-emergent);
- Intraocular injection for retinal pathology when performed in a facility;
- All potentially investigational and reconstructive/cosmetic therapies and procedures;
- Laser treatment of skin lesions
- Office surgical procedures that are performed in a facility, including, but not limited to:
 - Arthrocentesis;
 - Aspiration of a joint;
 - Colposcopy;
 - Electrodesiccation condylomata (complex);
 - Excision of a chalazion;
 - Excision of a nail (partial or complete);
 - Enucleation or excision of external thrombosed hemorrhoids
 - Injection of a ligament or tendon;
 - Oral surgery;
 - Pain management (including facet joint injections, trigger point injections, stellate ganglion blocks, peripheral nerve blocks, SI joint injections, and intercostals nerve blocks);
 - Proctosigmoidoscopy/flexible Sigmoidoscopy;
 - Removal of partial or complete bony impacted teeth (if a benefit);
 - Repair of lacerations, including suturing (2.5 cm or less);
 - Vasectomy;
 - Wound care and dressings (including outpatient burn care)
- Outpatient surgeries - All potentially reconstructive/cosmetic and investigational surgeries/procedures;
- Outpatient rehabilitation therapies including physical medicine, occupational therapy, respiratory therapy and manipulation therapy. Pulmonary rehabilitation programs;
- Sleep Studies for the diagnosis and medical management of obstructive sleep apnea syndrome
- Specialty Medical Injectable Medications
- Transplant evaluation and services. Preauthorization will include referral assistance to the Blue Quality Centers for Transplant network if appropriate.

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 forty-eight (48) hours or two (2) business days of the admission. If the hospital is a participating provider, the hospital is responsible for performing the notification. If the hospital is a non-participating provider, the member or the member's responsible party acting on the member's behalf is responsible for the notification.

HOW TO OBTAIN REQUIRED PREAUTHORIZATION

The member's identification card will show if preauthorization is required before receiving the listed services or supplies.

If preauthorization is required, members should present their identification card to their health care provider when medical services or supplies are requested. The member's participating provider will be asked to provide medical information on the proposed treatment to Capital's Clinical Management Department by calling **1-800-471-2242**.

If members use a non-participating provider or a BlueCard participating provider, it is their responsibility to obtain preauthorization. Members should call Capital's Clinical Management Department toll-free at **1-800-471-2242** to obtain the necessary preauthorization. A non-participating provider may call on the member's behalf. However, it is ultimately the member's responsibility to obtain preauthorization.

Capital's Clinical Management Department will notify the member's health care provider and the member of the authorization or denial of the requested procedures, services, and/or supplies within fifteen (15) days after Capital receives the request for preauthorization. Capital may extend the fifteen (15)-day time period one (1) time for up to fifteen (15) days for circumstances beyond Capital's control. Capital will notify the member prior to the expiration of the original time period if an extension is needed. The member and Capital may also agree to an extension if the member or Capital requires additional time to obtain information needed to process the member's preauthorization.

Preauthorization of elective admissions and selected services should be obtained at least seven (7) days prior to the date of service. Maternity admissions require notification within two (2) business days of the date of admission.

PREAUTHORIZATION OF MEDICAL SERVICES INVOLVING URGENT CARE

Special rules apply to preauthorization of urgent care medical services.

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 submit 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 Clinical Management Department receives the preauthorization request.

Members who are dissatisfied with an adverse preauthorization determination regarding an urgent care claim may submit an appeal. Urgent care appeals may be submitted orally by contacting Capital's Customer Service Department, toll-free, at **1-800-962-2242**. Capital will notify the member's health care provider and the member of the outcome of the appeal via telephone or facsimile no later than seventy-two (72) hours after Capital receives the appeal.

PREAUTHORIZATION PENALTY

When a procedure is not preauthorized when required, there may be a preauthorization penalty.

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, the allowable amount will not be subject to reduction.

When members undergo a procedure requiring preauthorization and fail to obtain preauthorization (when responsible to do so), 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.

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** (TDD number at **1-800-242-4816**) with questions regarding the preauthorization of a particular service.

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

Health care benefit programs issued or administered by Capital BlueCross and/or its subsidiaries, Capital Advantage Insurance Company® and Keystone Health Plan® Central. Independent licensees of the Blue Cross and Blue Shield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.



SERVICES REQUIRING PREAUTHORIZATION

The following services require preauthorization:

- All non-emergency inpatient admissions including acute care, long-term acute care, skilled nursing facilities, and rehabilitation hospitals;
- Non-emergent air and ground ambulance transports;
- Behavioral health (mental health care/substance abuse) – all inpatient admissions, partial hospitalization, outpatient services, and intensive outpatient programs (Behavioral health phone numbers are listed on the member’s ID card);
- Diagnostic assessment and treatment for autism spectrum disorder;
- Bio-engineered or biological wound care products;
- Category IDE Trials;
- Clinical Trials (including cancer related trials);
- Durable medical equipment (DME), orthotic devices and prosthetic appliances for all purchases and repairs greater than or equal to \$500 dollars. All DME rental items that are on the preauthorization list, regardless of price per unit, require preauthorization;
- Enhanced external counterpulsation (EECP);
- All testing for genetic disorders except: standard chromosomal tests, such as Down Syndrome, Trisomy, and Fragile X, and state mandated newborn genetic testing;
- Home health care;
- Home infusion therapy;
- Hyperbaric Oxygen Therapy (non-emergent);
- All high-tech, non-emergency imaging procedures including: MRIs (magnetic resonance imaging), MRAs (magnetic resonance angiography), CT (computerized tomography) scans, PET (positron emission tomography) scans, SPECT (single proton emission computerized tomography) scans, and all cardiac nuclear medicine studies, including nuclear cardiac stress tests;
- Intraocular injection for retinal pathology when performed in a facility;
- All potentially investigational and reconstructive/cosmetic therapies and procedures;
- Laser treatment of skin lesions;
- Manipulation therapy (chiropractic and osteopathic);
- All care performed by a non-participating provider.
- Office surgical procedures that are performed in a facility, including, but not limited to:
 - Arthrocentesis;
 - Aspiration of a joint;
 - Colposcopy;
 - Electrodesiccation condylomata (complex);
 - Excision of a chalazion;
 - Excision of a nail (partial or complete);
 - Enucleation or excision of external thrombosed hemorrhoids
 - Injection of a ligament or tendon;
 -
 - Oral surgery;
 - Pain management (including facet joint injections, trigger point injections, stellate ganglion blocks, peripheral nerve blocks, SI joint injections, and intercostals nerve blocks);
 - Proctosigmoidoscopy/flexible Sigmoidoscopy;
 - Removal of partial or complete bony impacted teeth (if a benefit);
 - Repair of lacerations, including suturing (2.5 cm or less);
 - Vasectomy;
 - Wound care and dressings (including outpatient burn care)
- Outpatient surgeries - All potentially reconstructive/cosmetic or investigational surgeries;
- Pulmonary rehabilitation programs;
- Rehabilitation therapies including physical medicine, occupational therapy, and respiratory therapy;
- Sleep Studies for the diagnosis and medical management of obstructive sleep apnea syndrome
- Specialty Medical Injectable Pharmaceuticals.
- Transplant evaluation and services. Preauthorization will include referral assistance to the Blue Quality Centers for Transplant network if appropriate;

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 to Keystone Health Plan® Central must occur within forty-eight (48) hours or two (2) business days of the admission. If the hospital is a participating provider, the hospital is responsible for performing the notification. If the hospital is a non-participating provider, the member or the member’s responsible party acting on the member’s behalf is responsible for the notification.


HOW TO OBTAIN REQUIRED PREAUTHORIZATION

Members should present their identification card to their health care provider when services or supplies are requested. The member's provider will need to provide medical information on the proposed treatment to Keystone Health Plan Central's Clinical Management Department by calling **1-800-471-2242**. Keystone Health Plan Central will verify the member's eligibility for benefit coverage, and the medical necessity of the service being requested. The member's participating provider is responsible for obtaining preauthorization. However, we recommend that members check with their provider to be sure that the necessary approvals were obtained before receiving services. Preauthorization of elective admissions and selected services should be obtained at least two (2) weeks prior to the date of service. Maternity admissions require notification within two (2) business days of the date of admission.

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 Keystone Health Plan Central at **1-800-669-7061** (TDD number at **1-800-669-7075**) with questions regarding the preauthorization of a particular service.

This information highlights Keystone Health Plan Central's Preauthorization Program. Members should refer to their Certificate of Coverage for the specific terms, conditions, exclusions and limitations relating to their *coverage*.

Finding a Participating Provider for CMM Plan, PPO 80, PPO 100, and Keystone Health Plan Central

Go to http://www.capbluecross.com	
Select <i>Find a Doctor or Facility</i> and on the next screen you can search for a doctor by name <i>or</i> by type or specialty.	
<p>Option One: Search by doctor's name Enter the required information and select a medical plan: <u>For the CMM Plan, select:</u> Comprehensive <u>For the PPO 80 and PPO 100, select:</u> PPO <u>For Keystone Health Plan Central, select:</u> Keystone Health Plan Central (HMO). Do not search for behavior health providers for PPO 100 or KHPC on this website. Integrated Behavioral Health (IBH) manages behavioral health services for these medical plans.</p>	<p><u>Please remember:</u> If you are enrolling in Keystone Health Plan Central (KHPC), you will need to select a primary care physician and get their NPI/PCP number for your enrollment form.</p> <div style="text-align: center;">  </div> <p>Once you select your Primary Care Physician from the CBC website, you will need to click on the doctor's View Profile button to obtain their NPI/PCP number.</p>
<p>Option Two: Search by type or specialty Enter the required information and select a medical plan: <u>For the CMM Plan, select:</u> Comprehensive <u>For the PPO 80 and PPO 100, select:</u> PPO <u>For Keystone Health Plan Central, select:</u> Keystone Health Plan Central (HMO). <i>When selecting the KHPC option, be sure to also check off the Primary Care Provider Only box if you are searching for a Primary Care Physician.</i> Do not search for behavior health providers for PPO 100 or KHPC on this website. Integrated Behavioral Health (IBH) manages behavioral health services for these medical plans.</p>	

Here is information about Lehigh's contribution to the cost of the medical plans and your out-of-pocket costs for each of them in 2014.

<u>Monthly Cost of Medical Coverage for 2014</u>					
2013 <u>Monthly Cost</u>	<u>Lehigh Contribution</u>	<u>CMM Plan Employee Contribution</u>	<u>PPO 80 Employee Contribution</u>	<u>PPO 100 Employee Contribution</u>	<u>KHP Central Employee Contribution</u>
Employee Only	\$479	\$117	\$156	\$200	\$76
EE & Spouse/Partner	\$992	\$295	\$388	\$482	\$205
EE & Child(ren)	\$902	\$265	\$349	\$434	\$183
EE & Family	\$1,429	\$441	\$571	\$708	\$302

Coverages the Four Medical Plans Have in Common

All Lehigh University medical coverage plans — the **CMM Plan**, **PPO 80**, **PPO 100**, and **Keystone Health Plan Central** — have identical prescription drug benefits from **Express Scripts** and vision benefits from **Davis Vision**.

Prescription Drug Benefit

A prescription plan administered by **Express Scripts** is available in each of the medical plans. It covers medications that require a prescription by either state or federal law and that are prescribed by a licensed practitioner. Insulin, insulin syringes, and needles are covered by prescription only.

You pay a percentage of the **average wholesale price (AWP)** for each prescription you fill, and the plan does not limit the number of prescriptions you may receive beyond restrictions of medical necessity, applicable legislation, or plan guidelines.

Up to a ninety-day supply of any covered medication can be dispensed at a pharmacy. In addition, you can receive up to a ninety-day supply of covered medications through the mail order prescription program. Mail order is a time- and money-saving way to get drugs you may be taking for an extended period of time.

- For all covered drugs you purchase at a pharmacy you'll pay:
 - **Generic:** Ten (10) percent of the AWP up to a maximum of \$25 for each thirty-day generic prescription; \$75 for 90 days;
 - **Brand Name:** Twenty (20) percent of the AWP up to a maximum of \$50 for each thirty-day brand name prescription; \$150 for 90 days.
- For all covered drugs you purchase through the mail order program you'll pay:
 - **Generic:** Ten (10) percent of the AWP up to a maximum of \$75 for each generic prescription;
 - **Brand Name:** Twenty (20) percent of the AWP up to a maximum of \$150 for each brand name prescription.

Remember that your final per prescription cost for mail order prescriptions may be lower than at your local pharmacy because the mail program buys drugs in larger quantities. As a result, you share in those savings. In addition, preventive care items as defined by The Affordable Care Act are covered in full.

Prescription Drug Maximum Costs		
In Pharmacy	Generic	Brand
30-day Supply	\$25	\$50
90-day Supply	\$75	\$150

The 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 migraine
- **Glaucoma** — used to treat increased pressure in the fluid inside the eye.
- **Combination Beta2 Agonists/corticosteroids Inhalers** — used to treat asthma
- **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.

What To Do If You Are Prescribed A Non-Preferred Drug

If your doctor prescribes a non-preferred drug, Express Scripts will inform the pharmacist, who will then let you know that the drug isn't covered. At this point, your doctor can either change the prescription to a covered Generic or Preferred drug in the same class, or confirm to Express Scripts's satisfaction that there is evidence of a medical reason for prescribing the specific medication. The doctor will need to fill out and return a fax form with the necessary clinical information.

Express Scripts understands that some patients are either allergic to, or receive no benefit from, an equivalent Preferred medication. That is why there is an exception policy. Even if you aren't granted an exception at first, there is still another level of appeal possible. All decisions to cover the non-preferred drug, however, do require clinical evidence to justify the exception.

Non-Covered Items

The following are examples of drugs or other charges **not** covered under the **Express**

Scripts prescription plan:

- Medications lawfully obtainable without a prescription, *excluding insulin*;
- Devices or appliances (except for diabetic supplies), such as support garments or other non-medicinal substances;
- Administration charges for drugs or insulin;
- Cosmetic drugs and medications used for cosmetic purposes (e.g., Rogaine [Minoxidil] for hair restoration and Retin-A for individuals over 19 years of age);
- Investigational or experimental drugs;
- Unauthorized refills;
- Vitamins and dietary supplements;
- Infertility drugs;
- Non-insulin injectables;
- Prescriptions covered without charge under Federal, State, or local programs, including Worker's Compensation; and
- Medications for eligible individuals confined to a rest home, nursing home, sanitarium, extended care facility, hospital, or similar entity.

This listing is neither exhaustive nor all-inclusive. If you have questions about coverage for specific medications, please address them to **Express Scripts** directly at 866-383-7420. You can also go to Express Scripts's website at <http://www.express-scripts.com>.

Vision Care Benefit

The **Davis Vision** program, offered through **Highmark Blue Shield**, is part of all medical plans offered by Lehigh. **Davis Vision** has more than 32,000 vision care providers and optical supplier locations across the United States. There are more than 3,295 providers and suppliers in Pennsylvania, with more than 195 in the Lehigh Valley area.

You and each dependent covered under your medical insurance can receive the services or supplies listed in the chart on the next page once every twelve months. If you work with a network provider/supplier, the services or materials you receive will be covered in full by the plan or covered from first dollar to the maximum level. If you go to non-participating suppliers or providers, there is a specific level of reimbursement for each service or supply the program covers.

You can receive any of the covered services and products as needed more often than once every twelve months if you use network providers or suppliers for all materials and services. When you use a network provider or supplier for additional covered services or supplies, you receive a 20 percent discount off of the provider's standard charge. If you wear both contact lenses and glasses, only one will be covered at the in-network benefit level each year. The other will be covered at the out-of-network level when you use a network provider or supplier for all materials and services. To check the network, call the number or go to the Website listed at the bottom of the chart. At the Website, follow prompts for general access or member access, as appropriate. The Lehigh University client control code for general access is **4100**.

Davis Vision Program		
Service/Product	Your In Network Cost	Out-of-Network Reimbursement to You
<i>Eye Exam</i>	\$0	\$32
<i>Eyeglass Lenses</i>		
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
<i>Frames</i>		
	\$0 for Davis fashion selection frames. Amount over \$60 for provider frames.	\$30
<i>Contact Lenses</i>		
Prescription and Fitting	\$0	Daily Wear: \$20 Extended Wear: \$30
Standard Contact Lenses	\$0	\$48
Specialty Contact Lenses	Amount over \$75	\$75
<p align="center">Telephone number and Web address for Davis Vision: 1-877-923-2847 (prior to initial enrollment)/1-800-999-5431 (once enrolled) http://www.davisvision.com</p>		

Dental Insurance

Dental insurance is available under **United Concordia's** *ConcordiaFlex* fee-for-service dental plan. Under *ConcordiaFlex* you can receive covered dental services from any qualified provider, anywhere in the country. However, you will eliminate the possibility of balance billing if you seek services from participating dental providers. Balance billing occurs when a service provider bills you above the *Maximum Allowable Charge (MAC)* negotiated by the plan. These balance charges do not affect coinsurance levels under the plan.

There are nearly 74,500 participating service providers across the United States, including 520 in the Lehigh Valley/Warren County region.

Emergency treatments are also covered at 100 percent of the MAC. Fillings and many more extensive dental services are covered at 80 percent of the MAC. Surgery, dental prosthetics, and braces (for children) are covered at 50 percent of the MAC. There is an annual benefit maximum of \$1,000 per person, and a lifetime orthodontic maximum of \$1,000 per person.

If you elect dental coverage, you must decide whom you want to cover:

- You alone;
- You and one other person — spouse/partner or dependent child; or
- You and two or more other persons — spouse/partner and child or children.

In general, you may cover your dependent children until the end of the month in which they become age 26. A disabled child dependent on you for support can be covered without age limitation subject to certification with the carrier.

You can choose dental coverage even if you do not enroll in any of Lehigh's medical plans. You can also cover a different set of dependents than the group for which you purchase medical coverage. For example, you can purchase medical coverage for yourself and your child and purchase dental coverage for yourself and your spouse/partner.

The Preventive Incentive

Cleanings and regular exams for each covered individual are 100 percent covered and do not count against the \$1,000 annual MAC limit. Included in this program each year are:

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

A detailed benefit summary is available on page 88 of this publication.

Cost for Dental Insurance

Lehigh University does not contribute to the premium cost for dental insurance. The monthly dental rates for 2014 are:

<u>Coverage</u>	<u>Monthly Amount</u>
Employee only	\$31.42
Employee + one person	\$62.84
Employee + two or more people	\$81.24

To view a list of participating dentists, visit **United Concordia's** Website at <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.

Concordia Flex Dental Benefit Summary
(Maximum annual benefit of \$1,000 per person)

Diagnostic & Preventive Service Benefits — Paid at 100% (Do 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 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, 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.*

Life Insurance

The university provides *Basic Life Insurance* benefits equal to one times your *Flexible Benefits Salary* (as defined on page 4) at no cost to you.

Purchasing Additional Life Insurance

You have the option to purchase Supplemental Life Insurance in increments of one to four times your Flexible Benefits 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 age-related rates.

Age (as of January 1)	Monthly Premium for \$1,000 of Coverage
Under 30	\$.035
30 to 34	\$.040
35 to 39	\$.065
40 to 44	\$.100
45 to 49	\$.150
50 to 54	\$.210
55 to 59	\$.320
60 to 64	\$.580
65 to 69	\$1.00
Over 70	\$1.670

If you are a new employee at the university, there is no restriction on the amount of coverage you can choose in your initial enrollment in Lehigh's Flexible Benefits Plan. However, for all succeeding enrollments, you will need to provide *proof of insurability* to increase coverage by more than one times salary during any flex plan year.

If you choose to increase your life insurance by more than one level, you will receive the default coverage increase (one level above what you have in 2013) and the increased coverage will become effective after approval of the evidence of insurability by Lincoln Financial.

Providing this evidence of insurability is your responsibility. Neither the University nor the carrier can assume it for you.

An accelerated death benefit is available for the Supplemental Life Insurance you purchase. If you are faced with a terminal illness, you will be able to access 50 percent of the value of this Supplemental Life Insurance coverage before your death.

Tax Issues to Consider

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 (see table on page 89) 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.

Determining How Much Life Insurance You Should Have

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

- 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?

You are paying for the supplemental coverage at favorable group rates. However, coverage at Lehigh's rates ends when you leave the University. At that point several coverage continuation options are available in these configurations:

- Continue the supplemental group term life insurance at term insurance rates established for colleges and universities through Lincoln Financial's continuation provision (until age 65);
- Convert the supplemental coverage to an individual whole life insurance policy;
- Continue the Basic Life Insurance at term insurance rates established for colleges and universities through Lincoln Financial's Continuation Provision (until age 65);
- Convert Basic Life Insurance to an individual whole life insurance policy; or
- Some combination of the above.

Buying Life Insurance for Your Dependents

With Flexible Benefits you can buy life insurance on 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.

If you are a new employee there is no restriction on the amount of dependent life insurance you select. However, for all succeeding enrollments, you will need to provide evidence of insurability to make any increase in dependent life insurance coverage on your spouse or partner. **Providing this evidence of insurability is your responsibility.** Neither the University nor the carrier can assume it for you.

The increased coverage level becomes effective after the approval of the evidence of insurability from Lincoln Financial.

You are the beneficiary for any dependent life insurance you select. It is not necessary for you to record a beneficiary designation for this coverage.

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

A Tax Issue: 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.

Long-term Disability Insurance

Long-term disability (LTD) insurance provides for the continuation of a percentage of your LTD Base Salary in the event that you experience a qualifying disability and are unable to work for a period longer than six months. The University pays the full premium cost for the coverage designed to replace up to 66-2/3 percent of your LTD Base Salary (described on page 4). You choose the manner in which the premium is 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.

More about LTD Coverage

Lehigh’s short-term disability plan, as defined in the *Faculty* and *Staff Guides*, provides coverage for the first twenty-six weeks (six months) of disability. In order to qualify for LTD benefits, you need to provide proof of your continued eligible disability. The insurance company determines if you qualify. To qualify, you will generally need to be totally disabled and, as a result, unable to work for 180 continuous days. 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.

LTD insurance assures a certain level of income if you’re unable to work due to a disability that lasts for more than six months. Other sources of disability income are taken into consideration to determine the benefit provided. These other sources of disability income can include Social Security benefits and Worker’s Compensation payments. These payments “offset” the benefit amount you receive from this plan. Your total disability income from all sources will not be less than the amount the plan assures. For example:

LTD Base Salary	\$27,000
Level of disability income (66-2/3% of \$27,000)	\$18,000
Offset by disability benefit from Social Security	<u>\$(8,000)</u>
Annual benefit provided:	<u>\$10,000</u>

Whether or not you have elected post-tax disability coverage, other sources of disability income will likely be subject to federal taxation.

If an employee becomes disabled during the first year of employment as the result of a medical condition for which treatment was recommended or received during the three months prior to employment at Lehigh, LTD coverage will not be available. A disability that begins after the first of the month following the first day of work that is NOT the result of a pre-

existing condition in the three months prior to employment at Lehigh is covered by the LTD program. A disability that begins after the first anniversary (12 months) of employment at Lehigh is covered by the LTD program. If a non-covered disability begins during the first year of employment, the employee must return to work and complete a 12-month waiting period before LTD coverage for that condition is available to him or her.

Flexible Spending Accounts

A flexible spending account (FSA) is a cash reimbursement vehicle that allows you to eliminate the payment of federal, FICA, and (in the case of Health Care accounts) Pennsylvania state income taxes on the funds you commit to the account.

You can establish a Health Care FSA to reimburse yourself for the cost of deductibles, coinsurances, and copayments from any medical, dental, or vision charges for which you have insurance; for balance billing costs; and for uncovered costs when you have no insurance for these kinds of expenses.

A Dependent Care FSA can be opened to reimburse yourself for the costs of covered dependent care expenses for individuals who are your tax dependents. These individuals can include children and other dependents who cannot be left alone while you work and your spouse/partner (if you have one) is working or attending school full-time as well.

*Remember that the **Internal Revenue Service** determines what supplies and services are eligible for reimbursement under FSAs.* You can check questions about covered services and supplies with the IRS, or contact the University's FSA administrator, **Ceridian**, at **877-799-8820**.

Pay Expenses with Pre-tax Dollars

You can use Health Care and Dependent Care FSAs to pay uninsured health care and dependent care expenses with pre-tax dollars you set aside during the plan year. These are individual reimbursement accounts, not group insurance plans. FSAs are funded by your contributions on a salary reduction basis.

You can be reimbursed from a Health Care FSA for out-of-pocket expenses associated with medical and dental costs, copayments, deductibles and coinsurance, and qualified health care expenses not paid by other coverage you may have (i.e., routine physicals, vision, hearing care, and certain non-prescription supplies).

Reimbursement Restriction Since 2011

Since January 1, 2011, over the counter medications can only be reimbursed through an FSA if they are prescribed by a doctor. A written prescription, on the doctor's prescription form, will be required to permit reimbursement. You may also be required to submit a "Physician's Statement Form" to support your reimbursement request. The form is available on Ceridian's website.

A Dependent Care FSA reimburses eligible dependent care expenses for children under the age of 13, and for other dependents, including but not limited to, your legally dependent parents, if you are:

- Single and require dependent care so you can work, or
- Married or have a partner and require dependent care so that both you and your spouse/partner can work and/or so that your spouse/partner can be a full-time student.

Subject to these conditions and as long as receipts are submitted, your Dependent Care Account reimburses expenses associated with dependent care on a pre-tax basis. Dependent Care FSAs can only reimburse you after the month for which you receive dependent care services and after the funds have been withheld from your pay.

FSA Maximum Contribution Amounts

- **Health Care Account** — You can set aside up to \$2,500 each plan year.
- **Dependent Care Account** — You can set aside up to \$5,000 each plan year. The \$5,000 maximum is subject to the following IRS limitations:
 - If you are married and you and your spouse/partner file separate tax returns, you can set aside up to \$2,500 per plan year, or \$208.34 per month, for the care of all eligible dependents.
 - If your spouse/partner has a similar account available with his or her employer, your total contribution to both accounts cannot be more than \$5,000.
 - The amount you set aside cannot be more than your taxable pay or your spouse/partner's taxable pay.

How the Accounts Work

At the beginning of each year, your individual Health Care FSA account will be credited with the amount you designate. Pre-tax reductions are made from your paycheck in equal installments beginning with your first pay after **January 1**.

When you have a reimbursable expense, you file a claim for payment from your account with the FSA Administrator (**Ceridian**). If your claim is for medical, vision, or dental expenses, it must be filed first with the medical or dental carrier (if you have these insurances). A copy of the carrier's explanation of benefits must be filed with your claim to the FSA administrator. Claims can be submitted as often as weekly. You will receive a tax-free reimbursement from your account.

Claims you submit must be for charges related to qualified services or supplies received during the plan year (**January 1 through December 31**). You have until **March 31** of the following year to submit claims for expenses incurred during the plan year.

The frequency of reimbursements you can receive from your Dependent Care Account will depend on your pay cycle and how often you submit claims. As soon as a qualified dependent care claim is received, any reimbursement requested — up to the accrued amount in your account — will be paid out and a check will go out to you the next Thursday. For claims that exceed the accrued amount, payments will be made either monthly or semi-monthly (depending on your pay cycle) until the entire claim is paid.

After March 31, if there is any money left in your account(s), it is forfeited.

Expenses Eligible for Reimbursement from the Health Care Account

Expenses that have not been and will not be reimbursed by any other health plan may qualify for payment through the Health Care Account. Here is a partial list of eligible health care expenses:

- Medical expenses up to the medical deductible limit and the coinsurance amounts you pay after the deductible, as well as medical plan copayments.
- Medical expenses not covered by medical insurance, like physicals and well baby care; dental procedures not covered by dental insurance; and hearing aids and exams.
- Prescription drug copayments.
- The cost of over-the-counter supplies that alleviate or treat personal injury or sickness (items that are only beneficial to general good health are not eligible).
- Vision care expenses not covered under any insurance you may have.

Whose Expenses Are Included?

Eligible expenses that have been incurred by you, your spouse, your tax dependents **and any of your adult children under the age of 26** may be reimbursed through your FSA.

Other health care services that qualify as medical deductions under IRS rules may be eligible for reimbursement. One source of information on these expenses is IRS Publication 502. However, not all of the expenses that can be deducted on your tax return are eligible for reimbursement through the Health Care Account. The IRS has specifically excluded some of the items from this treatment. Please contact Ceridian (877-799-8820) if you have a new expense item. They can tell you if the cost can be reimbursed through your FSA.

Eligible Dependent Care Expenses

Your Dependent Care Account reimburses expenses incurred for the following services only if the expenses are to allow you to work or go to school:

- A licensed nursery or day care center;
- Individuals (not including your dependents) who provide care for your eligible dependents in or outside your home;
- Housekeepers in your home (including food and lodging) hired to care for an eligible dependent.

You will need to provide proof of payment for your dependent care expenses — a canceled check or a signed statement — as well as the tax identification number of the service provider.

Please note that the following expenses are not eligible for reimbursement from your Dependent Care Account:

- Babysitting during non-working hours.
- Care provided by a twenty-four-hour nursing home. Eligible dependents must spend at least eight hours per day in your home.
- Education costs for children in kindergarten or higher.
- Overnight camp expenses.

FSAs Save You Money

Your accounts are funded by your setting aside a portion of your salary for deposit in either or both FSAs. You may want to consider an FSA if you typically pay (on an after-tax basis) the types of expenses that the FSAs reimburse and would prefer to do so on a pre-tax basis.

In the absence of an FSA, you pay for miscellaneous unreimbursed health and dependent care expenses after you cash your paycheck — *after taxes have already been deducted from your earnings*. With an FSA, you can pay for many of these expenses on a pre-tax basis. By directing a portion of your salary to an FSA, you actually reduce the amount of salary on which you will pay federal income, FICA, and (in the case of Health Care FSAs) Pennsylvania state taxes. Assuming your annual income is \$32,000, the chart below shows how you can reduce your taxes by paying your eligible expenses with these accounts. It is important to note that this example is based on 2013 tax rates for a married employee claiming four exemptions.

	Without the Flexible Spending Accounts	With the Flexible Spending Accounts
Salary	\$32,000	\$32,000
Reduction for Health Care Account	0	(1,000)
Reduction for Dependent Care Account	0	(2,000)
Net Income Before Taxes	\$32,000	\$29,000
Estimated federal income tax withheld	(810)	(510)
Estimated Social Security & Medicare taxes withheld (7.65%)	(2,448)	(2,219)
Estimated state taxes withheld (3.07%)	(982)	(890)
Estimated local taxes withheld (1.00%)	(320)	(290)
Take Home Pay	\$27,440	\$25,091
Health Care Expenses	(1,000)	0
Dependent Care Expenses	(2,000)	0
Remaining Spendable Income	\$24,440	\$25,091
Difference:		\$651 Saved!

*Federal income tax based on 2013 rates for married with four exemptions.

Manage Your Flexible Spending Account Online

It's the fastest and easiest way to manage your Flexible Spending Account. You can also print claim forms from this site.

- How do I begin?
 1. Go to <http://www.ceridian-benefits.com>.
 2. Login using your social security number
 3. The system will prompt you to create a login ID and password/pin and answer security questions. **Please note:** You will need **both** your login ID and password/PIN for future access to your account.
 4. Click on the link labeled "My Reimbursement Accounts."
- What will I find?
 - Account information and current claim status;
 - Which payments have been made and payment date; and
 - How much money you have left in your account.

Important Reminders About FSAs

1. The IRS requires that you designate how much of your salary will be deposited into each account at the beginning of the plan year:
 - Your contributions may go into one or both of the FSAs.
 - You may not transfer money between FSA accounts.
 - You may not rollover money from one year to the next.
 - Once you have designated a payroll reduction amount, it cannot be stopped or changed until the beginning of the next plan year unless you experience a QLE as previously defined on page 7.
2. Under current government regulations, FSAs are subject to the following conditions:
 - Any money in your FSAs that remains in the account at the end of the reimbursement period for the plan year will be forfeited. Under current tax law, any money remaining in your FSAs at the end of the reimbursement period for the plan year **cannot** be refunded directly to you. It will be used by Lehigh to offset future benefit costs. Consequently, **it is extremely important that you carefully estimate the amount(s)** you choose to contribute to the FSAs.
 - Voluntary contributions to your FSAs reduce both income and FICA taxes. As such, this could result in a slightly lower retirement benefit from Social Security.
3. You cannot be reimbursed from a Dependent Care FSA until all services have been received — that is until after the end of the month for which you seek reimbursement — and until the money is withheld from your pay.
4. Any money in your accounts that is not used to reimburse you for eligible expenses incurred through December 31 will be forfeited. This is required by law. Since there is some risk involved, you should put funds into an FSA only for those expenses you feel certain will be incurred.
5. You need to submit proper documentation to the administrator of the FSA (**Ceridian**), so obtain receipts for all expenses you want reimbursed.
6. You will receive a welcome letter and periodic statements that will show you the status of your FSAs (i.e., reimbursements, balance).
7. If you leave Lehigh for any reason (including retirement, disability, or death), any money committed to a Health Care FSA can still be used for expenses incurred during the entire plan year if you choose to continue to participate in the plan with after-tax dollars contributed through a **COBRA** election.
8. If you leave Lehigh during a plan year, you will have ninety (90) days following the end of the month in which your last work day occurs to make claims against an account you do not continue to fund under COBRA; but only for dates of service that occurred during your active employment.

Some Tax Issues With FSAs

With a *Health Care Account*, if you itemize deductions on your tax return, you cannot use expenses reimbursed by the *Health Care Account* to determine your eligibility for a federal income tax deduction. Since you need expenses totaling more than 10 percent of adjusted gross income to qualify, however, in most cases you have a greater tax advantage using a *Health Care Account*.

With a *Dependent Care Account*, you need to determine if using the account is more advantageous to you than using the federal income tax credit provided for dependent care expenses. Every dollar you receive in reimbursements from the Dependent Care Account offsets the amount available for the federal tax credit. If you receive a full \$5,000 reimbursement from the Dependent Care Account, the FSA *may* offer a greater tax advantage for you.

However, depending on total taxable income for you and/or your spouse/partner, the results can vary. You should consult your personal tax advisor to determine the best mechanism to use for your situation.

Frequently Asked Questions

Q: What is the last date to file Capital BlueCross claims for the CMM Plan, PPO 80, and PPO 100?

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

Q: What are the steps for completing an enrollment in any medical plan?

A: 1. Elect the coverage on your flexible benefits enrollment form or complete the annual online open enrollment process.
2. Complete a *Medical Enrollment/Change Application* form and forward it to Human Resources. If the medical plan you select requires that you choose a primary care physician, your application must include that information or it will not be complete. Your enrollment (and provider choice, if required) is then communicated to the plan by our office. **You must complete Step 2 for coverage to be accessible.**
It is your responsibility to complete both steps of the enrollment process. Your failure to do so does not constitute a QLE and will not permit you to dis-enroll from a plan you have initially selected before the next open enrollment period (the following November).

Q: I am considering using the mail order drug program for my routine, maintenance medication. What is the cost?

A: The cost of a three-month supply of prescription drugs through Express Scripts is 10 percent of the average wholesale price (AWP) for generic drugs up to a maximum cost of \$75 and 20 percent of the AWP for brand names up to a maximum cost of \$150. Remember that your final cost may be lower than at your local pharmacy because the mail program buys drugs in larger quantities. You share in the savings larger quantity purchases may produce. Check prescription prices with Express Scripts using the telephone number on your ID card.

Q: How does my medical plan work outside the United States?

A: 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. BlueCard Worldwide 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 United States, you can find information about the program and its services—including the process for locating a doctor or hospital—by visiting: <http://www.bcbs.com/already-a-member/traveling-outside-of-the.html>, or by calling 1-800-810-BLUE. Outside the United States call the service collect at 1-804-673-1177.

If you are enrolled in the CMM Plan, PPO 80, or PPO 100 medical plan — and receive services or supplies from BlueCard Worldwide providers or facilities — those charges will be

processed as in-network, meaning that you will be responsible only for any co-insurance, deductible, or co-payment imposed by your medical plan. You would be asked to pay only your portion of plan charges at the time of service, and the provider would file a claim with the medical plan on your behalf. Balance billing (see page 56) would not apply.

If you are enrolled in the Keystone HMO — and receive services or supplies from BlueCard Worldwide providers or facilities — the plan will cover urgent or emergency care you receive, just as it does when you receive such care in the U.S., but outside of Keystone’s twenty-one-county service area. Payment and billing would work just as they do here. You should always contact your primary care physician (PCP) as soon as you reasonably can after receiving out-of-area services or supplies. This will allow your PCP to continue to manage your care, in part by keeping in touch with the plan about treatment you’ve received and authorization for further services or supplies. Your PCP’s telephone number is printed on the front of your member ID card. Remember that routine medical care is not covered outside of the Keystone plan service area.

Doctors to whom BlueCard Worldwide would refer you meet program quality of care standards, such as speaking English and being acquainted with U.S. treatment practices and standards. That added knowledge could be useful since only medical treatments and supplies approved by the FDA are covered by American medical plans.

Q: Is there any other assistance available to me if I need medical services outside the United States?

A: If you are traveling on University business outside the U.S., you can use the International SOS program travel services assistance plan. If you become injured or ill while traveling within covered areas, the program will provide medical, personal, travel, and security assistance services to you and accompanying family members. International SOS is not medical insurance, but it is another source of support while on University business outside the U.S. You can learn more about the program — and other University travel insurance issues — from the International Programs office (610-758-3351) or the Risk Management office (610-758-3899).

Q: How are diabetic supplies covered by University-sponsored medical plans?

A: The **Express Scripts** drug card program covers insulin, diabetic tablets, syringes, and diabetic supplies. All University medical plans provide coverage for diabetic supplies (glucose monitors, lancets, test strips, insulin pumps, infusion pumps, injection aids), orthotics, and self-management education programs.

- The CMM fee-for-service plan covers these latter supplies without referral under the standard deductible/copayment benefit.
- PPO 80 subjects Durable Medical Equipment (DME) supplies to deductible and copayment as well.
- PPO 100 covers 100 percent of the cost of the latter supplies only with a prescription and only at a DME provider.
- Keystone Health Plan Central (KHP) offers two different levels of coverage — 100 percent at a DME provider (with a referral and prescription) or 50 percent at a pharmacy (with a prescription and KHP ID card). Insulin is covered only at 50 percent, regardless of purchase location.

Q: If I select the HMO, can I change my primary care physician?

A: Yes. You can change your Keystone HMO primary care physician by calling Keystone Member Services at **800-216-9741**. The change is normally effective the first of the month following the request.

Q: How often can I change from one health insurance coverage plan to another?

A: You can change to another plan **only** during the Open Enrollment period, typically held from mid-November to December. 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 (30) 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, increase supplemental life insurance, and/or to open or change goal amounts for an FSA. After thirty 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 at the Human Resources Website: www.lehigh.edu/~inhro/benefits_flexible.html. To enroll your new spouse and stepchild(ren) you must contact Human Resources, provide a copy of your marriage documentation, and complete the appropriate documents.

Q: How do I enroll my domestic partner and his/her dependent children in the plan?

A: The process for adding a domestic partner and his/her dependent children to your benefits program is similar to the process of adding any new dependents, with one exception. You and your partner will first need to complete affidavits to document and provide evidence that you are involved in a committed relationship. The affidavits are available on the HR Website or by calling HR at 610-758-3900. These completed affidavits are filed and retained in Human Resources.

Once this is done, you can complete a *Personal Information Change* form, which can be found on the HR Website or by calling HR at 610-758-3900. On this form you'll provide the names, dates of birth, and Social Security numbers of your dependents.

To include these dependents during the Open Enrollment process on the web for employees, all you need to do is indicate your coverage choices on the available screens. For example, if you want life insurance for your partner, you'll need to elect Dependent Life Insurance and identify the level of insurance you want to purchase. For medical plans, you'll select your plan choice and then indicate the level of coverage you need. You'll also have to complete a medical coverage enrollment form for the carrier you select — including primary care physicians if you elect Keystone Health Plan coverage.

During the benefit plan year, you will have thirty (30) days from the beginning of the partnership to add your partner and his or her dependent children to your health and/or dental

coverage. After thirty days, you must wait for the next Open Enrollment period.

Keep the spousal/partner surcharge in mind when adding your spouse/partner to your medical plan (see page 9). You must contact Human Resources and complete the appropriate affidavits.

Also, if you elect medical coverage for a domestic partner and/or the child(ren) of that partner, you will incur a tax liability equal to the value of the benefits provided unless your partner and his/her child(ren) are tax qualified dependents pursuant to section 152 of the **Internal Revenue Code**. Please see [Tax Information on Health Benefits for Domestic Partners](#) on the HR Website. You are also urged to consult with your personal tax advisor or attorney.

Q: I am expecting a baby soon. Can I add the baby to my coverage?

A: You have thirty (30) days from the date of birth or adoption placement to add a child (under age 26) to your medical and/or dental coverage. You must contact HR, provide proof of birth or adoption placement, and complete the appropriate documents.

Q: Can my grandchild or niece/nephew be covered under my health plan?

A: The child must meet certain qualifications to be covered under your health plan. If the child:

- Is under age 26
- Is living in a parent-child relationship with you and economically dependent upon you
- You have legal guardianship of or formally adopted the child.

he or she may be covered under your health plan. The natural parent cannot be living in the same household as the child. If disabled, special rules apply. The dependent must be enrolled within thirty (30) days from the date of legal custody or at Open Enrollment. You must contact HR, provide proof of custody, and complete the required documents.

Q: Can my dependent parents be covered by my medical plan?

A: No. Even if totally dependent on the employee, parents are not eligible for coverage.

Q: Can I submit claims to my Health Care Flexible Spending Account for my dependent parents?

A: Yes, you can submit claims for any person who is financially dependent on you and that you claim as a dependent on your income tax return. You can also submit claims for your adult child(ren) under 26 years of age, regardless of whether they are covered by your medical insurance (see question on page 105).

Q: Can I continue my health benefits if I resign?

A: Yes. **COBRA** continuation coverage provides you the option of continuing your medical and/or dental plan for up to eighteen (18) months. You would be responsible for paying the entire premium amount to **Ceridian** (Lehigh's COBRA administrator) plus a 2 percent adminis-

trative fee. The provisions of COBRA also apply to dependents that lose coverage. Contact HR for further information. You can also contact Ceridian directly at 1-800-877-7994.

Q: If I am disabled on a long-term basis, will I continue to receive income?

A: If you experience an eligible disability for a period exceeding six months, you may receive 66-2/3 percent of your pre-disability LTD Base Salary (see pages 4-5). This benefit is offset by any Worker's Compensation or Social Security disability benefits, and is provided under a Group Long-Term Disability policy with **Lincoln Financial**.

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

A: Your dependent or adult children can only remain covered under a university medical, dental, life insurance, or FSA program until they reach age 26. He or she can visit www.healthcare.gov to see options for purchasing individual medical insurance. If he or she is disabled, special rules 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, you can. 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) if you become 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 a pro-rated tax savings.

There are a number of important rules in the Flexible Benefits Plan. Most of them have been addressed throughout this booklet. We mention them again because they're important.

Special Rules

Changing your elections ...

The benefit elections you make during an enrollment period are effective until the end of the plan year (December 31). No changes can be made unless you experience a QLE and comply with the related IRS regulations on relevancy and time limits (see page 7).

Qualifying life events ...

The IRS allows Lehigh the option of permitting election changes if a participant experiences one of the following events:

- Birth or adoption of a child;
- Change in marital status;
- Change in dependent's status;
- Death of a dependent; or
- Loss or gain of access to coverage under another program (for you or a dependent).

Requested changes must be consistent with the event and submitted to Human Resources within 30 (thirty) days following the event.

Medical coverage for a new child ...

It is your responsibility to notify Human Resources when your child is born or placed in your home as the outcome of legal guardianship or adoption proceedings. Medical coverage of the child as a result of any of these events can begin with birth or placement, ***but only so long as you complete a Request to Change Flexible Benefits Elections form within thirty (30) days of the event.*** (See page 7 for more information on changing benefit elections.)

Newborns are automatically covered for up to thirty (30) days by the primary medical plan of the mother. However, the only way to maintain that child's coverage for this thirty-day period and beyond is for you to complete a *Request to Change Flexible Benefits Elections* form within thirty days of the birth. Carrier payment of the birth expenses are a benefit for the mother. This payment does not create or result in automatic coverage for the child. ***Newborn child medical coverage must be requested by the parent employee under the same rules as any other qualifying life event.*** (See page 7 for more details.)

When your dependents are no longer eligible for coverage ...

For medical, dental, and dependent life insurance coverage, it is **your** responsibility to notify Human Resources when your child reaches age 26.

Remember that you must file a QLE change request within thirty (30) days of the event. If you fail to do so in the case of a dependent whose benefit eligibility ends, we will retroactively cancel coverage. 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 Human Resources in a timely fashion.

Preauthorization for the CMM Plan, PPO 80, and PPO 100 ...

To receive the highest level of benefits it is sometimes necessary to obtain preauthorization for supplies or services. The following supplies or services, regardless of whether they are received as an inpatient or outpatient, require preauthorization:

- All non-emergency inpatient admissions including acute care, long-term acute care, skilled nursing facilities, rehabilitation hospitals and mental health care and substance abuse treatment facilities, including partial hospitalization. Emergent admissions require notification within 48 hours;
- Non-emergent air and ground ambulance transports;
- Behavioral health (mental health care/substance abuse) - intensive outpatient programs (Behavioral health phone numbers are listed on the member's ID card);
- Diagnostic assessment and treatment for autism spectrum disorder;
- Bio-engineered or biological wound care products.
- Category IDE Trials;
- Clinical Trials (including cancer related trials);
- Durable medical equipment (DME), orthotic devices and prosthetic appliances for all purchases and repairs greater than or equal to \$500 dollars. All DME rental items that are on the preauthorization list, regardless of price per unit, require preauthorization;
- Enhanced external counterpulsation (EECP)
- All testing for genetic disorders except; standard chromosomal tests, such as Down Syndrome, Trisomy, and Fragile X, and state mandated newborn genetic testing;
- Home health care;
- Home infusion therapy;
- Hyperbaric Oxygen Therapy (non-emergent);
- Intraocular injection for retinal pathology when performed in a facility;
- All potentially investigational and reconstructive/cosmetic therapies and procedures;
- Laser treatment of skin lesions
- Office surgical procedures that are performed in a facility, including, but not limited to:
 - Arthrocentesis;
 - Aspiration of a joint;
 - Colposcopy;
 - Electrodesiccation condylomata (complex);
 - Excision of a chalazion;

- Excision of a nail (partial or complete);
- Enucleation or excision of external thrombosed hemorrhoids
- Injection of a ligament or tendon;
- Oral surgery;
- Pain management (including facet joint injections, trigger point injections, stellate ganglion blocks, peripheral nerve blocks, SI joint injections, and intercostals nerve blocks);
- Proctosigmoidoscopy/flexible Sigmoidoscopy;
- Removal of partial or complete bony impacted teeth (if a benefit);
- Repair of lacerations, including suturing (2.5 cm or less);
- Vasectomy;
- Wound care and dressings (including outpatient burn care)
- Outpatient surgeries - All potentially reconstructive/cosmetic and investigational surgeries/procedures;
- Outpatient rehabilitation therapies including physical medicine, occupational therapy, respiratory therapy and manipulation therapy.
- Pulmonary rehabilitation programs;
- Sleep Studies for the diagnosis and medical management of obstructive sleep apnea syndrome
- Specialty Medical Injectable Medications
- Transplant evaluation and services. Preauthorization will include referral assistance to the Blue Quality Centers for Transplant network if appropriate.

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 forty-eight (48) hours or two (2) business days of the admission. If the hospital is a participating provider, the hospital is responsible for performing the notification. If the hospital is a non-participating provider, the member or the member's responsible party acting on the member's behalf is responsible for the notification.

Member identification cards indicate whether preauthorization is required before the listed supplies or services are received. If preauthorization is required, members should present their identification card to their health care provider when medical supplies or services are requested. The member's participating provider will be asked to furnish medical information on the proposed treatment to **Capital BlueCross' Clinical Management Department** by calling **1-800-471-2242**.

If members use a nonparticipating provider or a **BlueCard** participating provider, it is the member's responsibility to obtain preauthorization. Members can call Capital's Clinical Management Department toll-free at **1-800-471-2242** to obtain the necessary preauthorization. A non-participating provider may call on the member's behalf. However, it is ultimately the member's responsibility to obtain preauthorization.

Preauthorization of elective admissions and selected services should be obtained at least seven days prior to the date of service. Maternity admissions require notification within two business days of the date of admission.

Failure to secure preauthorization under the CMM Plan results in a 10 percent preauthorization penalty for the member. Failure to preauthorize under the PPO 80 plan results in a 20 percent preauthorization penalty for the member (on top of the 30 percent coinsurance re-

sponsibility for out-of-network services). Failure to preauthorize under the PPO 100 plan results in a 30 percent preauthorization penalty for the member (on top of the 20 percent coinsurance responsibility for out-of-network services).

Preauthorization for the Keystone Health Plan HMO ...

Remember that preauthorization is required for **all** supplies and services in the Keystone Health Plan Central HMO.

Taxable life insurance premiums over \$50,000 ...

The IRS requires Lehigh to include the taxable value of the life insurance premium that pays for life insurance in excess of \$50,000 on your W-2 form. The value is defined by the IRS and may differ from the premium amount actually paid.

Changing your life insurance by more than one level ...

If you choose to increase your life insurance by more than one level during a plan year, you must submit evidence of insurability. Your increased life insurance will not become effective until the carrier has approved the increased life insurance amount. You will be covered for the maximum life insurance you could have purchased without evidence during the review period, which is one level higher than you had in the prior plan year.

Increasing the level of dependent life insurance ...

You will need to provide evidence of insurability to increase the volume of spouse/partner group term life insurance you carry. No evidence is required to increase the level of dependent child life coverage.

Long-term disability benefits and taxes ...

If you choose to purchase long-term disability (LTD) benefits with pre-tax dollars, any future benefit you might receive under the plan will be subject to taxation. However, if you choose to pay taxes on the premium amount when you purchase long-term disability, some or all of your future benefits will **not** be taxable income for federal income tax purposes.

You must pay for the LTD benefit on a “post-tax” basis for a period of thirty-six (36) months to make the benefit 100 percent free of federal taxation. Remember, too, that other sources of disability income that may reduce your LTD payment (Social Security disability income, for example) will be subject to federal income tax.

Dependent Care Flexible Spending Account reimbursements ...

You can only be reimbursed from a Dependent Care FSA after all services have been received — that is, after the end of the month for which you seek reimbursement.

In addition, you can only be reimbursed up to the amount that has been withheld from your pay as of the request date.

Forfeiture of unspent Flexible Spending Account (FSA) dollars ...

Any balances remaining in your FSAs after March 31 of the year following the flexible spending account plan year are forfeited. This is a legal requirement; not a University policy.

The administrator for the FSAs will send you a welcoming letter and periodic updates

about the remaining balance in your account. **It is your responsibility to submit claims**, including all related documentation, to the claims processor before the end of the reimbursement period. Forfeited funds are used to offset the administrative cost of the Flexible Benefits plan.

Plan documents ...

Each University benefit plan is governed by specific and detailed plan documents. If there is a discrepancy between these plan documents and any plan description you might receive, the plan documents will govern.

Creditable Coverage Disclosure Notice

The federal government requires employers to provide the notice that begins on the next page to employees who are eligible for, or who are enrolled in, full Medicare medical coverage. The notice is also required to be given to every employee dependent who meets the same conditions. One way to make sure that Lehigh carries out this responsibility is to publish the notice in materials that are made available to every employee.

Neither the notice, nor the availability of Medicare D prescription drug coverage, requires anyone who may be Medicare eligible to enroll in Medicare or to use Medicare as their insurer. Certainly, no one who is covered by a University medical plan, as an employee or a dependent, is required to enroll in Medicare or Medicare D coverage as a result of Medicare drug coverage being available. Please call **Human Resources** at **610-758-3900** if you have any questions or concerns about this required notice.

Important Notice from Lehigh University About Your Prescription Drug Coverage and Medicare October 8, 2013

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 8, 2013
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”):

- CMM Plan, administered by Capital Blue Cross,
- PPO 80, administered by Capital Blue Cross,
- PPO 100, administered by Capital Blue Cross,
- Keystone Health Plan Central HMO, 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, and
- Health Care Flexible Spending Accounts, administered by Ceridian Benefits Services.

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-Central>. 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 16, 2012

Checklist for Benefit Enrollment

- Review benefit enrollment materials.
- Contact vendors with questions or visit their websites (see inside front cover).
- Complete your online enrollment to select benefits (if you're a current employee).
- Complete your *Flexible Benefits Enrollment Form* to select benefits (if you're a new employee).
- Complete a *Medical Enrollment/Change Application Form* if you are selecting a medical plan for the first time, changing medical plans, or changing the dependents you cover under a medical plan.
- Complete a *Dental Enrollment Form* if you are selecting the dental plan for the first time or changing the dependents you cover under the dental plan.
- Check your elections on the Employee component of the Campus Portal "Banner" icon after you have completed your enrollment and sent the appropriate forms to Human Resources.