BE WELL

QUICK-REFERENCE GUIDE
NOVEMBER 2013

Open Enrollment
Flex Benefits Updates for 2014

LEHIGH UNIVERSITY

Welcome to your annual quick-reference guide containing all the information and links you'll need to review and act on your flexible benefit options for 2014. The full reference guide and all the forms and links you need to complete your enrollment will be available online at **Open Enrollment Central:** https://hr.lehigh.edu/open-enrollment on November 1, 2013.

There you will also find ***Your Guide to the Online Open Enrollment Process 2014***, which walks you through the step-by-step process of updating your benefits selections for 2014 using the *Banner Open Enrollment* tool.

This year, **open enrollment will run from November 1 through November 15, 2013 and your benefit choices will become effective January 1, 2014**. Flexible benefits offer you a variety of options to address your benefit needs. You can review options for:

- Medical coverage;
- Dental insurance;
- Life insurance for yourself and dependents;
- Long-term disability insurance; and
- Flexible spending accounts.

There are some significant changes to coverage and access to coverage:

- There is an increase to the employee and employer medical premium cost share (see page 3 for details), however, there are no increases in co-payments or co-insurance fees.
- Adult children under the age of 26, *regardless of employment, marital or student status*, may now access an employee's medical, dental, life insurance and flexible spending account benefits.
- Deductibles, co-insurance, and co-pays for a variety of preventive appointments and procedures will be eliminated in compliance with the Patient Protection and Affordable Care Act. See page 12 for more information.

Important Reminders:

- If you make a change to your current medical coverage or dental insurance elections, you need to complete corresponding enrollment forms. These forms provide information to plan vendors about coverage changes you want to make. You can find both the **Medical Enrollment/Change Application** and the **Dental Insurance Enrollment Form** at http://hr.lehigh.edu/hr-forms. Please call Human Resources (HR) at extension 83900 — or stop by our office — if you need paper copies of either form. Return the completed enrollment forms to the HR office for processing.
- If you do nothing during open enrollment, your benefit elections will remain the same for 2014 as they are in 2013, **except** that you won't have a **Flexible Spending Account (FSA)** for the new year. The only way to have a Health Care or Dependent Care FSA for 2014 (in the absence of any later qualifying life event) is to commit to one during the open enrollment period.

Remember, this is your annual opportunity to review your current flexible benefit elections, to learn more about your alternatives, and to spend your benefit dollars wisely.

Need some advice? **Call us at 610-758-3900. We can help!**

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Open Enrollment Timeline

November 1: Online open enrollment opens.

November 15: Online open enrollment closes.

November 16—22: Flex benefit changes can be requested in writing. Online enrollment confirmations can be printed from your Banner account for your records.

After November 22: Flex changes can only be made in response to a qualifying life event.

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 for your prescription drug coverage. Please see page 7 for more details.

Medical Plan Benefit Comparison Chart

Plan Structure	*Comprehensive Major Medical (CMM) Plan*	*Preferred Provider Organization (PPO) 80*		*Preferred Provider Organization (PPO) 100*		*Keystone Health Plan Health Maintenance Organization (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 Maximums 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					

[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 prescription, per month; $50 brand prescription maximum per prescription, per month.
[L] With limitations defined by the plan or provided in the Affordable Care Act (see https://www.healthcare.gov/what-are-my-preventive-care-benefits/).
[M] Managed by Integrated Behavior Health (**IBH).** Contact **IBH** directly to coordinate services.
[P] Preauthorization required: 30 percent coinsurance if Capital Blue Cross procedures not followed in the CMM Plan; 50 percent coinsurance out-of-network in PPO80 and PPO 100; failure to preauthorize with IBH results in no benefit.

See also: Important Notices and Disclosures about the medical plan on pages 8 through 10.

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. Copayments do not affect the deductible and coinsurance maximum but do contribute to the out-of-pocket maximum that includes applicable physician copayments.

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

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

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

Preventive Care: Any covered medical service or supply that is received in the absence of symptoms or a diagnosed medical condition. Preventive care includes preventive health services like physical examinations, certain immunizations, and screening tests. Preventive care can also provide specific programs of education, exercise, or behavior modification that seek to manage disease or change lifestyle — programs for diabetes management, smoking cessation, childbirth preparation — and the like. Medical plans clearly define the types of services, supplies, and programs they offer as preventive benefits and they provide them based upon protocols established in the medical community with regard to factors like frequency, patient age, and suitability. The Patient Protection and Affordable Care Act also requires particular preventive services for particular individuals to be covered at no cost, provided the covered services are received from a network provider. These services can be reviewed on page 12 of this document or at https://www.healthcare.gov/what-are-my-preventive-care-benefits.

2014 Monthly Medical Prices

	University Contribution	Employee Premiums			
		CMM Plan	*PPO 80*	*PPO 100*	*HMO*
Individual	$479	$117	$156	$200	$76
Employee + Spouse/Partner	$992	$295	$388	$482	$205
Employee + Child(ren)	$902	$265	$349	$434	$183
Employee + Family	$1,429	$441	$571	$708	$302

Vision and Prescription Drug Plan Information

Davis Vision Program

Service/Product	Your In-Network Cost	Out-of-Network Reimbursement to You
Eye Exam	$0	$32
Eyeglass Lenses		
Standard Single Vision	$0	$25
Bifocal	$0	$36
Trifocal	$0	$46
Post Cataract	$0	$72
Non-standard (i.e., no line bifocals, tints, coatings)	Fixed Costs	No **Additional** Benefit
Frames	$0 for Davis fashion selection frames. Amount over $60 for provider frames.	$30
Contact Lenses		
Prescription and Fitting	$0	Daily Wear: $20 Extended Wear: $30
Standard Contact Lenses	$0	$48
Specialty Contact Lenses	Amount over $75	$75

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

Express Scripts Preferred Drug Step Therapy Program

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

- PPIs (proton pump inhibitors) —used to reduce stomach acid
- SSRIs (selective serotonin re-uptake inhibitors) — used to treat depression, anxiety, and some personality disorders
- Osteoporosis — used to strengthen fragile bones
- ARBs (angiotension II receptor blockers) — used to reduce blood pressure
- INS (intranasal steroids) — used to treat nasal allergies
- Hypnotics (insomnia medications) — used to treat sleep disorders
- Triptans — used to treat 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.

Coordination Of Benefits

If you have dependents covered by Lehigh's medical insurance plan, you will be asked to complete a **Coordination of Benefits Questionnaire**. You will receive the form from **Capital BlueCross**. This form will ask you if your spouse/partner also has coverage for your dependents on a plan from his or her employer and if your adult children have coverage with their employers.

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

Concordia Flex Dental Benefit Summary

Diagnostic and Preventive Service Benefits — Paid at 100% of MAC*. Does not count against maximum annual benefits of $1,000 per person.
Semi-annual cleaning, polishing, and examination Annual bitewing X-rays Complete X-ray series (every five years) Fluoride treatment (under age 19) Sealant: 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.*

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

2014 Monthly Dental Prices

***United Concordia* Dental**	
Employee Only	$31.42
Employee + One	$62.84
Employee + Two or More	$81.24

The Preventive Incentive

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

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

In addition, the coverage of these costs **DOES NOT** count toward your annual maximum. For more information on The Preventive Incentive, contact United Concordia Dental Customer Service at **1-800-332-0366**.

Need Help?

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

Provider	Phone	Web Address
Capital BlueCross and	800-216-9741	www.capbluecross.com
Integrated Behavioral Health (Mental Health/Substance Abuse benefits in Keystone Health Plan and PPO 100)	800-395-1616	www.ibhcorp.com/ User ID: lehigh Password: univ03
Magellan (Mental Health/Substance Abuse benefits in CMM and PPO 80)	1-866-322-1657	www.capbluecross.com www.magellanhealth.com
Express Scripts	866-383-7420	www.express-scripts.com
Davis Vision	877-923-2847 OR 800-999-5431	www.davisvision.com/ Control Code: 4100
United Concordia Dental	800-332-0366	www.ucci.com
Ceridian (Flexible Spending Account Administration)	877-799-8820	www.ceridian-benefits.com
Human Resources 428 Brodhead Avenue Bethlehem, PA 18015	610-758-3900 610-758-6226 (fax)	www.hr.lehigh.edu

Information Available on Campus

Representatives from **Capital BlueCross**, **Express Scripts**, **Davis Vision**, **Integrated Behavioral Health**, and the **UnitedConcordia** dental insurance plan will be on campus on **the following dates.** Take the time to visit with them and ask questions about how Lehigh's medical and dental plans work. HR reps will also be available.

DATE	LOCATION
Tuesday, November 5 **11:30am to 2:00pm**	University Center — 3rd floor Faculty Lounge West and Wood Dining Room Foyer, Iacocca Hall
Wednesday, November 6 **11:30am to 2:00pm**	University Center — 3rd floor Faculty Lounge West and Wood Dining Room Foyer, Iacocca Hall

Notice of Privacy Practices

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

Lehigh University Human Resources
428 Brodhead Avenue
Bethlehem, PA 18015

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

Creditable Coverage Disclosure Notice

The federal government requires employers to provide the notice that begins below 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 sent 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:

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.

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,

(Continued on page 8)

Important Notices and Disclosures

(Continued from page 7)

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**).

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

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 your are required to pay a higher premium (a penalty).

The following notices are 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. A paper copy is also available, free of charge, by calling 610-758-3900.

Important Notices and Disclosures

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 following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 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)

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

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2013. You should contact your State for further information on eligibility.

ALABAMA—Medicaid Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	**MASSACHUSETTS—Medicaid and CHIP** web: http://www.mass.gov/MassHealth phone: 1-800-462-1120	**PENNSYLVANIA—Medicaid** Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462
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	**MINNESOTA—Medicaid** Website: http://www.dhs.state.mn.us/ Click on **Health Care**, then **Medical Assistance** Phone: 1-800-657-3629	**RHODE ISLAND—Medicaid** Web: www.ohhs.ri.gov Phone: 401-462-5300
ARIZONA– CHIP Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	**MISSOURI—Medicaid** Web: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	**SOUTH CAROLINA—Medicaid** web: http://www.scdhhs.gov phone: 1-888-549-0820
COLORADO—Medicaid Medicaid web: http://www.colorado.gov/ Medicaid phone: 1-800-866-3513 Medicaid phone (out of state): 1-800-221-3943	**MONTANA—Medicaid** Web: http://www.medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084	**SOUTH DAKOTA—Medicaid** Website: http://dss.sd.gov Phone: 1-888-828-0059
FLORIDA—Medicaid Web: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	**NEBRASKA—Medicaid** Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278	**TEXAS—Medicaid** web: https://www.gethipptexas.com phone: 1-800-440-0493
GEORGIA—Medicaid Web: http://dch.georgia.gov/ Click on **Programs**, then **Medicaid**, then **Health Insurance Premium Payment** (*HIPP*) Phone: 1-800-869-1150	**NEVADA—Medicaid** Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	**UTAH—Medicaid** Web: http://health.utah.gov/upp Phone: 1-866-435-7414
IDAHO—Medicaid and CHIP Medicaid web: www.accesstohealthinsurance.idaho.gov Medicaid phone: 1-800-926-2588 CHIP web: www.medicaid.idaho.gov CHIP phone: 1-800-926-2588	**NEW HAMPSHIRE—Medicaid** Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218	**VERMONT—Medicaid** Web: http://www.greenmountaincare.org Phone: 1-800-250-8427
INDIANA—Medicaid Web: http://www.in.gov/fssa phone: 1-800-889-9949	**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	**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
IOWA– Medicaid web: http://www.dhs.state.ia.us./hipp phone: 1-888-346-9562	**NEW YORK—Medicaid** web: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831	**WASHINGTON—Medicaid** web: http://hrsa.dshs.wa.gov/premiumpymt/Apply.sthm phone: 1-800-562-3022 ext. 15473
KANSAS– Medicaid Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	**NORTH CAROLINA—Medicaid** Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100	**WEST VIRGINIA—Medicaid** Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
KENTUCKY—Medicaid web: http://chfs.ky.gov/dms/default.htm phone: 1-800-635-2570	**NORTH DAKOTA—Medicaid** Web: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-888-755-2604	**WISCONSIN—Medicaid** web: http://www.badgercareplus.org/pubs/p-10095.htm phone: 1-800-362-3002
LOUISIANA—Medicaid Web: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	**OKLAHOMA—Medicaid** web: http://www.insureoklahoma.org phone: 1-888-365-3742	**WYOMING—Medicaid** Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531
MAINE—Medicaid Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	**OREGON—Medicaid and CHIP** web: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov phone: 1-877-314-5678	

Frequently Asked Questions

Q: What is the last date to file Capital BlueCross claims for the CMM Plan, PPO 80, and PPO 100 medical plans?
A: Claims must be filed within twelve (12) months of the date of service for any of the Capital BlueCross medical plans.

Q: How often may I change from one health insurance coverage plan to another?
A: The only time you can change to another carrier is during the open enrollment period, held this year from **November 1 to 15**. 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, and/or increase your supplemental life insurance. 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 step-child(ren) you must contact Human Resources, provide a copy of your marriage documentation, and complete the appropriate documents.

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: 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 pro-rated tax savings.

Q: How do I enroll my domestic partner and his/her children in the plan during Open Enrollment?
A: There are two steps in adding your domestic partner and his/her dependents to your plan. First, you will need to declare your partnership and inform Lehigh of your new dependents. You do this by completing a *Personal Information Change Form*, available on the HR Website or at the HR office, and by completing **affidavits** to document and provide evidence of your partnership. The affidavit forms are also available on the HR website and at the HR office. Once you have established your partnership and added your partner's children to your personal information, you can add them to your benefits during online Open Enrollment. 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 wish to purchase. For medical plans, select your plan choice and then indicate the level of family coverage you need.

For more Frequently Asked Questions, refer to the 2014 Flexible Benefits Enrollment and Reference Guide *posted online at: https://hr.lehigh.edu/benefits . Or, to get answers from a flexible benefit provider, see the* **Need Help?** *chart on page 6.*

A Note About International Travel

All four of Lehigh's medical coverage plans are administered by **Capital BlueCross**, which is a member of the **BlueCross-BlueShield Association**. That affiliation makes the *BlueCard Worldwide* program available to employees and dependents covered under any Lehigh medical plan. *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 US, you can find information about the program and its services — including the process for locating a doctor or hospital — by calling **1-800-810-BLUE**. Outside the US call collect at **1-804-673-1177**.

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

Preventive Care and The Affordable Care Act

The Patient Protection And Affordable Care Act requires particular preventive services for particular individuals to be covered at no cost, provided the covered services are received from a network provider. Check healthcare.gov for complete details. Benefits include:

For Adults

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol Misuse screening and counseling
- Aspirin use to prevent cardiovascular disease for men and women of certain ages
- Blood Pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal Cancer screening for adults over 50
- Depression screening for adults
- Diabetes (Type 2) screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease
- HIV screening for everyone ages 15 to 65, and others at increased risk
- Immunization vaccines for adults--doses, recommended ages, and recommended populations
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- Syphilis screening for all adults at higher risk
- Tobacco Use screening for all adults and cessation interventions for tobacco users

Especially For Women

- Anemia screening on a routine basis for pregnant women
- Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer
- Breast Cancer Mammography screenings every 1 to 2 years for women over 40
- Breast Cancer Chemoprevention counseling for women at higher risk
- Breastfeeding support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
- Cervical Cancer screening for sexually active women
- Chlamydia Infection screening for younger women and other women at higher risk
- Contraception: FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt "religious employers."
- Domestic and interpersonal violence screening and counseling for all women
- Folic Acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk
- Gonorrhea screening for women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- HIV screening and counseling for sexually active women
- Human Papillomavirus (HPV) DNA Test every 3 years for women with normal cytology results who are 30 or older
- Osteoporosis screening over age 60 depending on risk factors
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Sexually Transmitted Infections counseling for sexually active women
- Syphilis screening for all pregnant women or other women at increased risk
- Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Urinary tract or other infection screening for pregnant women
- Well-woman visits to get recommended services for women under 65

For Children

- Autism screening at 18 and 24 months
- Behavioral assessments at various ages.
- Blood Pressure screening at various ages.
- Cervical Dysplasia screening for sexually active females
- Depression screening for adolescents
- Developmental screening for children under 3
- Dyslipidemia screening for children at higher risk of lipid disorders at various ages
- Fluoride Chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, Weight and Body Mass Index measurements for children at various ages.
- Hematocrit or Hemoglobin screening
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Hypothyroidism screening for newborns
- Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary – check the healthcare.gov website for a detailed list
- Lead screening for children at risk of exposure
- Medical History for all children throughout development at various ages.
- Obesity screening and counseling
- Oral Health risk assessment for young children.
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis at various ages
- Vision screening for all children.