BE WELL

Open Enrollment Quick Reference Guide
November 2015

LEHIGH UNIVERSITY

Open Enrollment Flex Benefits Updates for 2016

This is your annual Flex Benefits Open Enrollment quick-reference guide. It contains information and links you should review to select your flexible benefits for the 2016 benefit plan year, which runs from January 1 to December 31, 2016.

Flex Benefits include:

- Medical insurance
- Dental insurance
- Life insurance for you and your dependents
- Long-term disability insurance
- Flexible spending accounts

This year, the online Open Enrollment process runs November 2 through 16, 2015. Your benefits choices take effect January 1, 2016.

OPEN ENROLLMENT CENTRAL

Open Enrollment Central -- hr.lehigh.edu/open-enrollment -- is your one-stop shop on the web to ensure you are fully informed about your benefits. There, you will find the *Flexible Benefits Open Enrollment Guide*, *Your Guide To The Open Enrollment Process*, links to important forms and much more. Open Enrollment Central will be online November 2, 2015.

PREMIUM INCREASES

Medical and supplemental life insurance premiums will increase this year. Refer to the new monthly medical insurance premium prices on page 3. The new supplemental life premiums can be found at Open Enrollment Central.

SUPPLEMENTAL LIFE POLICY UPDATE

If you are considering increasing the level of supplemental life insurance, please refer to updated policy information on Open Enrollment Central.

ONLINE SPOUSE/PARTNER SURCHARGE WAIVER REQUEST

Employees who include a spouse or partner who has access to medical insurance through his/her own employer or former employer will automatically be assessed a monthly $100 spousal surcharge.

To avoid paying the surcharge, an employee must positively affirm that his or her spouse/partner does not have access to medical insurance elsewhere. This is done through a spouse/partner surcharge waiver request. The spouse/partner surcharge waiver request can be easily accessed and completed via an online survey form located in the **Open Enrollment Central** forms section. It must be completed and submitted by November 25, 2015 to avoid the surcharge.

If you have a spouse/partner on your medical plan and don't complete the request prior to November 25, 2015, you will be charged a $100 monthly surcharge starting in January 2016. You will continue to be charged $100 monthly if you do not submit the waiver request. If your waiver request is accepted, the surcharge will stop, but prior months' charges will not be refunded.

The bottom line: Don't delay. Complete the waiver request before November 25, 2015.

THE HEALTH BENEFITS SURVEY

Our current health care plan designs were introduced in 2006. Since then, the basic plan designs have remained relatively stable. As the University looks to contain costs and the health care regulatory and legislative environment continues to shift, we are undertaking a thorough review of current and possible future offerings. Part of the review is a staff and faculty survey. You will receive a link to the survey via an email from Mercer. Please complete the survey by midnight, November 23, 2015.

OUR ANNUAL VERY IMPORTANT REMINDERS

- If you make a change to your current medical coverage or dental insurance elections, you must complete corresponding enrollment forms. These forms provide information to our vendors about those changes. Find the forms at Open Enrollment Central. You can also vist the office at 428 Brodhead if you need paper copies. Return the forms to HR.
- If you do nothing during Open Enrollment, your benefit elections will remain the same for 2016 as they were in 2015 with the exception of Flexible Spending Accounts (FSA). FSAs do not automatically roll into the next plan year. To continue a Health Care or Dependent Care FSA for 2016, you MUST make that selection via the Open Enrollment.
- If you have a 2015 Healthcare FSA, you can carry up to $500 of any unclaimed balance into the new year, even if you do not enroll in a 2016 Healthcare FSA.
- This is your annual opportunity to carefully consider how you choose to spend your benefits dollars. After the Open Enrollment period ends, changes to your benefits can only be made in response to a Qualifying Life Event.

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

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. See page 7 for more details.

CONTENTS

Medical Plan Benefit Comparison Chart

Plan Structure	Comprehensive Major Medical Plan (CMM)	Preferred Provider Organization 80 (PPO 80)		Preferred Provider Organization 100 (PPO 100)		Keystone Health Plan Health Maintenance Organization
		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	$4150/person $8300/family	$4150/person $8300/family	Unlimited	$4150/person $8300/family	Unlimited	$4150/person $8300/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. Out of pocket maximum $2700/person, $5400 per family. More information on page 4. [G]					
Vision Care	Davis Vision Program. More information on page 4.					

[A] Preauthorization required from Magellan Behavioral Health, Contact Magellan directly to coordinate services.
[CI] Coinsurance: Portion of a covered charge paid by both the insured and the plan.
[CP] Copayment: Flat dollar amount paid to provider by the insured for a covered service or supply at the time service or supply is received.
[D] Deductible: Total amount of covered charges the insured must pay in full during plan year before any payment is made by plan.
[G] $25 generic prescription maximum per prescription, per month; $50 brand prescription maximum per prescription, per month.
[L] With limitations defined by the plan or provided in the Affordable Care Act (see https://www.healthcare.gov/preventive-care-benefits/).
[M] Managed by Integrated Behavior Health (IBH). Contact IBH directly to coordinate services.
[P] Preauthorization required: 30 percent coinsurance if Capital Blue Cross procedures not followed in the CMM Plan; 50 percent coinsurance out-of-network in PP080 and PPO 100; failure to preauthorize with KHP 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 declines to accept the payment level determined by a medical plan as payment in full. The provider then bills the insured for the amount of the charge that exceeds plan payment plus deductible, coinsurance, and/or copayment.

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

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

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

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

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

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

2016 Monthly Medical Prices

	University Contribution	Employee Premiums			
		CMM Plan	PPO 80	PPO 100	HMO
Individual	$511	$141	$190	$242	$92
Employee + Spouse/Partner	$1,058	$363	$471	$584	$257
Employee + Child(ren)	$962	$322	$419	$521	$226
Employee + Family	$1,525	$529	$684	$847	$374

Vision and Prescription Drug Plan Information

Davis Vision Program

Service/Product	Your In-Network Cost	Out-of-Network Reimbursement to You
Eye Exam	$0	$32
Eyeglass Lenses		
Standard Single vision	$0	$25
Bifocal	$0	$36
Trifocal	$0	$46
Post Cataract	$0	$72
Non-standard (i.e. no line bifocals, tins, 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 (angiorension II receptor blockers): used to reduce blood pressure
- INS (intranasal steroids): used to treat nasal allergies
- Hypnotics (insomnia medications): used to treat sleep disorders
- Triptans: used to treat migraines
- Glaucoma: used to treat increased pressure in the fluid inside the eye.
- Combination Beta2 Agonists/corticosteroids inhalers: used to treat asthma
- Corticosteroids Inhalers: used to treat asthma
- Estrogen Replacement Therapy: used to treat menopausal symptoms and potential calcium deficiency
- Insulin: used to control diabetes.

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

Coordination of Benefits

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

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

Concordia Flex Dental Benefit Summary

Diagnostic and Preventive Service Benefits - Paid at 100% of MAC*. 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 and crowns
Prosthetics: Dentures and bridges; no implants

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

Orthodontic lifetime benefit maximum of $1,000 per person

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

The Preventive Incentive

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

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

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

2016 Monthly Dental Prices

United Concordia Dental

Employee Only	$31.42
Employee + One	$62.84
Employee + Two or More	$81.24

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

A Note About International Travel

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

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

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

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

Need Help?

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

Provider	Phone	Web Address
Capital BlueCross and Keystone Health Plan	**800-216-9741**	**www.capbluecross.com**
Integrated Behavioral Health (mental health/substance abuse benefits in Keystone Health Plan and PPO100)	**800-395-1616**	**www.ibhcorp.com** **To access EAP/WorkLife:** **user id: lehigh** **password: univ03**
Magellan (mental health/substance abuse benefits in CMM and PPO80)	**866-322-1657**	**www.magellanhealth.com**
Express Scripts	**866-383-7420**	**www.express-scripts.com**
Davis Vision	**877-923-2847** **or** **800-999-5431**	**www.davisvision.com** **control code: 4100**
United Concordia Dental	**800-332-0366**	**www.ucci.com**
WageWorks (Flexible Spending Account administration)	**855-774-7441**	**www.wageworks.com**
Human Resources 428 Brodhead Avenue Bethlehem, PA 18015	**610-758-3900** **610-758-6226 (fax)**	**https://hr.lehigh.edu**

Campus Visits By Insurance Vendors

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

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

Tuesday, November 10
and
Wednesday, November 11

12:00 noon to 1:30 p.m.

University Center Faculty Lounge
and
Iacocca Hall Siegel Lobby

Notice of Privacy Practices

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

Lehigh University Human Resources
428 Brodhead Avenue
Bethlehem, PA 18015

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

Creditable Coverage Disclosure Notice

Important Notice from Lehigh University About Your Prescription Drug Coverage and Medicare

October 9, 2015

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 infor mation 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.

Important Notices and Disclosures

(Continued from page 7)

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 9, 2015
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

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 COVERAGE 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 in the full *Flexible Benefits Enrollment and Reference Guide,* 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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2015. Contact your State for more information on eligibility.

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, 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 10/31/2016)

Stay Up-To-Date on your benefits and more throughout the year!

Read SPOTLIGHT

go to spotlight.lehigh.edu

Important Notices and Disclosures

ALABAMA – Medicaid Website: www.myalhipp.com Phone: 1-855-692-5447	**MINNESOTA** – Medicaid Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	**PENNSYLVANIA** – Medicaid Website: http://www.dhs.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	**MISSOURI** – Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	**RHODE ISLAND** – Medicaid Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
COLORADO – Medicaid Medicaid Website: http://www.colorado.gov/hcpf Phone: 1-800-221-3943	**MONTANA** – Medicaid Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	**SOUTH CAROLINA** – Medicaid Website: http://www.scdhhs.gov Phone: 1-888-549-0820
FLORIDA – Medicaid Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	**NEBRASKA** – Medicaid Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	**SOUTH DAKOTA** - Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059
GEORGIA – Medicaid Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 404-656-4507	**NEVADA** – Medicaid Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	**TEXAS** – Medicaid Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493
INDIANA – Medicaid Website: http://www.in.gov/fssa Phone: 1-800-889-9949	**NEW HAMPSHIRE** – Medicaid Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218	**UTAH** – Medicaid and CHIP Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414
IOWA – Medicaid Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	**NEW JERSEY** – Medicaid and CHIP Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	**VERMONT**– Medicaid Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
KANSAS – Medicaid Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	**NEW YORK** – Medicaid Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831	**VIRGINIA** – Medicaid and CHIP Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
KENTUCKY – Medicaid Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	**NORTH CAROLINA** – Medicaid Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100	**WASHINGTON** – Medicaid Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/ index.aspx Phone: 1-800-562-3022 ext. 15473
LOUISIANA – Medicaid Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	**NORTH DAKOTA** – Medicaid Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	**WEST VIRGINIA** – Medicaid Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
MAINE – Medicaid Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740/TTY 1-800-977-6741	**OKLAHOMA** – Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	**WISCONSIN** – Medicaid Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
MASSACHUSETTS – Medicaid and CHIP Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	**OREGON** – Medicaid Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	**WYOMING** – Medicaid Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

Frequently Asked Questions

Q: What is the last date to file Capital BlueCross claims for the CMM, PPO80 or PPO100 medical plans?
A: Claims must be filed within twelve (12) months of the date of service for any of the Capital BlueCross medical plans.

Q: How often may I change from one health insurance plan to another within our medical plans?
A: The only time you can change to another carrier is during the annual open enrollment period, held this year from November 2 - 16. If you are dissatistifed with your current coverage, please contact Human Resources. It is important to tell us about any problems you encounter.

Q: I am 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 at hr.lehigh.edu/open-enrollment. 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: I am expecting a baby/adopting a child soon. Can I add my new child 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 Human Resources, 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 on my medical plan?
A: No. Your dependent or adult children can only remain covered under a university medical, dental, life insurance, or FSA program until they reach age 26. He or she will be offered COBRA continuation medical and dental coverage at that time. He or she can also visit www.healthcare.gov to see options for purchasing individual medical insurance. If your child is disabled, special rules may apply. Please contact HR for more information.

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

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

Q: I enrolled my non-working spouse/partner on my insurance plan. How do I avoid being charged the Spouse/Partner Surcharge?
A: The Spouse/Partner Surcharge of $100 per month is assessed when an employee's spouse/partner has access to medical insurance via an employer or former employer but still chooses to be enrolled in Lehigh's plan. If your spouse/partner does not have such access, you must complete the online Spouse/Partner Surcharge Waiver Request form to avoid being charged. If you do not complete the spousal surcharge waiver request prior to November 25, 2015, you will be charged the surcharge starting in January 2016. You will continue to be charged $100 monthly if you do not submit the waiver request. Please note that if your waiver request is accepted, the surcharge will stop, but prior months' charges will not be refunded.

For more Frequently Asked Questions, refer to the 2016 Flexible Benefits Enrollment and Reference Guide posted online at hr.lehigh.edu/open-enrollment. Or, to get answers from a flexible benefits provider, see the Need Help? chart on page 6.

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 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 vary
•Sexually Transmitted Infection (STI) prevention counseling for higher risk adults
•Syphilis screening for 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 higher risk women
•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 arc 30 or older
•Osteoporosis screening over age 60 depending on risk factors
•Rh lncomparibiliry 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.
•Hemarocrit 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.