Flex Benefits Updates for 2020

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 2020 benefit plan year, which runs from January 1 to December 31, 2020. This year, the online Open Enrollment period runs November 4 through 18, 2019. Your benefits choices take effect January 1, 2020. For complete information, consult the 2020 Flexible Benefits Enrollment and Reference Guide on the Lehigh Benefits website, available Monday, November 4.

WHAT’S NEW?

Changes in 2020

• Medical coverage monthly premiums are increasing. Plan premiums are listed on page three.
• Total Out-of-Pocket Maximums have increased in all plans. Maximums are managed as a single total figure including healthcare and pharmacy expenses.
• Deductibles have increased in the High Deductible Health Plan.

IMPORTANT REMINDER

If you wish to have a healthcare or dependent care Flexible Spending Account (FSA) in 2020 or make employee contributions to a Health Savings Account (HSA) in 2020, you must make these elections during Open Enrollment. FSAs and employee contributions to HSAs DO NOT automatically roll forward from the previous year.

ENROLLING IS EASY

Enroll on the Web

• Log in to “Connect Lehigh” from the upper left corner of the Inside Lehigh homepage.
• Select the “Employee” tab.
• Select “Lehigh Benefits” from the list of applications.
• Complete the tasks on your “To Do” list.
• Select the button under the words “Enroll Now!” that reads “Click Here to View Your Benefits.”

Or Use The App

• Download the Benefitfocus app from The App Store or the Google Play Store.
• Log in by using the ID “lehighbenefits” on the initial screen, then sign in with your Lehigh ID and password.

Whether you use the web or the app, you'll be asked to confirm your dependents and answer a few questions before you begin enrollment. You can review your current elections, use the comparison shopping tool to view estimated out of pocket costs for you in each plan, change your elections, update your beneficiary information and more.

ARE YOU

Considering the High Deductible Plan with HSA

AND

Turning 65 and eligible for Social Security or Medicare This Year?

See page 8 for very important information about Health Savings Accounts

BE WELL

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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:** The portion of a charged amount that is paid by 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 $25 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 screenings. Preventive care also can provide specific programs of education, exercise, or behavior modification that seek to manage disease or change lifestyle: programs for diabetes management, smoking cessation, childbirth preparation and the like. Medical plans clearly define the types of services, supplies, and programs they offer as preventive benefits and they provide them based upon protocols established in the medical community with regard to factors like frequency, patient age, and suitability. The Patient Protection and Affordable Care Act also requires particular preventive services for particular individuals to be covered at no cost, provided the covered services are received from a network provider. These services can be reviewed at [healthcare.gov/coverage/preventive-care-benefits](http://healthcare.gov/coverage/preventive-care-benefits).

### 2020 Monthly Medical Insurance Prices

<table>
<thead>
<tr>
<th>University Contribution</th>
<th>Employee Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HDHP Plan</td>
</tr>
<tr>
<td><strong>Individual</strong></td>
<td>$554</td>
</tr>
<tr>
<td><strong>Employee + Spouse/Partner</strong></td>
<td>$1,144</td>
</tr>
<tr>
<td><strong>Employee + Child(ren)</strong></td>
<td>$1,040</td>
</tr>
<tr>
<td><strong>Employee + Family</strong></td>
<td>$1,649</td>
</tr>
</tbody>
</table>

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*For all coverage levels other than employee only, the entire family deductible must be met before the HDHP plan starts paying medical and pharmacy benefits to anyone in the plan. Medical and pharmacy expenses count toward the deductible.

**Depending on which medical plan you choose, Mental Health and Substance Abuse benefits are provided through either Magellan Health Services or Integrated Behavioral Health. Prior authorization is required in all plans. Failure to preauthorize with IHP results in no benefit.

**Care from out-of-network providers is not covered, other than in an emergency, as determined by Capital Blue Cross. See the Summary of Benefits and Coverage and Plan Design Details sections of the 2020 Enrollment and Reference Guide to learn more about specific coverages and limits as well as preauthorization information.

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Summary of Medical Plan Options

<table>
<thead>
<tr>
<th>Network</th>
<th>PPO</th>
<th>PPO Plus</th>
<th>HDHP</th>
<th>Keystone HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-network</td>
<td>Out-of-network</td>
<td>In-network</td>
<td>Out-of-network</td>
<td>In-network</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$310</td>
<td>$195</td>
<td>$0</td>
<td>$195</td>
</tr>
<tr>
<td>Family</td>
<td>$620</td>
<td>$390</td>
<td>$300</td>
<td>$390</td>
</tr>
</tbody>
</table>

**Out-of-Pocket Maximum for all medical and prescription drug charges**

| Individual | $4,000 | No limit | $4,000 | No limit | $6,900 | No limit | $4,000 |
| Family | $8,000 | No limit | $8,000 | No limit | $13,800 | No limit | $8,000 |

| Office Visit | | | | | | |
| 20% coinsurance | | | | | | |
| Preventive Care (Administered in accordance with Preventive Health Guidelines & PA state mandates) | No charge | | | | | |
| Hospital Services | | | | | | |
| Inpatient | 20% coinsurance | 30% coinsurance | 10% coinsurance | 20% coinsurance | 20% coinsurance | 30% coinsurance | 10% coinsurance |
| Outpatient | 20% coinsurance | 30% coinsurance | 10% coinsurance | 20% coinsurance | 20% coinsurance | 30% coinsurance | 10% coinsurance |
| Urgent Care | 20% coinsurance | 30% coinsurance | 10% coinsurance | 20% coinsurance | 20% coinsurance | 30% coinsurance | 10% coinsurance |
| Maternity Services | | | | | | |
| Preventive/Prenatal Care | 20% coinsurance | 30% coinsurance | 10% coinsurance | 20% coinsurance | 20% coinsurance | 30% coinsurance | 10% coinsurance |
| Hospital | 20% coinsurance | 30% coinsurance | 10% coinsurance | 20% coinsurance | 20% coinsurance | 30% coinsurance | 10% coinsurance |
| Mental Health ** | | | | | | |
| Inpatient | 20% coinsurance | 30% coinsurance | 10% coinsurance | 20% coinsurance | 20% coinsurance | 30% coinsurance | 10% coinsurance |
| Outpatient | 20% coinsurance | 30% coinsurance | 10% coinsurance | 20% coinsurance | 20% coinsurance | 30% coinsurance | 10% coinsurance |

| Prescription Drugs | | | | | | |
| Generic | 10% coinsurance | 10% coinsurance | | | | |
| Brand | 20% coinsurance | 30% coinsurance | | | | |
| Non-Franchise | 30% coinsurance | 30% coinsurance | | | | |

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2020 Monthly Medical Insurance Prices

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<th>University Contribution</th>
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</tr>
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Vision and Prescription Drug Plan Information

<table>
<thead>
<tr>
<th>Davis Vision Program</th>
<th>Out-of-Network Reimbursement to You</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service/Product</td>
<td>Your In-Network Cost</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>$0</td>
</tr>
<tr>
<td>Eyeglass Lenses</td>
<td>$0</td>
</tr>
<tr>
<td>Standard Single vision</td>
<td>$0</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$0</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$0</td>
</tr>
<tr>
<td>Post Cataract</td>
<td>$0 up to $36</td>
</tr>
<tr>
<td>Non-standard (i.e. no line bifocals, trims, coatings)</td>
<td>Fixed Costs No Additional Benefit</td>
</tr>
<tr>
<td>Frames</td>
<td>$0 for Davis fashion selection frames. Amount over $100 for non-Davis frames at Visionworks, less 20% coverage discount Other providers. amount over $60 $30</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>$0</td>
</tr>
<tr>
<td>Prescription and Fitting</td>
<td>Daily Wear: $20 Extended Wear: $30</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>Amount over $75, less 15% discount on average Specialty: $48 Disposable: $75</td>
</tr>
<tr>
<td>Medically Necessary Contacts (w/prior approval)</td>
<td>$0</td>
</tr>
</tbody>
</table>

Coordination of Benefits/ Spousal Surcharge

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.

If you choose to have your spouse or partner covered by Lehigh’s medical insurance plan, you will be charged a $100/month surcharge until you complete a Spousal Surcharge Waiver request and HR approves it.

The waiver request form is provided during Open Enrollment. If you provide the form later and it is received after January 1, if you provide the form later and it is approved, the surcharge will stop, however, you will not receive a refund for prior months.

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: Under age 16. One sealant per permanent first and second molars in three years
- Emergency treatment: Palliative (to alleviate pain), not restorative

Basic Service Benefits - Paid at 80% of MAC*

- Inpatient consultation
- Anesthesiology: Novocain, IV sedation, general
- Basic restorative: 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
- Prosthodontics: 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.

Express Scripts Prescription Drug Benefit

Lehigh’s prescription drug program is based on a three-tiered formulary that determines the amount of coverage you will receive for your drugs. Below are the coverage levels for each tier.

<table>
<thead>
<tr>
<th>Retail</th>
<th>Mail Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>10% ($25 maximum) per 30-day supply</td>
</tr>
<tr>
<td>Formulary Brand Name</td>
<td>20% ($50 maximum) per 30-day supply</td>
</tr>
<tr>
<td>Non-Formulary Brand Name</td>
<td>30% ($100 maximum) per 30-day supply</td>
</tr>
</tbody>
</table>

If you have questions about whether your prescriptions are considered “formulary” or “non-formulary,” contact Express Scripts at 1-866-383-7420 or www.express-scripts.com.

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 BlueCross Blue Shield Global Core program available to employees and dependents covered under any Lehigh medical plan. BlueCross Blue Shield Global Core 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. You can also visit the Global Core website at https://www.bcbsglobalcore.com.

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 Office of International Affairs (610-758-4977) or Risk Management (610-758-3899).
Need Help?

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

Provider | Phone | Web Address
--- | --- | ---
AFLAC | 800-433-3036 | www.aflacgroupinsurance.com
Capital Blue Virtual Care (telehealth) | 855-818-DOCS | www.captbluecross.com/was/portal/cap/home/explore/resource/virtual-care
Lehigh Benefits/Benefitfocus | 844-342-4002 | Log In Via Connect Lehigh
Capital BlueCross and Keystone Health Plan | 800-216-9741 | www.capbluecross.com
Health Advocate | 866-695-8622 | email: answers@healthadvocate.com web: healthadvocate.com/members
Health Equity (HSA administration) | 866-346-5800 | www.healthequity.com
Integrated Behavioral Health (mental health/substance abuse benefits in Keystone Health Plan and PPO Plus) | 800-395-1616 | To access EAP/WorkLife: user id: lehigh password univ03
Magellan (mental health/substance abuse benefits in HDHP and PPO) | 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: 4010
United Concordia Dental | 800-332-0366 | www.ucii.com
WageWorks (FSA administration) | 855-774-7441 | www.wageworks.com

Campus Visits by Insurance Vendors

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

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

Tuesday, November 12
12:00 - 1:30 p.m.
Iacocca Hall, Siegel Gallery

Wednesday, November 13
12:00 to 1:30 p.m.
University Center, Faculty Lounge

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
306 South New Street, Suite 437
Bethlehem, PA 18015

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact the Director of Human Resources Services at the above address or call 610-758-3900.

Frequently Asked Questions

Q: What is the last date to file Capital BlueCross claims for the HDHP, PPO or PPO Plus 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 plan is during the annual open enrollment period, held this year from November 4 - 18. 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 expecting a baby/adopting a child soon. When and how should I add my new child to my coverage?
A: Adding a child to your family is a Qualifying Life Event. As a result, you have thirty one (31) days from the date of birth or adoption placement to add a child (under the age of 26) to your insurance. You should add your child as soon as possible during that timeframe.

Remember: Open Enrollment insurance elections are for the 2020 plan year. Therefore, if you need to add a child (under 26) to your insurance, you should add your child as soon as possible during that timeframe.

Q: I am getting married soon. Can I add my new spouse to my insurance?
A: Yes. Qualifying medical expenses incurred by your adult child (under 26 years old) are eligible for reimbursement through your FSA. The same 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).

Q: I enrolled my non-working spouse/partner on my insurance plan. Can I avoid being charged a surcharge?
A: The Spouse/Partner Surcharge of $100 per month may be 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 as primary coverage. 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 by the end of open enrollment on November 18, 2019, you may be charged the surcharge starting in January 2020. You will continue to be charged $100 monthly if you do not submit a waiver request that is then approved by HR. Please note that if your waiver request is accepted, the surcharge will stop, but prior months’ charges will not be refunded.

Q: How do I access Managed Behavioral Health (Mental Health) benefits under my medical plan?
A: Your first step should always be to contact the proper service provider by phone. Your provider varies by plan:

HDHP
Magellan Health Services 866-322-1657

PPO
Magellan Health Services 866-322-1657

PPO Plus
Integrated Behavioral Health 860-395-1616

Keystone
Integrated Behavioral Health 800-395-1616
## Health Advocate Services

Health Advocate’s Health Advocacy service provides employees and their families with confidential, one-on-one help from an industry expert who knows the ins and outs of the complex healthcare system. Personal Health Advocates are skilled at working with healthcare providers, insurance plans and other health-related organizations to resolve complex clinical and administrative issues, including:

- Assistance with eldercare and Medicare issues
- Finding Doctors
- Healthcare coaching
- Help obtaining second opinions
- Help resolving claim disputes
- Navigating insurance plans
- Researching treatments
- Scheduling appointments
- Uncovering bill mistakes

## Voluntary Benefits

Lehigh offers employees the following voluntary critical illness and accident insurance products through AFLAC.

### Accident Insurance

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

### Critical Illness Insurance

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

There are two coverage options: $10,000 and $20,000. Please note that there is no duplication of coverage. If you and your spouse/partner both have this insurance for a dependent, you will receive only one payment.

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## Important Reminder for Healthcare FSA Users

The **WageWorks HealthCare Card** is a debit card that you can use at the point of sale to access your healthcare FSA funds when paying for allowable charges. Once the year turns over from 2019 to 2020, you will only be able to use the card to pay for **2020 expenses**. You will need to file for reimbursement of 2019 expenses via the WageWorks website or app no later than March 31, 2020.

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## Contributing to an HSA past age 65

As you approach Medicare eligibility at age 65, please be aware of some important rules regarding Medicare and your health savings account (HSA).

### Medicare Eligibility

Being medicare eligible means you have met the requirements to qualify for Medicare Part A (hospital insurance), but may not have applied yet. You can be Medicare eligible and still contribute to your HSA beyond age 65, as long as you have postponed applying for Social Security payments and Medicare benefits.

### Medicare Enrollment

Once you are enrolled in any part of Medicare, you will not be eligible to contribute to an HSA in the months following your Medicare effective date. A pro-rated contribution must be determined for the year in which Medicare becomes effective.

### Social Security Enrollment

If you are receiving Social Security payments prior to age 65, you will automatically be enrolled in Medicare when you turn 65 and will not be able to contribute to an HSA. **Taxes and penalties will be applied by the IRS if you continue contributing.**

For more detailed information, download the information sheet from Health Equity at the following link: [https://hr.lehigh.edu/sites/hr.lehigh.edu/files/medicare.pdf](https://hr.lehigh.edu/sites/hr.lehigh.edu/files/medicare.pdf)