

Open Enrollment Quick Reference Guide November 2025



LEHIGH

UNIVERSITY

Flex Benefits Updates for 2026

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 2026 benefit plan year, which runs from January 1 to December 31, 2026. This year, the online Open Enrollment period runs November 3 through 17, 2025. Your benefits choices take effect January 1, 2026. For complete information, consult the *2026 Employee Benefits Guide* on the Lehigh Benefits website, available Monday, November 3.

WHAT'S NEW?

Changes For 2026

- **Premiums** for all medical plans and dental insurance are increasing. Premiums are listed on page 3.
- Medical plan **out of pocket costs** are changing. See page 2 for more details.
- Prescription plan **out of pocket costs** are changing. See page 4 for more details.
- The **spouse/partner surcharge** for the medical plan is increasing.
- **Contribution limits** for all Flexible Spending Accounts and Health Savings Accounts are increasing.

ENROLLING IS EASY

Enroll on the Web

- Go to <https://go.lehigh.edu/benefitfocus> and log in with your Lehigh credentials
- Acknowledge the tasks in your **To Do List**.
- Select the button 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.

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, change your elections, update your beneficiary information and more.

ARE YOU

Turning 65 and eligible for Medicare this year?
AND
Considering the High Deductible Plan with HSA?

See page 8 for very important information about Health Savings Accounts.

IMPORTANT REMINDER

FSAs and employee contributions to HSAs DO NOT automatically renew from the previous year. If you want a healthcare or dependent care Flexible Spending Account (FSA) or plan to make employee contributions to a Health Savings Account (HSA) in 2026, you must make these elections during Open Enrollment.

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Summary of Medical Plan Options

	PPO		HDHP		Keystone HMO***
Network	National		National		21 County/Lehigh Valley
	In-network	Out-of-network	In-network	Out-of-network	In-network
Annual Deductible					
Individual	\$600	\$800	\$2,000	\$2,500	\$300
Family	\$1,200	\$800 /person	\$4,000*	\$5,000*	\$600
Coinsurance	20%	40%	20%	40%	N/A
Out-of-Pocket Maximum for all medical and prescription drug charges					
Individual	\$5,000	No limit	\$5,000	No limit	\$4,000
Family	\$10,000	No limit	\$10,000	No limit	\$8,000
Physician Services					
Office Visit	\$30 copay/visit	40% coinsurance	20% coinsurance	40% coinsurance	\$30 copay/visit
Specialist Visit	\$50 copay/visit	40% coinsurance	20% coinsurance	40% coinsurance	\$50 copay/visit
Preventive Care (Administered in accordance with Preventive Health Guidelines & PA state mandates)	No charge	Mandated screenings and immunizations: 40% coinsurance; Routine physical exams: Not covered	No charge	Mandated screenings and immunizations: 40% coinsurance; Routine physical exams: Not covered	No charge
Hospital Services					
Inpatient Coverage	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	\$250/admission
Outpatient Hospital	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	\$100 copay/outpatient surgery
Emergency Room	\$250 copay/service, waived if admitted		20% coinsurance after deductible		\$250 copay/visit, waived if admitted
Urgent Care	\$50 copay/ service	40% coinsurance	20% coinsurance	40% coinsurance	\$50 copay/ service
Maternity Services					
Prenatal/ Postpartum Care	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	No charge
Hospital	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	\$250/admission
Mental Health **					
Inpatient	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	\$250/admission
Outpatient	\$30 copay/visit	40% coinsurance	20% coinsurance	40% coinsurance	\$30 copay/visit
Substance Abuse **					
Inpatient	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	\$250/admission
Outpatient	\$30 copay/visit	40% coinsurance	20% coinsurance	40% coinsurance	\$30 copay/visit
Prescription Drugs					
Generic	20% coinsurance	Coinsurance plus amount over Express Scripts allowable amount	20% coinsurance after deductible is met	Coinsurance plus amount over Express Scripts allowable amount after deductible	20% coinsurance
Brand Forumulary	25% coinsurance	Coinsurance plus amount over Express Scripts allowable amount	25% coinsurance after deductible is met	Coinsurance plus amount over Express Scripts allowable amount after deductible	25% coinsurance
Brand Non-Forumulary	35% coinsurance	Coinsurance plus amount over Express Scripts allowable amount	35% coinsurance after deductible is met	Coinsurance plus amount over Express Scripts allowable amount after deductible	35% coinsurance

*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.

** Managed Behavioral (Mental) Health services are administered by Capital Blue Cross for all of the medical plans. To search for providers of managed behavioral health please go to My Care finder at <https://www.capbluecross.com/wps/portal/cap/home/find/my-care-finder>. **Preauthorization is required in all plans.**

***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 *2026 Employee Benefits Guide* to learn more about coverages and limits as well as preauthorization information.

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 \$30 at the time of an office visit. Copayments do not affect the deductible and coinsurance maximum, but do contribute to the out-of-pocket maximum that includes applicable physician copayments.

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

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

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

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

2026 Monthly Medical Insurance Prices

	University Contribution	Employee Premiums		
		HDHP Plan	PPO	Keystone HMO
Individual	\$ 762	\$45	\$301	\$145
Employee + Spouse/Partner	\$1,568	\$172	\$746	\$409
Employee + Child(ren)	\$1,425	\$145	\$664	\$358
Employee + Family	\$2,262	\$252	\$1,082	\$592

Vision and Prescription Drug Plan Information

Davis Vision Program		
Service/Product	Your In-Network Cost	Out-of-Network Reimbursement
Eye Exam	\$0	\$32
Eyeglass Lenses		
Standard Single vision	\$0	\$25
Bifocal	\$0	\$36
Trifocal	\$0	\$46
Post Cataract	\$0	up to \$72
Non-standard (i.e. no line bifocals, tints, coatings)	Fixed Costs	No Additional Benefit
Frames		
	\$0 for Davis fashion selection frames up to \$100 at all providers. Amount over \$150 for non-Davis frames at Visionworks, less 20% overage discount. Amount over \$100 less 20% discount at other providers.	\$30
Contact Lenses		
Prescription and Fitting	\$0	Daily: \$20 Extended: \$30
Lenses	Amount over \$75, less 15% discount on overage	Specialty: \$48 Disposable: \$75
Medically Necessary lenses (prior approval)	\$0	up to \$225
1-877-923-2847 (prior to initial enrollment) 1-800-999-5431 (once enrolled) or www.davisvision.com		

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 \$125/month surcharge until you complete a Spousal Surcharge Waiver request and HR approves it.

The waiver request form is provided during the online enrollment process. Failure to submit the waiver request during Open Enrollment will result in the monthly surcharge beginning on 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.

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.

	Retail	Mail Order
Generic	20% (\$30 maximum) per 30-day supply	20% (\$75 maximum) per 90-day supply
Formulary Brand Name	25% (\$60 maximum) per 30-day supply	25% (\$150 maximum) per 90-day supply
Non-Formulary Brand Name	35% (\$120 maximum) per 30-day supply	35% (\$300 maximum) per 90-day supply

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.

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
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.

2026 Monthly Dental Prices

United Concordia Dental	
Employee Only	\$38.86
Employee + One	\$77.76
Employee + Two or More	\$100.52

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 three 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 BlueShield Global Core program available to employees and dependents covered under any Lehigh medical plan. BlueCross BlueShield 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
Alight (expert medical opinion)	888-361-3944	mymedicalally.alight.com
Capital Blue Virtual Care (telehealth)	n/a - Download the Virtual Care App	https://www.capbluecross.com/wps/portal/cap/home/find/virtual-care
BenefitsVIP Service Center (general Lehigh benefits questions)	866-293-9736	email: solutions@benefitsvip.com
Capital BlueCross and Keystone Health Plan	800-216-9741	www.capbluecross.com
Capital BlueCross Managed Behavioral Health (mental health benefits)	866-322-1657	www.capbluecross.com
Davis Vision	800-999-5431	www.davisvision.com control code: 5167
Express Scripts	866-383-7420	www.express-scripts.com
Health Advocate (Advocacy Services)	866-695-8622	email: answers@healthadvocate.com web: healthadvocate.com/lehighuniversity Registration code: EFL8M2S
Health Equity (HSA administration)	866-346-5800	www.healthequity.com
Health Advocate Employee Assistance Program	866-695-8622	healthadvocate.com/lehighuniversity Registration code: EFL8M2S
United Concordia Dental	800-332-0366	www.ucci.com
Wageworks/Health Equity (FSA administration)	855-774-7441 or 877-924-3967	https://www.wageworks.com/
Voya (Voluntary Benefits)	877-236-7564	presents.voya.com/ebrc/Lehigh

On Site Benefits Vendor Fair

Take some time to visit with representatives from Capital Blue Cross, United Concordia (dental), Health Advocate (EAP and advocacy) and Alight (second opinion and surgery decision support).

Human Resources representatives will also be available.

Wednesday, November 5, 2025

11:00 am to 1:00 pm

Butz Lobby

Zoellner Arts Center

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 Benefits 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 or PPO 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 3-17. 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 2026 plan year. Therefore, if you need to add a child to your insurance coverage for the remainder of 2025, you need to provide the appropriate information and documentation outside of the Open Enrollment process. **To do so, log into Lehigh Benefits and select "Life Event" in the "Manage Account" section on the left side of the screen before beginning Open Enrollment.** You will be prompted to provide information and documentation on your new dependent.

Completing the Life Event section triggers the system to add your child to your insurance for the remainder of 2025. You may continue on to select your 2026 benefits through the Open Enrollment process. If your new child is not yet listed as a dependent, you'll need to add them when prompted.

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: The instructions in the question above regarding adding a new child also apply in this situation. You have thirty-one (31) days from the date of your marriage to add your spouse and/or stepchild(ren) to your health and/or dental coverage, purchase dependent life insurance, and/or increase your supplemental life insurance. After 31 days, you must wait for the next open enrollment period. (see next column for more)

If your spouse has access to health insurance through his or her employer, keep the spousal surcharge in mind when considering adding them to your medical plan. See the *Flexible Benefits Enrollment and Reference Guide* online on our website.

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

A: No. Your dependent or adult children can only remain covered under a university medical, dental, life insurance, or FSA program until the end of the month in which they reach age 26. They will be offered COBRA continuation medical and dental coverage at that time. They 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. 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. How can I avoid being charged a surcharge?

A: The Spouse/Partner Surcharge of \$125 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 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. Read more on page 4 of this booklet for more important information.

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. Capital BlueCross provides managed behavioral health benefits for all four medical plans. You can call 866-322-1657.

More About Your Benefits

Maximize Your Benefits in 2026

Did you know there are ways for you to use your Lehigh benefits that can save you money? Here are just a few. Learn more at hr.lehigh.edu/benefits.

- The **cost estimator tool** in the Lehigh Benefits enrollment platform allows you to model expenses, whether expected or unexpected, so you can choose the medical plan that is right for you for the coming year.
- The **tax advantages** of a Flexible Spending Account or Health Savings Account can reduce your taxable income which can help you save on taxes when April rolls around.
- **AblePay** is a tool available to you that allows you to save on your medical expenses.
- **HealthAdvocate's** advocacy and Employee Assistance Program can help you dispute medical bills and access other services.
- The Capital Blue Cross **Virtual Care app** saves money on copays for routine doctor's visits.

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 2025 to 2026, you will only be able to use the card to pay for **2026 expenses**. You will need to file for reimbursement of 2025 expenses via the WageWorks website or app no later than March 31, 2026.

Alight

Alight (formerly ConsumerMedical), a free expert medical opinion service, is a benefit for Lehigh faculty and staff. Alight services include:

- Find the best doctors and hospitals in their area and insurance network
- Verify any doctor's credentials, skills, and experience treating their condition
- Get a second opinion from top specialists, either in person or virtually
- Connect with experts in their diagnosis from leading medical institutions

For more information, visit <https://hr.lehigh.edu/alightexpert-medical-opinion-service>.



Contributing to an HSA after age 65

As you approach Medicare eligibility, be aware of these important facts to avoid IRS taxes and penalties

Fact: Once you are enrolled in any part of Medicare, you will not be eligible to contribute to (or receive contributions from Lehigh into) an HSA in the months following your Medicare effective date.

Fact: If you are receiving Social Security payments prior to age 65, you will automatically be enrolled in Medicare when you turn 65.

Fact: If you do not stop contributing to your HSA after enrolling or being automatically enrolled in Medicare, you will be subject to taxes and penalties from the IRS.

What This Means for Your HSA: 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.

The Bottom Line: Because Lehigh's HDHP medical plan automatically includes the HSA, if you are Medicare eligible you should assess your current situation and consider your medical plan decision very carefully.

For more information, download this sheet from Health Equity: <https://hr.lehigh.edu/sites/hr.lehigh.edu/files/medicare-and-your-hsa.pdf>