
# 2026
# EMPLOYEE BENEFIT GUIDE

CLICK HERE TO GET STARTED

Lehigh University is committed to providing you and your family with a comprehensive and competitive benefits package. Our goal is to provide high-quality, valuable benefits that are sustainable for both you and the University in the long term.

This Flexible Benefits Enrollment & Reference Guide provides details about the benefits available to you through Lehigh for 2026:

- Medical (including Prescription Drug and Vision)
- Dental
- Spending and savings accounts
- Life insurance (for you and your dependents)
- Disability
- Voluntary Accident, Critical Illness and Hospital Indemnity

Consider all your benefit plan choices carefully. Read this guide to find out what's new for the upcoming year and the important changes we have made. Think about which plans make the most sense for you and your family and finally, make any needed changes during Open Enrollment. Be sure to compare each plan's features and your payroll contributions, and consider which plan best fits your needs.

Open Enrollment is your once-a-year chance to make changes to your benefits. During Open Enrollment you can:

- Change plans
- Add or delete dependents from your coverage
- Change coverage levels
- Enroll in a Healthcare or Dependent Care Flexible Spending Account (FSA)
- Elect to contribute to the Health Savings Account (HSA) if you enroll in the High Deductible Health Plan (HDHP) option for 2026

The benefit elections you make during Open Enrollment are effective from January 1, 2026 through December 31, 2026.

## NAVIGATION ICONS

By clicking on the top navigation bar, topics listed in the left sidebar and interactive icons found in the lower right hand corner of all pages, you can jump to specific sections within this guide just like you would on your favorite websites.

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**CONTACT INFORMATION**

You are eligible for benefits if you are a full-time (or work at least 75% of a full work schedule), salaried member of Lehigh's faculty or staff employed in a benefits-eligible position. You can also enroll your eligible dependents, including your:

- Spouse/partner*
- Child(ren) up to the end of the month in which they become age 26
- Disabled child(ren) without age limitation (coverage, and its continuation, is subject to required certification with the carrier)

All benefits included in the Flexible Benefits Plan — Flexible Spending Accounts and Medical, Dental, Life, Dependent Life, and Long-Term Disability insurances — are available to new staff members on the first of the month following their first work day. For new faculty members, benefits are available beginning on their first work day. However, their coverage does not begin until enrollment selections are completed online in Lehigh Benefits.

***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 request must be submitted each year, and is provided during the online enrollment process. Learn more about eligibility and submitting your election on the Lehigh Benefits site or contact HR at **610.758.3900** or **inben@lehigh.edu**.

## DON'T MISS YOUR CHANCE TO ENROLL!

- If you are a current employee: Enrollment for 2026 benefits is November 3-17, 2025 for coverage effective January 1, 2026.
  - If you do nothing during Open Enrollment, your current elections will continue in 2026 with one exception: Flexible spending accounts and employee HSA contributions must be renewed.
- If you are a new hire: New employees (both faculty and staff members) must enroll within 30 days of your first day of work.
  - Coverage for faculty members is effective as of their first day of work provided they complete their enrollment in Lehigh Benefits within the first 30 days of employment.
  - Coverage for staff members is effective on the first of the month following their start date, provided they complete their enrollment in Lehigh Benefits within the first 30 days of employment.
  - If you miss your enrollment period deadline, you will be assigned Lehigh's default benefit coverage of PPO individual coverage at a monthly cost of $301. No dependents will be enrolled in medical coverage; nor will dental insurance, supplemental or dependent life insurance, or FSAs be available to you or any dependents.

You will not be able to make a change to your benefits during the year unless you experience a Qualifying Life Event (QLE).

## ENROLLMENT IS EASY

Enroll on the Web

- Go to **go.lehigh.edu/benefitfocus** and sign in using your Lehigh SSO credentials.

*NOTE: As annual notices are updated, you may need to review your To Do list prior to proceeding with enrollment or benefits changes.*

## OR USE THE APP

- Download **Benefitplace** (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.

CLICK HERE for a List of Qualifying Life Events and documentation needed.

## CHANGING YOUR COVERAGE DURING THE YEAR

The benefit elections you make during Open Enrollment take effect on the following January 1, and remain in effect until the next Open Enrollment period, unless you experience a Qualifying Life Event (QLE), such as getting married or divorced or having or adopting a baby. You can add or drop dependents from your coverage as the result of a QLE, however you cannot change your medical plan election (e.g., you can add a new spouse to your medical coverage, but you can't change plans as a result of getting married).

You MUST notify Lehigh Benefits within 31 days of a QLE and request appropriate benefit changes when you experience:

- Change in marital/partnership status such as marriage/registration or divorce/dissolution
- Addition or change in number of dependents through birth/adoption of child or change in child dependent's status (such as reaching age 26)
- Death of a dependent child or spouse/partner
- Changes related to employment or location including change in employment, retirement, significant change in residence location or reduction in work hours below the Affordable Care Act's employer plan eligibility threshold; or, eligibility for healthcare marketplace

Failure to submit a QLE change request within 31 days will retroactively cancel coverage in the case of a dependent whose benefit eligibility ends. We cannot refund premiums paid for coverage that was not available. In other words, paying for coverage that your dependent is not entitled to receive will not create that entitlement. It means that you are paying more for coverage than you need to. Furthermore, you may jeopardize your dependent's access to COBRA coverage by failing to notify Lehigh Benefits in a timely fashion.

Learn more about QLEs by visiting the Lehigh Benefits website or contacting the Lehigh BenefitsVIP Service Center at **866.293.9736** or **solutions@benefitsvip.com**.

## WHAT HAPPENS TO YOUR COVERAGE IF YOU LEAVE LEHIGH?

Your coverage will continue through the last day of the month in which your employment ends. However, you have the opportunity to continue your coverage under the Consolidated Omnibus Budget Reconciliation Act's (COBRA) continuation legislation, which provides you the option of continuing your medical and/or dental plan for up to 18 months. You would be responsible for paying the entire premium amount to Lehigh's COBRA administrator plus a 2% administrative fee.

The provisions of COBRA also apply to dependents that lose coverage, including a child who turns 26. For medical and dental coverage, it is your responsibility to notify Lehigh Benefits when your child reaches age 26 or you may jeopardize your dependent's access to COBRA coverage. Additional information is available through the Lehigh Benefits website or by contacting Lehigh BenefitsVIP Service Center at **866.293.9736** or **solutions@benefitsvip.com**.

**ANNUAL DEDUCTIBLE**
The amount you pay each year out of your own pocket before your medical plan covers a portion of the cost for covered expenses through coinsurance. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered healthcare services subject to the deductible. If you enroll in any coverage level other than "employee only" for the High Deductible Health Plan, you will need to meet the entire family deductible before the plan pays. Any one family member, or any combination of family members, can satisfy the deductible.

**BALANCE BILLING**
When a provider bills you for the difference between the provider's charge and the allowed amount under your benefit plan. For example, if the provider's charge is $100 and the allowed amount under your plan is $70, the provider may bill you for the remaining $30. An in-network provider may not balance bill you for covered services.

**COINSURANCE**
The share of the costs of a healthcare service after meeting your deductible. For example, if the coinsurance amount is 20%, then your medical plan pays 80% of the cost and you pay for the remaining 20% out-of-pocket. When you choose an in-network provider, the coinsurance you pay is significantly lower than for an out-of-network provider.

**CO-PAYMENT**
A fixed amount (for example, $25) you pay for a covered healthcare service, usually when you receive the service. The amount can vary by the type of covered healthcare service (e.g., office visit for a pediatrician vs. specialist visit for an orthopedist).

**COVERED CHARGE**
The charge for services rendered or supplies furnished by a provider that qualifies as an eligible service and is paid for in whole or in part by your plan. May be subject to deductibles, copayments, coinsurance, or maximum allowable charge, as specified by the terms of the insurance contract.

**COVERED SERVICE**
A service or supply (specified in the plan) for which benefits may be available. The plan will not pay for services that are not covered by the plan.

**DEPENDENT**
Individuals who rely on you for support including children and spouse, generally qualify as dependents for healthcare and insurance benefits.

**EMERGENCY ROOM CARE**
Care received in an emergency room.

**FORMULARY (PRESCRIPTION DRUG COVERAGE)**
The Plan includes a list of preferred drugs that are either more effective at treating a particular condition than other drugs in the same class of drugs, or as effective as and less costly than similar medications. Non-preferred (non-formulary) drugs may also be covered under the prescription drug program, but at a higher cost-sharing tier. Collectively, these lists of drugs make up the Plan's Formulary. The Plan's Formulary is updated periodically and subject to change. To check where your medications fall within the plan's formulary please call Express Scripts at **866.383.7420**.

**IN-NETWORK**
Doctors and other healthcare providers, hospitals, clinics, laboratories and outpatient facilities that have negotiated discounted rates with your plan. Depending on your plan, you may have the choice to receive care from either an in-network provider or an out-of- network provider, but you'll generally pay more if you choose to see an out-of-network provider. In some cases, your plan will refer to network providers as "preferred" providers.

**MAXIMUM ALLOWABLE CHARGE (MAC)**
The limit the plan has determined to be the maximum amount payable for a covered service.

**OUT-OF-NETWORK**
Doctors and other healthcare providers, hospitals, clinics, laboratories and outpatient facilities that do not have negotiated discounted rates with your plan. You will generally pay more when you receive care from an out-of-network provider because that provider is not bound by contracted pricing. You are responsible for paying the difference between the amount the plan is willing to pay (sometimes called the maximum allowable charge) and the provider's charge.

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CLICK HERE for information on Alight and how to find the right care.

Lehigh offers three medical plans through Capital Blue Cross. While all of the options cover the same services and treatments, and cover preventive care in full when received from in-network providers, they differ in how much you pay in payroll contributions and what you pay when you receive care. To make an informed decision about which option is right for you and your family, evaluate your healthcare needs and review how you pay for services under each option.

## YOUR THREE MEDICAL INSURANCE OPTIONS INCLUDE:

Capital Blue Cross Preferred Provider Organization (PPO) plans.

- **PPO**
- **High Deductible Health Plan (HDHP)**
- **Keystone Health Maintenance Organization (HMO)**

*When you enroll in a medical plan through the University, you are automatically enrolled in Prescription Drug coverage through Express Scripts and Vision coverage with Davis Vision.*

## THE PPO PLAN

With the PPO plan, you have a choice each time you need care — you may choose healthcare providers within the plan's network or visit any provider outside the network. However, you'll typically pay more for care when you use out-of-network providers. That's because Capital Blue Cross negotiates discounted fees for covered services with providers in their network, which allows us to set the in-network annual deductible at a lower level than the annual deductible for out-of-network care.

If you choose the PPO plan, you will pay more in premium contributions, but less when you receive care.

## THE HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

The HDHP gives you more control over how you spend — or save — your healthcare dollars. If you enroll in the HDHP, you can contribute to a tax advantaged Health Savings Account (HSA) that includes a contribution from Lehigh. You can also choose to contribute up to annual IRS limits. Use this account to help pay for eligible healthcare expenses today, or to save for future medical, dental, and vision expenses. See the **Health Savings Account** section for more information.

Like the PPO plan, you have the freedom to see both in-network and out-of-network providers, but you'll typically pay more for services from out-of-network providers and you'll have to satisfy a separate, higher out-of-network deductible. Additionally, the HDHP network is the same network that is available in the PPO plan.

The HDHP has a higher annual deductible than the PPO plan, but you'll pay less in payroll contributions. It's important to note that medical and pharmacy expenses will count toward meeting your deductible. If you cover any dependents, you must meet the entire family deductible before the plan begins reimbursing your medical or prescription drug expenses. One family member, or all family members combined can satisfy the deductible.

## THE KEYSTONE HMO

The HMO provides the maximum level of coverage with lower premiums and the lowest out-of-pocket costs. In return, you'll be required to receive care from in-network providers, manage your care through a Primary Care Physician (PCP) and receive referrals from your PCP if you would like to receive care from a specialist. Care received from out-of-network providers will not be covered, other than in an emergency, as determined by Capital Blue Cross. This may be the most cost-effective option for employees living in the 21 county area surrounding the University who are comfortable with using only in-network providers.

**CLICK HERE** for information on how to choose the right plan for you.

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## PPO PLAN - NATIONAL NETWORK

| | In-Network | Out-of-Network |
|---|---|---|
| **Annual Deductible** | Individual: $600 / Family: $1,200 | Individual: $800 / Family: $800 pp |
| **Coinsurance Level** *(after deductible)* | 20% | 40% |
| **Out-of-Pocket Maximum** *(including deductible)* | Individual: $5,000 / Family: $10,000 | No limit / No limit |
| **Preventive Care**<br>*Administered in accordance with Preventive Health Guidelines & PA state mandates)* | Covered 100% | Mandated screenings and immunizations: 40% coinsurance; Routine physical exams: Not covered |
| **Physician's Office Services**<br>*All visits for treatment of illness and injury* | | |
| Primary physician office visit<br>Specialist physician office visit | $30 copay per visit<br>$50 copay per visit | 40% coinsurance<br>40% coinsurance |
| **Emergency Room Treatment** | $250 copay per visit<br>Waived if admitted | $250 copay per visit<br>Waived if admitted |
| **Urgent Care Center** | $50 copay per visit | 40% coinsurance |
| **Inpatient Hospital Care** | 20% coinsurance | 40% coinsurance |
| **Outpatient Hospital** | 20% coinsurance | 40% coinsurance |
| **Maternity** *Prenatal / Postpartum Care* | 20% coinsurance | 40% coinsurance |
| **Maternity** *Hospital* | 20% coinsurance | 40% coinsurance |
| **Mental Health and Substance Abuse Services**** | | |
| Inpatient rehabilitation<br>Outpatient Rehabilitation and office visits | 20% coinsurance<br>$30 copay per visit | 40% coinsurance<br>40% coinsurance |
| **Prescriptions** | **Prices are maximums* | |
| **Retail (30-day)**<br>Generic/Brand/Brand Non-Formulary | $30/$60/$120 | Coinsurance plus amount over Express Scripts allowable amount |
| **Retail (90-day)**<br>Generic/Brand/Brand Non-Formulary | $90/$180/$360 | |
| **Mail Order (90-day)**<br>Generic/Brand/Brand Non-Formulary | $75/$150/$300 | |

*** Managed behavioral (mental) health benefits are provided through Capital Blue Cross. Preauthorization is required in all plans.*

*See the Summary of Benefits and Coverage and Plan Design Details to learn more about specific coverages and limits as well as preauthorization information.*

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## WHO SHOULD ENROLL IN THE HIGH DEDUCTIBLE HEALTH PLAN (HDHP)?

Do you expect your usage to be moderate to low (only wellness visits and occasional illness)? If so, consider the plan with the higher deductible. You could save money by paying less from your paycheck for your coverage. If you are concerned about the risk of unexpected expenses, consider purchasing voluntary accident, critical illness or hospital indemnity insurance.

### HDHP PLAN - NATIONAL NETWORK

| | In-Network | Out-of-Network |
|---|---|---|
| **Annual Deductible** | Individual: $2,000 / Family: $4,000* | Individual: $2,500 / Family: $5,000* |
| **Coinsurance Level** *(after deductible)* | 20% | 40% |
| **Out-of-Pocket Maximum** *(including deductible)* | Individual: $5,000 / Family: $10,000 | No limit / No limit |
| **Preventive Care**<br>*Administered in accordance with Preventive Health Guidelines & PA state mandates)* | Covered 100% | Mandated screenings and immunizations: 40% coinsurance;<br>Routine physical exams: Not covered |
| **Physician's Office Services**<br>*All visits for treatment of illness and injury* | | |
| Primary physician office visit | 20% coinsurance | 40% coinsurance |
| Specialist physician office visit | 20% coinsurance | 40% coinsurance |
| **Emergency Room Treatment** | 20% coinsurance | 20% coinsurance |
| **Urgent Care Center** | 20% coinsurance | 40% coinsurance |
| **Inpatient Hospital Care** | 20% coinsurance | 40% coinsurance |
| **Outpatient Hospital** | 20% coinsurance | 40% coinsurance |
| **Maternity** *Prenatal / Postpartum Care* | 20% coinsurance | 40% coinsurance |
| **Maternity** *Hospital* | 20% coinsurance | 40% coinsurance |
| **Mental Health and Substance Abuse Services****<br>Inpatient rehabilitation | 20% coinsurance | 40% coinsurance |
| Outpatient Rehabilitation and office visits | 20% coinsurance | 40% coinsurance |
| **Prescriptions** | **Prices are maximums* | |
| **Retail (30-day)**<br>Generic/Brand/Brand Non-Formulary | $30/$60/$120 | Coinsurance plus amount over Express Scripts allowable amount |
| **Retail (90-day)**<br>Generic/Brand/Brand Non-Formulary | $90/$180/$360 | |
| **Mail Order (90-day)**<br>Generic/Brand/Brand Non-Formulary | $75/$150/$300 | |

**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 benefits are provided through Capital Blue Cross. Preauthorization is required in all plans.*

*See Summary of Benefits and Coverage & Plan Design Details for more information about specific coverages and limits as well as preauthorization.*

HealthEquity

## HEALTH SAVINGS ACCOUNT (HSA)

The HSA is a tax-advantaged savings account you can use to help cover the costs of your healthcare when you enroll in the High Deductible Health Plan (HDHP). Lehigh's HSA administrator is HealthEquity. Here are some important things to know about the HSA:

- **Money from Lehigh.** Lehigh will contribute up to $600 per year to your HSA when you enroll in employee only coverage, and up to $1,200 per year to your account for any other level of coverage. Note, this contribution will be made per pay period and will be prorated based on the date your coverage begins. You must open an HSA in order to receive the Lehigh contribution.
- **Works like a bank account.** Use the money to pay for eligible healthcare expenses — use your HSA debit card to pay when you receive care or reimburse yourself for payments you've made (up to the available balance in the account).
- **You can save.** You decide how much to save and can change that amount at any time. Contribute up to the 2026 annual IRS limit of $4,400 for individuals or $8,750 for family coverage (these amounts include Lehigh's contribution); $1,000 additional contribution allowed for employees age 55+.
- **Never pay taxes.** Contributions are made from your paycheck on a before-tax basis, and the money will never be taxed when used for eligible expenses.
- **It's your money.** Unused money can be carried over each year and invested for the future — you can even take it with you if you leave your job. This includes the contribution from Lehigh.
- **Can be paired with a Limited Purpose Flexible Spending Account (LPFSA).** You can use your HSA for eligible medical, dental and vision expenses. You can use your LPFSA for tax savings on eligible dental and vision expenses.
- **Please Note.** HSA contribution limits as well as catch up contribution limits are based on a calendar year and should be prorated based on the actual number of months you are covered under the HDHP plan.
- **Important restrictions apply when you become Medicare/Social Security eligible.** Once you are enrolled in any part of Medicare, you will not be eligible to contribute to an HSA. If you are receiving Social Security payments prior to age 65 you will be enrolled in Medicare automatically when you turn 65 and will become ineligible to contribute to an HSA. Taxes and penalties will be applied by the IRS if you continue contributing. Download this **information sheet** from HealthEquity for more information.

For more information about the HSA, including how to set up an account and rules and restrictions, contact HealthEquity at **866.346.5800** or **healthequity.com** or visit the resource center at **learn.healthequity.com/lehighuniversity/hsa**.

CLICK HERE for HSA eligible expenses

| TIERS | 2026 LEHIGH ANNUAL HSA CONTRIBUTION | | 2026 EMPLOYEE HSA MAXIMUM CONTRIBUTION | | 2026 FEDERAL HSA MAXIMUM ANNUAL CONTRIBUTION |
|---|---|---|---|---|---|
| **Individual Coverage** | $600 | + | $3,800 | = | $4,400 |
| **Family Coverage** | $1,200 | + | $7,550 | = | $8,750 |

Catch up contributions for those over age 55 is $1,000 annually.

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## THE KEYSTONE HMO

The HMO provides the maximum level of coverage with lower premiums and the lowest out-of-pocket costs. In return, you'll be required to receive care from in-network providers, manage your care through a Primary Care Physician (PCP) and receive referrals from your PCP if you would like to receive care from a specialist. Care received from out-of-network providers will not be covered, other than in an emergency, as determined by Capital Blue Cross. This may be the most cost-effective option for employees living in the 21 county area surrounding the University who are comfortable with using only in-network providers.

### KEYSTONE HMO PLAN - 21 COUNTY / LEHIGH VALLEY

| | In-Network |
|---|---|
| **Annual Deductible** | Individual: $300 / Family: $600 |
| **Coinsurance Level** *(after deductible)* | N/A |
| **Out-Of-Pocket Maximum** *(including deductible)* | Individual: $4,000 / Family: $8,000 |
| **Preventive Care**<br>*Administered in accordance with Preventive Health Guidelines & PA state mandates)* | Covered 100% |
| **Physician's Office Services** *All visits for treatment of illness and injury* | |
| Primary physician office visit<br>Specialist physician office visit | $30 copay per visit<br>$50 copay per visit |
| **Emergency Room Treatment** | $250 copay per visit. Waived if admitted. |
| **Urgent Care Center** | $50 copay per visit |
| **Inpatient Hospital Care** | $250/admission |
| **Outpatient Hospital** | $100 outpatient surgery copay |
| **Maternity** *Prenatal/Postpartum Care* | No charge |
| **Maternity** *Hospital* | $250/admission |
| **Mental Health and Substance Abuse Services**** | |
| Inpatient Rehabilitation<br>Outpatient Rehabilitation and Office Visits | $250/admission<br>$30 copay per visit |
| **Prescriptions**<br>**Retail (30-day)**<br>Generic/Brand/Brand Non-Formulary | **Prices are maximums*<br><br>$30/$60/$120 |
| **Retail (90-day)**<br>Generic/Brand/Brand Non-Formulary | $90/$180/$360 |
| **Mail Order (90-day)**<br>Generic/Brand/Brand Non-Formulary | $75/$150/$300 |

*** Managed behavioral (mental) health benefits are provided through Capital Blue Cross. 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 Summary of Benefits and Coverage & Plan Design Details for more information about specific coverages and limits as well as preauthorization.*

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Preventive care is any covered medical service or supply that is received in the absence of symptoms or a diagnosed medical condition. Preventive care includes preventive services such as physical examinations, certain immunizations, and screening tests.

Federal laws covering medical, dental and/or vision preventive care change often. Check to see what's covered at **healthcare.gov/preventive-care-benefits**.

## IN-NETWORK PREVENTIVE CARE

Preventive care is 100% covered in all healthcare plans when received from in-network providers. Preventive care includes services such as physical examinations and certain immunizations.

Preventive services are divided into three groups:

- Adults
- Maternity
- Children

## CAPITAL BLUE CROSS VIRTUAL CARE

Capital Blue Cross Virtual Care gives covered employees access to board-certified physicians via video consultation on your smartphone, tablet or computer. The Virtual Care app is available in the Google Play and App Stores.

You can use Virtual Care if you have a health problem and need urgent care; if you're not sure you need emergency care; or if you're simply traveling and need a doctor's advice. Doctors can diagnose, recommend treatment and even write short-term prescriptions for most non-emergency medical issues. This benefit is included in all medical plans offered by the University. The copay is $10 for HMO and PPO subscribers, and $64 for HDHP subscribers.

Visit **capbluecross.com/virtualcare** or the app to find approved providers or to contact patient support.

EXPRESS SCRIPTS®

All of Lehigh's medical plans include prescription drug benefits through Express Scripts. You can fill your prescriptions at retail pharmacies or through the Express Scripts Home Delivery program. While you have the option to choose which delivery option fits into your lifestyle, you will save time and may save money by having your medication delivered by mail.

Using generic drugs, which cost less than brand-name drugs, can save you money. A generic drug is a drug that contains the same active ingredients as the brand name drug, but can only be produced after the brand-name drug's patent has expired. With the introduction of our three-tiered plan, it's important to check with your doctor and pharmacy to see if any of your current medications are non-formulary and subject to higher charges.

| | 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 |

## FILLING YOUR PRESCRIPTIONS BY MAIL ORDER COULD SAVE YOU MONEY

You are not required to select mail order, but it may be the best, most economical choice:

- **FREE shipping** right to your door
- **25%** average savings over retail
- **90-day supply,** at reduced maximum pricing, so you won't worry about running out
- **24/7 access** to a pharmacist from the privacy of your home
- **Automatic refills** every three months

DavisVision

Vision coverage through Davis Vision is also included in your medical plan coverage. The vision plan provides a benefit for an exam and lenses and frames on a yearly basis. You have the freedom to see any vision provider you choose, but the plan generally covers services at a higher level when you receive care from doctors who participate in the Davis Vision network. If you decide to go to an out-of-network provider, you'll be reimbursed for exams and eyewear according to the schedule of benefits detailed below.

| | In-Network | Out-of-Network: Reimbursement to You |
|---|---|---|
| **Eye Exams** | $0 copay | $32 |
| **Lenses** | | |
| 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 |
| **Contact Lenses** (Every 12 months) | | |
| Prescription Evaluation and Fitting | $0 | Daily Wear: $20<br>Extended Wear: $30 |
| Contact Lenses | Amount over $100, less 15% discount on overage | Specialty: $48<br>Disposable: $75 |
| Medically Necessary Contact Lenses (w/prior approval) | $0 | Lenses (w/prior approval) $0 up to $225 |
| **Frames** | All providers: $0 for Davis fashion selection frames up to $100. Non-Davis frames: At Visionworks- amount over $150 for non-Davis frames, less 20% discount on overage.<br>At other providers - amount over $100, less 20% discount on overage. | $30 |

## FIND A VISION PROVIDER

To find a provider who participates in the Davis Vision network, call **800.999.5431** or go to **davisvision.com** and follow prompts for general access or member access, as appropriate.

The Lehigh University client control code for general access is **5167**.

Prior to initial enrollment, call **877.923.2847**.

UNITED CONCORDIA
Insuring America's Dental Health



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### THE PREVENTIVE INCENTIVE

Preventive care is important for your teeth, too. Cleanings and regular exams for each covered individual are covered at 100% and do not count against the $1,000 annual maximum benefit limit. United Concordia's plan annually includes:

- 2 cleanings (6 months apart)
- 2 exams
- 1 set of x-rays

Dental coverage is available even if you waive medical coverage through Lehigh. Unlike medical, where the University pays the majority of your cost for coverage (i.e., the monthly premium), Lehigh does not contribute toward the cost of your dental coverage. You pay the full cost for the coverage, however your contributions are based on attractive group coverage rates.

You have the flexibility to receive care from any dentist you choose, but you will pay less when you visit a dentist who participates in the United Concordia dental provider network. This is because network providers cannot charge more than the Maximum Allowable Charge (MAC). This restriction does not apply to out-of-network providers. When you receive care from an out-of-network provider, you are responsible for any charges in excess of the MAC.

Visit United Concordia's website at **ucci.com** or call **800.332.0366** to find a participating provider.

**UNITED CONCORDIA DENTAL BENEFIT SUMMARY (MAXIMUM ANNUAL BENEFIT OF $1,000 PER PERSON)**

| Diagnostic & Preventive Service Benefits — Paid at 100% (Does not count toward maximum annual benefit) |
|---|
| Semi-annual cleaning, polishing, and examination<br>Annual bitewing X-rays<br>Complete X-ray series (every five years)<br>Fluoride treatment (under age 19)<br>Sealant: Under age 16. One sealant per permanent first and second molars in three years.<br>Emergency treatment: Palliative (to alleviate pain), not restorative |
| **Basic Service Benefits — Paid at 80% of MAC*** |
| Inpatient consultation<br>Anesthetics: Novocain, IV sedation, general<br>Basic restoration: Amalgam and composite fillings<br>Non-surgical periodontics<br>Endodontics<br>Oral surgery<br>Simple extraction<br>Repair of crowns, inlays, onlays, bridges, and dentures |
| **Major Service Benefits — Paid at 50% of MAC*** |
| Surgical periodontics<br>Inlays, onlays, crowns<br>Prosthetics: Dentures and bridges; no implants |
| **Orthodontia (under age 19) — Paid at 50% of MAC*** |
| Orthodontia lifetime benefit maximum of $1,000 per person |

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

CLICK HERE to compare HSA and FSAs

**THE HEALTHCARE FSA LIMIT IS $3,400**

**THE DEPENDENT CARE FSA LIMIT IS $7,500**

## WHAT IS A FLEXIBLE SPENDING ACCOUNT (FSA)?

A Flexible Spending Account is a tax-advantaged account that allows you to use pre-tax dollars to pay for qualified medical or dependent care expenses. Your annual FSA election(s) will be deducted from your paycheck in equal installments over the course of the plan year and will not count as income for federal, state (in most states), local and Social Security tax purposes.

## ANNUAL CONTRIBUTIONS

If you elect the PPO, HMO, or waive Lehigh medical coverage, you can participate in either or both of the following:

- Healthcare FSA
- Dependent Care FSA

If you elect the HDHP, you can participate in either or both of the following:

- Limited Purpose Healthcare FSA (covers dental and vision claims)
- Dependent Care FSA

Medical FSA contributions are limited by the IRS to $3,400 per person in 2026; an employee and spouse may each contribute up to the limit.

For a Dependent Care FSA, the IRS limits contributions to $7,500 per year if you are married and filing a joint return, or if you are a single parent. If you are married and filing separately, you may contribute up to $3,750 annually per parent. The plan year is from January 1 to December 31.

## USE IT OR LOSE IT

FSA's are "use it or lose it" programs. Budget appropriately and use all the funds within the FSA calendar year. The IRS requires any unused amount over $680 will be forfeited. However, you are able to carry over up to $680 of unused dollars to the next calendar year. Claims for 2026 must be submitted to Wageworks by March 31st, 2027.

You may make a change to your contribution rate is if you experience an IRS qualified status change such as marriage, birth of a child, adoption of a child, divorce, death, etc.

## QUALIFIED MEDICAL EXPENSES FOR FSA USE

You can use your Healthcare FSA for expenses that would generally qualify as medical, dental and vision expenses, including, but not limited to:

- Deductibles
- Office visits
- Prescription drugs
- Hospital stays
- Lab work or x-rays
- Eyeglasses or contact lenses
- Hearing aids
- Dental work
- Crutches, braces or wheelchairs

List of Eligible Expenses

**1: FUND**

The 2026 maximum employee FSA contribution:

Medical FSA: $3,400

Dependent Care FSA: $7,500

**2: ESTIMATE**

Estimate how much to deduct for each FSA

Your election cannot be changed until Open Enrollment for 2027 (unless there is a qualifying event)

**3: PAY**

When you go to your doctor or pharmacy, they submit services to insurance.

Use your FSA Card to pay for expenses (except for DCFSA)

**4: USE/LOSE***

Estimate contributions carefully.

Dependent Care FSA funds that you do not use will not carry over to the following year (you LOSE it).

Unspent Medical FSA funds exceeding $680 will not carry over to the following year.

More Healthcare FSA Information

More Dependent Care FSA information

## FINANCIAL PROTECTION

Life and disability insurance can provide important financial protection as well as peace of mind for you and your family by replacing income or covering medical expenses in the case of injury or death. Selecting the right level of coverage to ensure adequate protection begins with you.

## BASIC LIFE INSURANCE

As part of Lehigh's benefits program, you automatically receive Basic Life Insurance benefits equal to one times your salary at no cost to you. For purposes of life insurance, your salary is your base salary as budgeted at the start of the plan year (i.e., January 1) or your hire date if you're a new employee.

## IMPORTANT TAX NOTE FOR LIFE INSURANCE

Because the cost of life insurance is paid with pre-tax dollars, some taxable income will result from the value of coverage over $50,000. There are no tax consequences for coverage of $50,000 or less. If your coverage exceeds $50,000, the Internal Revenue Service (IRS) requires the University to include the taxable value of the premium that purchases life insurance in excess of $50,000 on your W-2 form. The IRS defines the taxable value, and this value may be different from the actual premium paid. The difference in the amount of extra taxable income is generally minimal unless you are crossing an age bracket during the plan year.

Lehigh determines the age-based premium using your age on January 1; the IRS uses your age on December 31. In addition, you'll pay FICA (Social Security and Medicare) taxes on that amount as well if your pay is less than the Social Security wage base maximum.

### PROOF OF INSURABILITY

New employees can elect up to the maximum amount without submitting Evidence Of Insurability for themselves and their dependents.

For all future enrollments, however, employees are required to provide Evidence Of Insurability for increasing coverage by more than one times salary during any plan year.

### HOW MUCH LIFE INSURANCE DO YOU NEED?

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

- What are your financial commitments and for what expenses would your family be responsible if you should die?
- What other resources are available to those who are financially dependent on you?
- What standard of living do you want your dependents to have without you?
- How much life insurance do you already have?

Under current law, premiums for dependent life insurance cannot be paid with tax-free dollars. The cost of the Dependent Life Insurance option you choose will be paid through salary deduction on an after-tax basis.

## SUPPLEMENTAL LIFE INSURANCE

You have the option to purchase Supplemental Life Insurance for you and your dependents.

- **For you:** You can purchase supplemental coverage in increments of one to four times your salary. The combined maximum total coverage available for Basic Life Insurance and Supplemental Life Insurance is five times your base salary, up to a limit of $1,500,000. The cost of the supplemental coverage is based on your age:

| AGE (AS OF JANUARY 1) | MONTHLY PREMIUM FOR $1,000 OF COVERAGE |
|---|---|
| 16 to 29 | $0.038 |
| 30 to 34 | $0.044 |
| 35 to 39 | $0.071 |
| 40 to 44 | $0.110 |
| 45 to 49 | $0.165 |
| 50 to 54 | $0.231 |
| 55 to 59 | $0.352 |
| 60 to 64 | $0.638 |
| 65 to 69 | $1.100 |
| Over 70 | $1.837 |

- **For your dependents:** You can buy life insurance for your spouse/partner, your child(ren), or both. Dependent Life insurance can cover a child from 15 days of age up to the end of the month in which they become age 26. You are the beneficiary for any Dependent Life insurance you select.

*Important note regarding duplication of coverage: If your spouse is also a benefits-eligible Lehigh employee you cannot carry spousal life insurance for them. Also, only one of you may carry life insurance for your children. Paying for duplication of coverage does not mean the insurance company will pay more than one claim.*

| DEPENDENT LIFE PREMIUMS | | |
|---|---|---|
| Coverage Options | Monthly Premium | Life Insurance Amount |
| **Spouse/Partner** | $2.20 | $10,000 |
| | $4.40 | $20,000 |
| | $6.60 | $30,000 |
| **Child(ren)** | $0.40 | $5,000 |
| | $0.80 | $10,000 |

Lehigh's Short Term Disability (STD) plan, as defined in the Faculty and Staff Guides, provides coverage for the first 26 weeks (six months) of disability. Once you have exhausted your STD benefit, Lehigh's Long Term Disability (LTD) plan continues to replace a portion of your earnings — 66 2/3% of your LTD Base Salary — if, after 26 weeks, you are still unable to work for an extended period of time due to an illness or injury. The University pays the full cost of this coverage.

- For the period January 1 - June 30, your LTD Base Salary is your base salary as of January 1.
- For the period July 1 - December 31, your LTD Base Salary is your base salary as budgeted for the new fiscal year.

## SELECTING PRE- OR POST-TAX PREMIUM PAYMENTS

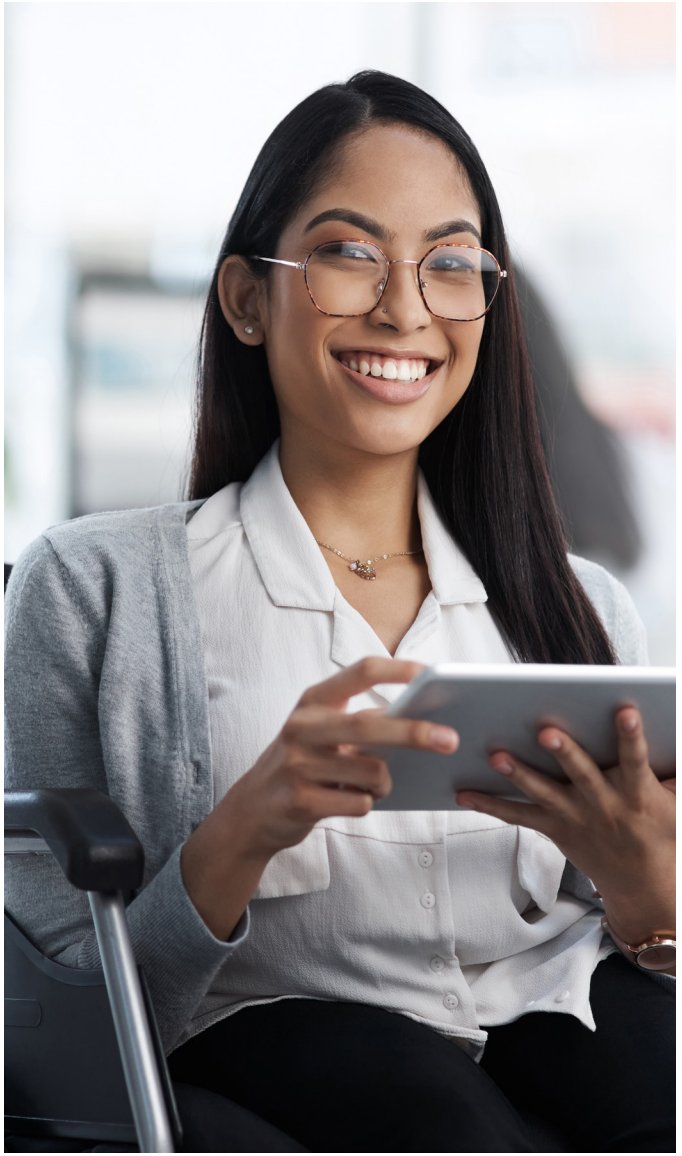
You decide if you want the premium for your LTD coverage paid pre- or post-tax. The choice you make affects how your benefit is taxed when paid.

- Purchasing LTD coverage on a "pre-tax" basis means paying federal income tax on the benefit if you become disabled but paying no federal income tax on the premium.
- Purchasing LTD coverage on a "post-tax" basis means paying federal income tax on the premium but paying no federal income tax on the benefit if you become disabled.

To qualify, you need to be totally disabled and, as a result, unable to work for 180 continuous days. The insurance company, not Lehigh, determines whether you are disabled and eligible for LTD. Once benefit payments begin, they can continue for as long as you are totally disabled and until you reach your Normal Retirement Age (as defined by your access to full Social Security income benefits) or longer if your disability begins after age 60.

Other sources of disability income are taken into consideration to determine the benefit provided. Disability benefits received from any state disability plan, Social Security, and the LTD portion of the disability plan, combined, won't exceed 66 2/3% of your benefits eligible pay.

Additional information is available through the Lehigh Benefits website or by calling Human Resources at **610.758.3900**.



CONTRIBUTIONS

In addition to your primary medical plan, consider voluntary Accident, Critical Illness or Hospital Indemnity coverage through Voya. These plans supplement your primary medical plan. and provide additional coverage to help pay expenses your medical plan may not cover.

These plans do not provide the level of medical insurance coverage you need to meet healthcare reform requirements. You pay the full cost of coverage through post-tax payroll deductions, which means your benefit, when paid, is tax-free.

## ABOUT ACCIDENT INSURANCE

You can't always avoid accidents — but you can help protect yourself from accident-related costs that can strain your budget. Accident insurance supplements your medical plan by providing cash benefits in cases of accidental injuries. You can use this money to help pay for medical expenses not covered by your medical plan, such as your deductible or coinsurance, or for ongoing living expenses, such as your mortgage or rent.

You have two benefit coverage options: Low or High.

Benefits are paid:

- Directly to you, unless assigned to someone else.
- In addition to any other coverage, such as through your medical plan.
- Tax-free, because you pay for each of these benefits with after-tax money.
- The policy pays a benefit up to a specific amount for:
  - Dislocation or fracture
  - Initial hospital confinement
  - Intensive care
  - Ambulance
  - Medical expenses
  - Outpatient physician's treatment

The actual benefit amounts depend on the type of injuries you have and the medical services you need.

**CLICK HERE** for information about Accident Insurance.

## ABOUT CRITICAL ILLNESS INSURANCE

When a serious illness strikes, Critical Illness insurance can provide financial support to help you through a difficult time. It protects against the financial impact of certain illnesses, such as a heart attack or cancer.

You receive a lump-sum benefit to cover out-of-pocket expenses for your treatments that are not covered by your medical plan. You can also use the money to take care of your everyday living expenses like housekeeping services, special transportation services and day care.

You have two coverage options: $10,000 or $20,000.

**CLICK HERE** for information about Critical Illness Insurance.

## ABOUT HOSPITAL INDEMNITY INSURANCE

Hospital Indemnity insurance pays a fixed daily benefit if you have a covered stay in a hospital, critical care unit or rehabilitation facility. Hospital Indemnity Insurance is a limited benefit policy; it is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

You may use your benefit for any purpose, such as paying out-of-pocket medical expenses, deductibles, copays, groceries, gas, utilities and more.

You have two benefit options: Low or High.

Benefits are paid directly to you, unless assigned to someone else.

**CLICK HERE** for information about Hospital Indemnity Insurance,

*Important note regarding duplication of coverage: If you are taking family coverage and both parents are Lehigh employees, only one should cover the family. Duplication of coverage does not guarantee duplication of benefit payment.*

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NEWBORN'S ACT)
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA, ALSO KNOWN AS JANET'S LAW)
Under WHCRA, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas. Call your Plan Administrator for more information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)
QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.
SPECIAL ENROLLMENT RIGHTS (HIPAA)
If you have previously declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
Special Enrollment Rights CHIPRA – Children's Health Insurance Plan
You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:
You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
You become eligible for a CHIP premium assistant subsidy under state Medicaid or CHIP (Children's Health Insurance Program). You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

COVERAGE EXTENSION RIGHTS UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)
If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

MICHELLE'S LAW
Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage.
The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the plan. Coverage will be continued until:
One year from the start of the medically necessary leave of absence, or
The date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008
This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that:
The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive that the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)
GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee's "genetic information," which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual.
GINA also prohibits employers from requesting, requiring, or purchasing an employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical record and may be disclosed to third parties only in very limited situations.

NO SURPRISES ACT
When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.
What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.
"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.
"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.
You're protected from balance billing for:
Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.
If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections. You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.
When balance billing isn't allowed, you also have these protections:
• You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
• Generally, your health plan must:
o Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
o Cover emergency services by out-of-network providers.
o Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
o Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

PREMIUM ASSISTANCE UNDER MEDICAID AND 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, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:
U.S. Department of Labor Employee Benefits Security Administration
www.dol.gov/agencies/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

PAPERWORK REDUCTION ACT STATEMENT
According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.
OMB Control Number 1210-0137 (expires 1/31/2026)

## DOCUMENTATION AND DATES FOR QUALIFYING LIFE EVENTS

Below are the situations that qualify as a change in status:

- **Adoption**
  Event Date: Date adoption is finalized
  Documentation: Finalized adoption decree
- **Birth**
  Event Date: Baby's birth date
  Documentation: Birth Certificate
- **Divorce**
  Event Date: Date the divorce is finalized
  Documentation: Finalized divorce decree
- **Eligible for Other Coverage**
  Event Date: Date new coverage becomes effective
  Documentation: Benefits confirmation statement showing who is covered and date of new coverage
- **Loss of Coverage by Dependent**
  Event Date: First day you and or/dependents no longer have coverage
  Documentation: Benefits confirmation statement showing who was covered and date of termination of coverage
- **Marriage**
  Event Date: Date of Marriage
  Documentation: Marriage certificate
- **Annual Open Enrollment for Spouse/Partner**
  Event Date: Date new coverage becomes effective
  Documentation: Benefits confirmation statement showing who is covered and start date of new coverage
- **Spouse/Partner Gained Coverage Due to Employment Status Change Event**
  Date: Date new coverage becomes effective
  Documentation: Benefits confirmation statement showing who is covered and start date of new coverage
- **Spouse/Partner Loses Coverage Due to Employment Status Change Event**
  Date: First day you and/or dependents no longer have coverage
  Documentation: Benefits confirmation statement showing who was covered and termination date of the coverage

## PPO PLAN

| MONTHLY CONTRIBUTIONS | | |
|---|---|---|
| | | University Contribution |
| Employee | $301 | $762 |
| Employee Plus Spouse/Partner | $746 | $1,568 |
| Employee Plus Child(ren) | $664 | $1,425 |
| Employee Plus Family | $1,082 | $2,262 |

## HDHP PLAN

| MONTHLY CONTRIBUTIONS | | |
|---|---|---|
| | | University Contribution |
| Employee | $45 | $762 |
| Employee Plus Spouse/Partner | $172 | $1,568 |
| Employee Plus Child(ren) | $145 | $1,425 |
| Employee Plus Family | $252 | $2,262 |

## KEYSTONE HMO

| MONTHLY CONTRIBUTIONS | | |
|---|---|---|
| | | University Contribution |
| Employee | $145 | $762 |
| Employee Plus Spouse/Partner | $409 | $1,568 |
| Employee Plus Child(ren) | $358 | $1,425 |
| Employee Plus Family | $592 | $2,262 |

# UNITED CONCORDIA DENTAL PLAN

| MONTHLY CONTRIBUTIONS | |
|---|---|
| Employee | $38.86 |
| Employee + 1 | $77.76 |
| Employee + 2 or more | $100.52 |

## BENEFIT CARRIER CONTACT INFORMATION

| PROVIDER | BENEFIT | TELEPHONE | WEB ADDRESS |
|---|---|---|---|
| **Alight** | Expert Medical Opinion & Surgery Decision Support | 888.361.3944 | mymedicalally.alight.com |
| **BenefitsVIP Service Center** | General Lehigh Benefits Questions | 866.293.9736 | solutions@benefitsvip.com |
| **Capital Blue Cross & Keystone Health Plan Central**<br>Group #00515044 | Medical Insurance | 800.216.9741 | capbluecross.com |
| **Capital Blue Managed Behavioral (Mental) Health** | Behavioral (Mental) Health Insurance | 866.322.1657 | capbluecross.com |
| **Capital Blue Virtual Care** | Telehealth | 855.818.3627 | capbluecross.com/virtualcare |
| **Davis Vision**<br>Group #LHU | Vision Insurance | 877.923.2847 \|<br>800.999.5431 | davisvision.com<br>Control code: 5167<br>Your ID number is your LIN |
| **Express Scripts**<br>Group #LEHIGHU | Prescription Plan | 866.383.7420 | express-scripts.com<br>Create an account for full access.<br>Your ID number is your LIN |
| **Health Advocate** | Advocacy Service | 866.695.8622 | answers@healthadvocate.com<br>healthadvocate.com/members |
| **Health Advocate EAP** | Employee Assistance Program | 866.799.2728 | HealthAdvocate.com/lehighuniversity<br>Registration code: EFL8M2S |
| **HealthEquity** | Health Savings Account Administration | 866.346.5800 | healthequity.com |
| **United Concordia**<br>Group #250021021 | Dental | 800.332.0366 | ucci.com |
| **WageWorks / Health Equity** | Flexible Spending Account Administration | 855.774.7441 /<br>877.924.3967 | wageworks.com<br>ID Code is the last four of your LIN |
| **Voya Voluntary Benefits** | Accident, Critical Illness, Hospital Indemnity | 877.236.7564 | presents.voya.com/ebrc/Lehigh |

## HOW TO CHOOSE YOUR MEDICAL PLAN

Using the comparison tools on Lehigh Benefits will help you find the plan that's best for you.

Lehigh Benefits offers a powerful financial modeling tool to project the total cost of your medical coverage elections using:

- The average claims experience of Lehigh employees, if you have not participated in the plan in the past
- Your own claims experience if you've been covered by a Lehigh plan in prior years
- The national average claims experience for persons with similar age, gender, and regional demographics as you and your dependents, and
- Customized modeling of your projected medical claims for next year

Take the time to review plan features — such as a Health Savings Account (HSA) with a contribution from Lehigh — and not just what you contribute from your paycheck. Consider your needs and preferences:

**1. How much coverage do I need?**

- See how the services you'll likely need in 2026 are covered under each medical plan
- Do you need supplemental coverage?

**2. What will be my total cost?**

- Out of your paycheck: Your contributions for coverage
- Out of your pocket: What you pay when you receive care
  - Copays
  - Deductibles
  - Coinsurance

**3. How do I prefer to pay?**

- Pay more from my paycheck, and less when I need care (lower deductible plans)
- Pay less from my paycheck, and more when I need care (higher deductible plans)
  - Consider your ability to cover large/unexpected medical bills

**4. Do I want an HSA?**

- Only available to employees in the HDHP
- Lehigh contributes to your HSA (in 2026, $600 individual/$1,200 family)
- You can also contribute through pre-tax payroll deductions
- Money carries over year to year — build tax-free savings to pay for eligible health expenses, now or in the future
  - Additional restrictions apply

Health Savings Accounts are not for everyone. If you are or will be enrolling in Social Security, Medicare A or B, or Tricare (military benefits) you will be ineligible for an HSA account, which could preclude you from enrolling in the HDHP. You can read more in the HDHP User's Guide at Lehigh Benefits.

## ALIGHT EXPERT MEDICAL OPINION SERVICE

Alight is a free benefit that can help you find the right doctor and get high-quality medical care. ConsumerMedical provides support to help:

- Find the best doctors and hospitals in their area and network
- Verify any doctor's credentials, skills, and experience
- Get a second opinion from top specialists
- Connect with experts in their diagnosis

For more information visit **hr.lehigh.edu/alight-expertmedical-opinion-service**

## HSA EXPENSES

HSAs are tax-advantaged accounts, so the IRS defines the types of expenses you can pay for with your account. You can use your HSA funds to pay for most medical, dental and vision care and services, for you, your legal spouse and your tax-eligible dependents – even if they aren't enrolled on your medical plan! Below are examples of eligible and ineligible HSA expenses. For a full list, please visit **healthequity.com**.

### ELIGIBLE HSA EXPENSES:

- Deductibles, coinsurance and copays
- Primary care or specialist office visits
- Urgent care visits
- Prescriptions and over-the-counter medications
- Durable medical equipment
- Chiropractic and physical therapy
- Feminine care products
- Dental expenses (e.g., cleanings, fillings, braces)
- Vision expenses (e.g., eye exams, laser eye surgery, glasses, contacts)
- Hearing aids
- COBRA and Medicare premiums

### INELIGIBLE HSA EXPENSES:

- Dietary supplements
- Personal use items (e.g., deodorant, teeth whitening)
- Medicated shampoos, conditioners and soaps
- Non-prescription sunglasses
- Gym membership fees

## HEALTHCARE FSA

Your Healthcare FSA funds can be used for prescriptions, doctor's office copays, health insurance deductibles and coinsurance. Many over-the-counter (OTC) treatments are also eligible, though keep in mind that many require a prescription, letter of medical necessity or doctor's directive.*

Your full annual Healthcare FSA election will be available to you when an eligible expense occurs regardless of whether you have deposited enough to cover the full amount at that point in time. Employees do not have to be enrolled in the healthcare plans to participate in the Healthcare FSA.

The 2026 maximum contribution limit is $3,400.

A rollover of up to $680 is allowed from one calendar year to the next.

## CLAIM FILING DEADLINE

Claims must be filed by March 31 of the following plan year for claims incurred through December 31 of the current plan year.

Eligible Expense Examples

- Acupuncture
- Blood pressure monitoring device
- Breast pumps and related supplies
- Chiropractic care
- Contact lenses and related materials
- Dental treatment
- Eye examination, eye glasses and reading glasses
- Hearing aids
- Physical therapy
- Smoking cessation programs and medications
- Sunscreen and sunblock (SPF 15+, broad spectrum)
- Weight loss program necessary to treat a specific medical condition

## INELIGIBLE EXPENSE EXAMPLES

- Cosmetics and cosmetic surgery
- Deodorant
- Exercise equipment
- Fitness programs
- Funeral expenses
- Hair transplants
- Household help
- Illegal operations and treatments
- Insurance premiums
- Maternity clothes
- Teeth whitening

Visit the **fsastore.com** for products that are FSA eligible.

**OTC items that contain a drug or medication require a prescription in order to be reimbursed. A "prescription" means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state where the medical expense is incurred, and the prescription must be issued by an individual who is legally authorized to issue a prescription in that state.*

## DEPENDENT CARE FSA

If you work and have children, a disabled spouse or qualifying dependent parents, you know how important it is to have reliable and affordable care for them while you are at work. A Dependent Care FSA (also sometimes called Dependent Care Assistance Program [DCAP]) allows you to pay for these expenses and get a tax break at the same time. Expenses must be for qualifying dependents under federal tax law. Unlike the Medical FSA, you may only receive reimbursement from your

Dependent Care FSA equal to the amount you have actually deposited.

The 2026 maximum contribution limit is $7,500.

## CLAIM FILING DEADLINE

Claims must be filed by March 31 of the following plan year for claims incurred through March 15.

## ELIGIBILITY REQUIREMENTS

To be reimbursed through your Dependent Care FSA for child and dependent care expenses, you must meet the following conditions:

- You must have incurred the expenses in order for you and your spouse, if married, to work or look for work, unless your spouse was either a full-time student or was physically or mentally incapable of self-care.
- You cannot have made the care payments to someone you can claim as your dependent on your federal tax return or to your child who is under age 19.
- Your filing status must be single, qualifying widow(er) with a dependent child, married filing jointly, or married filing separately.
- You and your spouse must maintain a home that you live in for more than half the year with the qualifying child or dependent.

## DEPENDENT CARE FSA EXPENSE EXAMPLES

- Before school or after school care (other than tuition)
- Qualifying custodial care for dependent adults
- Licensed day care centers
- Nursery schools or preschools
- Placement fees for a dependent care provider, such as an au pair
- Child care at a day camp, nursery school or by a private sitter
- Late pick-up fees
- Summer or holiday day camps

## INELIGIBLE DEPENDENT CARE FSA EXPENSE EXAMPLES

- Expenses for non-disabled children 12+
- Educational expenses including kindergarten or private school tuition fees
- Amounts paid for food, clothing, sports lessons, field trips, entertainment or transportation
- Overnight camp expenses
- Registration fees and late payment fees
- Payment for services not yet provided (payment in advance)
- Medical care

## HSA VS. FSA

| ACCOUNT FEATURE | HSA | LIMITED PURPOSE FSA | HEALTHCARE FSA | DEPENDENT CARE FSA |
|---|---|---|---|---|
| **Available if you enroll in the…** | HDHP | HDHP | • PPO<br>• Keystone HMO<br>You can also contribute to the Healthcare FSA if you waive medical coverage through Lehigh, provided neither you nor your spouse is enrolled in a high deductible health plan elsewhere | All medical plans, or no coverage (you do not need to be enrolled in a medical plan through Lehigh to enroll in the Dependent Care FSA) |
| **Maximum annual contribution (including Lehigh contribution)** | • $4,400 Employee only<br>• $8,750 all other coverage levels<br>• $1,000 additional contribution allowed for employees age 55+<br>*Note: Lehigh contributes up to $600 for employee only coverage and $1,200 for all other levels of coverage* | $3,400 | $3,400 | $7,500 (combined employee/ spouse amount) |
| **Eligible expenses** | Qualified healthcare expenses (including medical, prescription drug, dental and vision) | Qualified dental and vision expenses only | Qualified healthcare expenses (including medical, prescription drug, dental and vision) | Qualified expenses for dependents (not to be used for healthcare expenses for dependents) |
| **Earns interest tax-free** | Yes | Not applicable | Not applicable | Not applicable |
| **Carryover of unused funds to the next year** | Yes | Up to $680 | Up to $680 | No |
| **Portability if you leave Lehigh** | Yes | No | No | No |
| **Access to contributions** | Current account balance only | Entire amount elected for the year | Entire amount elected for the year | Current account balance only |

# ACCIDENT INSURANCE

| MONTHLY CONTRIBUTIONS | |
|---|---|
| **LOW PLAN** | |
| Employee | $2.26 |
| Employee Plus Spouse/Partner | $5.30 |
| Employee Plus Child(ren) | $6.27 |
| Employee Plus Family | $983 |
| **HIGH PLAN** | |
| Employee | $5.65 |
| Employee Plus One | $11.30 |
| Employee Plus Child(ren) | $12.26 |
| Employee Plus Family | $17.91 |

# CRITICAL ILLNESS INSURANCE

| EMPLOYEE MONTHLY CONTRIBUTIONS | | |
|---|---|---|
| **NON-TOBACCO USER** | | |
| AGE | $10,000 | $20,000 |
| Under 25 | $2.30 | $4.60 |
| 25-29 | $2.50 | $5.00 |
| 30-24 | $3.20 | $6.40 |
| 35-39 | $3.80 | $7.60 |
| 40-44 | $5.60 | $11.20 |
| 45-49 | $6.70 | $13.40 |
| 50-54 | $8.60 | $17.20 |
| 55-59 | $12.30 | $24.60 |
| 60-54 | $12.70 | $25.40 |
| 65-69 | $26.80 | $53.60 |
| 70+ | $50.90 | $101.80 |

| **TOBACCO USER** | | |
|---|---|---|
| AGE | $10,000 | $20,000 |
| Under 25 | $3.70 | $7.40 |
| 25-29 | $4.10 | $8.20 |
| 30-24 | $5.40 | $10.80 |
| 35-39 | $6.60 | $13.20 |
| 40-44 | $10.00 | $20.00 |
| 45-49 | $12.10 | $24.20 |
| 50-54 | $14.50 | $29.00 |
| 55-59 | $23.00 | $46.00 |
| 60-54 | $23.60 | $47.20 |
| 65-69 | $47.10 | $94.20 |
| 70+ | $81.40 | $162.80 |

CLICK HERE for spouse and child rates.

# HOSPITAL INDEMNITY INSURANCE

| MONTHLY CONTRIBUTIONS | |
|---|---|
| **LOW PLAN** | |
| Employee | $11.86 |
| Employee Plus Spouse/Partner | $25.75 |
| Employee Plus Child(ren) | $21.74 |
| Employee Plus Family | $35.63 |
| **HIGH PLAN** | |
| Employee | $23.17 |
| Employee Plus Spouse/Partner | $48.90 |
| Employee Plus Child(ren) | $40.60 |
| Employee Plus Family | $66.33 |

## Additional Medical Plan Information

Click the links below to read the Plan Highlights, Summary Benefit Charts and Preventive Services documents for each plan.

**PPO Plan**

**HDHP Plan**

**HMO Plan**