

2020 Enrollment & Reference Guide for Medical Coverage

This booklet contains all of the information needed to understand your coverage options for 2020.



**BE
WELL**

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see the Legal Notices section for details.

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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 Health Care 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 2020.

The benefit elections you make during Open Enrollment are effective from January 1, 2020 through December 31, 2020.

After Open Enrollment ends, you will not be able to make benefit changes until next year's Open Enrollment unless you experience a Qualifying Life Event (QLE) (e.g., you get married or become a parent).

***If you choose to have your spouse or partner covered by Lehigh's medical insurance plan, you will be charged a \$100/month surcharge until you complete a Spousal Surcharge Waiver request and HR approves it.** Learn more about eligibility and submitting your election on the Lehigh Benefits website or by calling the Lehigh Benefits Service Center at 1-844-342-4002.



Enrollment Is Easy

Enroll on the Web

- Log in to “Connect Lehigh” from the upper left corner of the **Inside Lehigh** homepage
 - Select the “Employee” tab
 - Select “Lehigh Benefits” from the list of applications.
 - Review your “To Do” list.
 - Select the button under the words “Enroll Now!” that is labeled “Click Here To View Your Benefits.”
- 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 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.

Changing Your Coverage During the Year

The benefit elections you make during Open Enrollment take effect on the following January 1.

Your elections 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 from the PPO to the HDHP as a result of getting married).

It is your responsibility to notify Lehigh Benefits within 31 days of a QLE and request appropriate flexible 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

If you fail to submit a QLE change request within 31 days, we will retroactively cancel coverage in the case of a dependent whose benefit eligibility ends. However, 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 simply 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.

See the list at right for more information on required documents and key dates. Learn more about QLEs by visiting the Lehigh Benefits website or calling the Lehigh Benefits Service Center at 1-844-342-4002.

What Happens to Your Coverage if You Leave Lehigh?

Your coverage does not end right away if you separate from the University. The Consolidated Omnibus Budget Reconciliation Act's (COBRA) continuation coverage 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 calling 1-844-342-4002.

DOCUMENTATION AND DATES FOR QUALIFYING LIFE EVENTS

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

Your 2020 Medical Options

Lehigh offers four 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 health care needs and review how you pay for services under each option.

IN-NETWORK PREVENTIVE CARE

Preventive care is 100% covered in all health care 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
- Women
- Children

Go to the **Preventive Care** section for details.

Your four medical insurance options include:

Capital Blue Cross Preferred Provider Organization (PPO) plans:

- PPO
- PPO-Plus
- Capital Blue Cross 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 Plans

With the PPO or PPO Plus plans, you have a choice each time you need care — you may choose health care 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 a PPO plan, you will pay more in premium contributions, but less when you receive care.



The HDHP

The HDHP gives you more control over how you spend — or save — your health care 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 health care 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 and PPO Plus plans.

The HDHP has a higher annual deductible than the PPO plans, but you'll pay less in payroll contributions. It's important to note that the full family deductible must be satisfied before the plan pays benefits for anyone covered in the plan. **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.**

Although they cover the same services, there are some key differences between the HDHP and the PPOs:

HDHP	PPO
<ul style="list-style-type: none"> • Lower payroll deductions • Pay more out-of-pocket when receiving care • Higher annual deductible • Lehigh contribution to the HSA 	<ul style="list-style-type: none"> • Higher payroll deductions • Pay less out-of-pocket when receiving care • Lower annual deductible • No HSA

Find more information about this plan by reading the HDHP User's Guide available on Lehigh Benefits.

The Keystone HMO

The HMO provides the maximum level of coverage with lower premiums and the lowest out-of-pocket costs. In addition, you will not be responsible for first satisfying an annual deductible before the plan pays benefits. 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.

WHO SHOULD ENROLL IN THE 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 or critical illness insurance.

HEALTH ADVOCATE BENEFIT

The Health Advocate benefit offers access to a personal advocate and clinical resources to help resolve a wide range of issues, including but not limited to:

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

To contact Health Advocate by phone, call 1-866-695-8622.

2020 Monthly Medical Premiums

PLAN	Individual	Employee + Spouse/Partner	Employee+ Child	Employee+ Family
University Contribution (All Plans)	\$554	\$1,144	\$1,040	\$1,649
HDHP	\$35	\$133	\$113	\$196
PPO	\$235	\$581	\$517	\$843
PPO Plus	\$318	\$766	\$684	\$1,111
Keystone Health Plan (HMO)	\$113	\$318	\$279	\$460

Summary of Medical Plan Options

The table below provides a summary comparison for key benefits across the medical plan options available for 2020. See the Summary of Benefits and Coverage and Plan Design Details sections of this guide for more information about each plan and covered preventive services.

	PPO		PPO Plus		HDHP		Keystone HMO***
Network	National		National		National		21 County/ Lehigh Valley
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network
Annual Deductible							
Individual	\$200	\$500	\$0	\$500	\$1,400	\$2,500	\$0
Family	\$600	\$500 /person	\$0	\$500 /person	\$2,800*	\$5,000*	\$0
Coinsurance	20%	30%	10%	20%	20%	30%	N/A
Out-of-Pocket Maximum for all medical and prescription drug charges							
Individual	\$4,000	No limit	\$4,000	No limit	\$6,900	No limit	\$4,000
Family	\$8,000	No limit	\$8,000	No limit	\$13,800	No limit	\$8,000
Physician Services							
Office Visit	\$25 copay/visit	30% coinsurance	\$25 copay/visit	20% coinsurance	20% coinsurance	30% coinsurance	\$25 copay/visit
Specialist Visit	\$40 copay/visit	30% coinsurance	\$40 copay/visit	20% coinsurance	20% coinsurance	30% coinsurance	\$40 copay/visit
Preventive Care (Administered in accordance with Preventive Health Guidelines & PA state mandates)	No charge	Mandated screenings and immunizations: 30% coinsurance; Routine physical exams: Not covered	No charge	Mandated screenings and immunizations: 20% coinsurance; Routine physical exams: Not covered	No charge	Mandated screenings and immunizations: 30% coinsurance; Routine physical exams: Not covered	No charge
Hospital Services							
Inpatient Coverage	20% coinsurance	30% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance	\$200/admission
Outpatient Hospital	20% coinsurance	30% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance	No charge
Emergency Room	\$100 copay/service, waived if admitted		\$100 copay/visit, waived if admitted		20% coinsurance		\$100 copay/visit, waived if admitted
Urgent Care	\$40 copay/service	30% coinsurance	\$40 copay/service	20% coinsurance	20% coinsurance	30% coinsurance	\$40 copay/ service
Maternity Services							
Prenatal/ Postpartum Care	20% coinsurance	30% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance	No charge
Hospital	20% coinsurance	30% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance	No charge
Mental Health **							
Inpatient	20% coinsurance	30% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance	No charge
Outpatient	\$25 copay/visit	30% coinsurance	\$25 copay/visit	20% coinsurance	20% coinsurance	30% coinsurance	\$25 copay/visit
Substance Abuse **							
Inpatient	20% coinsurance	30% coinsurance	No charge	20% coinsurance	20% coinsurance	30% coinsurance	No charge
Outpatient	\$25 copay/visit	30% coinsurance	\$25 copay/visit	20% coinsurance	20% coinsurance	30% coinsurance	\$25 copay/visit
Prescription Drugs							
Generic	10% coinsurance	Coinsurance plus amount over Express Scripts allowable amount	10% coinsurance	Coinsurance plus amount over Express Scripts allowable amount	10% coinsurance	Coinsurance plus amount over Express Scripts allowable amount	10% coinsurance
Brand Forumulary	20% coinsurance	Coinsurance plus amount over Express Scripts allowable amount	20% coinsurance	Coinsurance plus amount over Express Scripts allowable amount	20% coinsurance	Coinsurance plus amount over Express Scripts allowable amount	20% coinsurance
Brand Non-Forumulary	30% coinsurance	Coinsurance plus amount over Express Scripts allowable amount	30% coinsurance	Coinsurance plus amount over Express Scripts allowable amount	30% coinsurance	Coinsurance plus amount over Express Scripts allowable amount	30% 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.

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

***Care from out-of-network providers is not covered, other than in an emergency, as determined by Capital Blue Cross.

See the **Summary of Benefits and Coverage** and **Plan Design Details** sections of the **2020 Enrollment and Reference Guide** to learn more about specific coverages and limits as well as preauthorization information.

Preventive Care

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 <https://www.healthcare.gov/preventive-care-benefits>.

Capital Blue Cross Virtual Care

Capital Blue Cross Virtual Care (formerly Amwell telehealth) 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 \$59 for HDHP subscribers.** Visit www.capbluecross.com/virtualcare or the app to find approved providers or to contact patient support.



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 an 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 2020 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 2020, \$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

Prescription Drug Plan

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.

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**, 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

	Retail	Mail Order
Generic	10% (\$25 maximum) per 30-day supply	10% (\$75 maximum) per 90-day supply
Formulary Brand Name	20% (\$50 maximum) per 30-day supply	20% (\$150 maximum) per 90-day supply
Non-Formulary Brand Name	30% (\$100 maximum) per 30-day supply	30% (\$300 maximum) per 90-day supply

For definition of “formulary” and “non-formulary,” consult the “glossary on page 19. 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.



Vision Coverage

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.

To find a provider who participates in the Davis Vision network, call 1-800-999-5431 or go to www.davisvision.com and follow prompts for general access or member access, as appropriate. The Lehigh University client control code for general access is 4100.

Prior to initial enrollment, call 1-877-923-2847.

Davis Vision Program		
Service/Product	Your In-Network Cost	Out-of-Network Reimbursement to You
Eye Exam	\$0	\$32
Eyeglass Lenses		
Standard Single Vision	\$0	\$25
Bifocal	\$0	\$36
Trifocal	\$0	\$46
Post Cataract	\$0	up to \$72
Non-standard (i.e., no line bifocals, tints, coatings)	Fixed Costs	No Additional Benefit
Frames	\$0 for Davis fashion selection frames. Amount over \$110 for non-Davis frames at Visionworks, less 20% discount on overage; amount over \$60 at other providers.	\$30
Contact Lenses		
Prescription Evaluation and Fitting	\$0	Daily Wear: \$20 Extended Wear: \$30
Contact Lenses	Amount over \$75, less 15% discount on overage	Specialty: \$48 Disposable: \$75
Medically Necessary Contact Lenses (w/prior approval)	\$0	up to \$225



Tax-Advantaged Accounts

Health Savings Account (HSA)

The HSA is a tax-advantaged savings account you can use to help cover the costs of your health care 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 health care 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 2020 annual IRS limit of \$3,550 for individuals or \$7,100 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.
- **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 Health Equity for more information.](https://hr.lehigh.edu/sites/hr.lehigh.edu/files/medicare.pdf)** (<https://hr.lehigh.edu/sites/hr.lehigh.edu/files/medicare.pdf>)

For more information about the HSA, including how to set up an account and rules and restrictions, contact HealthEquity at 1-866-346-5800 or www.healthequity.com or visit the resource center at learn.healthequity.com/lehighuniversity/hsa.

Glossary

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 health care services subject to the deductible. Note that if you enroll in any coverage level other than "employee only" for the High Deductible Health Plan (HDHP), you will need to meet the entire family deductible before the plan pays benefits. 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 (sometimes called a preferred provider, depending on your plan) may not balance bill you for covered services.

Coinsurance

The way you share in the cost for most covered services after you meet the deductible. For example, if the coinsurance amount is 80%, 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 health care service, usually when you receive the service. The amount can vary by the type of covered health care 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 health care 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 1-866-383-7420.

In-Network

Doctors and other health care 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 health care 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.

Out-of-Pocket Maximum

The most you will pay during the plan year for in-network care before your plan begins to pay 100% of eligible expenses. This limit does not include your premium or expenses for services not covered by your plan, nor does it include balance billing, amounts above the Maximum Allowable Charge (MAC) for your plan, or out-of-pocket costs for Davis Vision plan services and products. It's important to check your plan and see what other charges may not be included.

Preferred Provider

A provider who has a contract with your plan to provide services to you at a discount. In some cases, there may be a "preferred network" as a subset of your plan's overall network. In this instance, preferred providers offer additional savings on covered services.

Primary Care Physician (PCP)

A physician who directly provides or coordinates a range of health care services for a patient. You are required to select a primary care physician (PCP) to receive benefits through the HMO plan.

Premium

A health insurance premium is the monthly fee that is paid to an insurance company or health plan to provide health coverage. You and Lehigh both contribute to pay the cost of your premium, with Lehigh paying the majority of the cost.

Prescription Drugs

Medications that by law require a prescription.

Preventive Care

Any covered service or supply that is received in the absence of symptoms or a diagnosed condition. Preventive care includes preventive health services like physical examinations, certain immunizations, screening tests, and dental cleanings. 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 etc. 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

www.healthcare.gov/coverage/preventive-care-benefits

Specialist

A specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. The Keystone HMO plan requires a referral to see a specialist, while the PPO plans and the HDHP do not require a referral.

Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Frequently Asked Questions

When is Open Enrollment?

For current employees: Open Enrollment begins on November 4th and ends on November 18th. Open Enrollment is your once-a-year chance to make changes to your benefits. You will not be able to make benefit changes until next year's Open Enrollment unless you experience a Qualifying Life Event (QLE) (e.g., you get married or have a baby). You must notify Lehigh Benefits of your QLE within 31 days of the event.

For new hires: You must enroll within 30 days of your first day of work.

What changes can I make during Open Enrollment?

During enrollment you can:

- Change plans
- Add or delete dependents from your coverage
- Change coverage levels
- Enroll in a Health Care or Dependent Care Flexible Spending Account (FSA), and/or elect the Health Savings Account (HSA) if you enroll in the High Deductible Health Plan (HDHP) option for 2020.

How do I enroll?

1. Login to "Connect Lehigh" from the upper left corner of the Inside Lehigh home page
2. Select the Employee tab, then "Lehigh Benefits" from the list of applications.
3. Click on the "Click Here to View Your Benefits" button and proceed.

You can also now enroll via the Benefitfocus app.

1. Download the Benefitfocus App via the App Store or the Google Play Store.
2. Sign into the system with the ID "lehighbenefits."
3. Log in using your Lehigh ID and password.

Who is eligible for benefits through Lehigh University?

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, and disabled child(ren) without age limitation (coverage and its continuation is subject to required certification with the carrier). More information is available through Lehigh Benefits or by calling the Benefits Service Center at 1-844-342-4002.

When will my changes become effective?

For current employees: The benefit elections you make during Open Enrollment are effective from January 1, 2020 through December 31, 2020.

For new hires:

- Coverage for faculty members is effective as of their first day of work provided they complete their enrollment in Lehigh Benefits within the first thirty days of employment.
- Coverage for staff members is effective on the first of the month following your start date, provided completed enrollment materials are received within 30 days of your first work day.

What happens if I do not enroll by the deadline?

New Employees: If you miss your enrollment period deadline, you will be assigned Lehigh's default benefit coverage, the PPO plan at an employee cost of \$235 per month. No dependents will be enrolled in medical coverage; nor will dental insurance, supplemental or dependent life insurance, or flexible spending accounts be available to you or any dependents.

Current Employees: You will receive the same coverage you had in the prior year, with the exception of any flexible spending account or health savings account employee contributions which must be renewed annually.

How do I know what benefits to select?

You should select your benefits based on the needs of you and your family, as well as your financial situation. Use the tools available on the Lehigh Benefits website to help you make informed decisions about your benefits.

Are there any changes to the medical plans for 2020?

Monthly premiums and out of pocket maximums have increased. See the **Your 2020 Medical Options, Summary of Benefits and Coverage and Plan Design Details** sections of this publication for information about the plans available to you.

How do I find a provider?

For all medical plans, visit <https://www.capbluecross.com> and click *Find a Provider*. You must choose your network in order to see the list of all available in-network providers.

- Select *PPO Network* for PPO, PPO Plus, and HDHP
- Select *HMO Network* for Keystone

To find a dental provider, visit www.ucci.com and click *Find a Dentist*. You must select Concordia Advantage Plus as your network before seeing all available in-network providers.

To find a vision provider, visit www.davisvision.com and click *Find a Provider*.

For all plans other than the Keystone HMO, you have the option to receive care from any provider you choose regardless of whether he or she participates in the plan's network. Keep in mind that you'll typically pay more for care when you use out-of-network providers.

What is a Health Savings Account (HSA)?

An HSA is a tax-advantaged savings account that you can use like a bank account to pay for qualified medical, dental and vision expenses. You can use the money in your HSA this year or, if you don't use it now, you can save it for use in the future — even in retirement.

To be eligible to contribute money to an HSA, you must be enrolled in a High Deductible Health Plan (HDHP). See the **Health Savings Account (HSA)** section to find more information.

If I need more information regarding Open Enrollment, where can I find support?

See the **Where to Go for Help** section on the next page to find contact information for Lehigh's benefit providers. You may also call the Lehigh Benefits Service Center at 1-844-342-4002.



Where to Go for Help

Contact/Provider	Type of Benefit	Telephone Number	Web Address
Aflac	Voluntary Benefits Administration	800-433-3036	www.aflacgroupinsurance.com
Capital Blue Cross and Keystone Health Plan Central Group #00515044	Medical Insurance	800-216-9741	www.capbluecross.com
Capital Blue Virtual Care	Telehealth	855-818-DOCS	www.capbluecross.com/virtualcare
Davis Vision Group #LHU	Vision Insurance	877-923-2847 or 800-999-5431	www.davisvision.com Control code: 4100 Your ID number is your LIN.
Express Scripts Group #LEHIGHU	Prescriptions Plan	866-383-7420	www.express-scripts.com Create an account for full access. Your ID number is your LIN.
Health Advocate	Advocacy Service	866-695-8622	answers@healthadvocate.com www.healthadvocate.com/members
HealthEquity	Health Savings Account Administration	866-346-5800	www.healthequity.com
Integrated Behavioral Health	Mental Health/ Substance Abuse benefits in Keystone Health Plan and PPO Plus	800-395-1616	www.ibhcorp.com To access EAP/Work Life resources: User ID: lehigh Password: univ03
LehighBenefits/ Benefitfocus	Enroll in your benefits	844-342-4002	Email: LehighBenefits@benefitfocus.com
Magellan Health Services	Mental Health/ Substance Abuse benefits in PPO and HDHP	866-322-1657	www.magellanhealth.com/MBH
United Concordia Group #250021021	Dental	800-332-0366	www.ucci.com
WageWorks	Flexible Spending Account Administration	855-774-7441 or 877-924-3967	www.wageworks.com

Legal Notices

Review the following notices which are required by law to help you understand your rights. If you have any questions, please call Lehigh University Human Resources at 610-758-3900.

Women's Health and Cancer Rights Act of 1998 (WHCRA) Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call Lehigh's Human Resources at (610)758-3900.

Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) Notice

Under federal law, group health plans and health insurance issuers generally may not 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).

Notices Required By the Patient Protection and Affordable Care Act

Retroactive Cancellation of Coverage (Rescission)

Your medical benefit cannot be cancelled retroactively except in the case of fraud, intentional misrepresentation of material fact, or failure to pay required contributions on a timely basis. A 30 day notice will be provided if coverage is rescinded. An example of fraud or intentional misrepresentation may include things such as retaining your former spouse on your medical benefits after your divorce decree is final. As a University medical plan participant, it is your responsibility to notify Human Resources of any changes to a dependent's status within 31 days of a status change event. Failure to provide timely notice to Human Resources constitutes intentional misrepresentation of material fact.

The Designation of Primary Care Providers

The Keystone Health Plan Central Health Maintenance Organization Plan (KHPC) generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the plan network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of participating primary care providers, contact the plan at 800-216-9741. You do not need prior authorization from KHPC or from any other person (including your primary care doctor) in order to obtain access to obstetrical or gynecological care from a health care professional in the plan network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan at 800-216-9741.

The ACA's individual mandate requires that nearly everyone have medical coverage or pay a penalty. If you are benefits-eligible and enroll in a Lehigh health plan, you will be in compliance with the individual mandate.

- Our health plans offer the level of coverage to satisfy the individual mandate.
- Our health plans offer affordable coverage with at least the minimum benefit value (called "minimum essential coverage") required under the ACA.
- Anyone can shop in the public health insurance marketplace. While some low-income individuals qualify for subsidized coverage, Lehigh employees generally will not qualify because of the cost and benefit value of our health plans.
- If you shop in the health insurance marketplace, you may find the options offered to be more expensive than the University's coverage because Lehigh pays a large part of the cost for your medical coverage. Generally, in the public marketplace, you will pay the entire cost of your coverage.
- For more information about the ACA, visit www.healthcare.gov.

Premium Assistance Under Medicaid and The Children’s Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility.

Alabama - Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidprecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	GEORGIA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://www.dhs.iowa.gov/hawki Phone: 1-888-257-8563

KANSAS – Medicaid	NEVADA – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Medicaid Website: http://dhcnp.nv.gov/ Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/ Phone: 1-800-635-2570	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Hotline: NH Medicaid Service Center - 1-888-901-4999
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	NEW YORK – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	NORTH CAROLINA – Medicaid
Website: http://www.mass.gov/eohhs/gof/departments/mass-health/ Phone: 1-800-862-4840	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	NORTH DAKOTA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	OREGON – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha 402-595-1178	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462

RHODE ISLAND – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347 or 401-462-0311 (Direct RlTe Share Line)	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH CAROLINA – Medicaid	WASHINGTON – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
SOUTH DAKOTA - Medicaid	WEST VIRGINIA – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
TEXAS – Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
UTAH – Medicaid and CHIP	WYOMING – Medicaid
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VERMONT– Medicaid	
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	

To see if any other states have added a premium assistance program since July 31, 2019, 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 12/31/2019)

Creditable Coverage Disclosure Notice

Important Notice from Lehigh University About Your Prescription Drug Coverage and Medicare October 5, 2019

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Lehigh University and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Lehigh University has determined that the prescription drug coverage offered by the Express Scripts plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Lehigh University coverage will not be affected. You can retain your existing coverage and choose not to enroll in a Part D plan now. Or, you can enroll in a Part D plan as a supplement to, or in lieu of, the other coverage. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. If you do decide to join a Medicare drug plan and drop your current Lehigh University coverage, be aware that you and your dependents will be able to enroll back into the Lehigh University benefit program during the open enrollment period under the plan, providing you are an active, benefits eligible employee at that time.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Lehigh University and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information at 610-758-3900. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Lehigh University changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 5, 2019
Name of Entity/Sender: Lehigh University
Contact – Position/Office: Director of Human Resource Services
Office of Human Resources
Address: 306 South New Street, Suite 437
Bethlehem, PA 18015
Phone Number: 610-758-3900



Lehigh University Benefit Plans Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Lehigh University sponsors the following employee welfare benefit plans (collectively referred to as the “Plans”):

- PPO, administered by Capital Blue Cross,
- PPO Plus, administered by Capital Blue Cross,
- Keystone Health Plan Central HMO, administered by Capital Blue Cross,
- High Deductible Health Plan, administered by Capital Blue Cross,
- Behavioral Health Benefits, administered by Magellan Behavioral Health and Integrated Behavioral Health,
- Employee Assistance Program, administered by Integrated Behavioral Health,
- United Concordia Dental, insured by United Concordia Life and Health Insurance Co.,
- Davis Vision, insured by Highmark Blue Shield,
- Express Scripts Pharmacy Benefits, administered by Express Scripts,
- Health Care Flexible Spending Accounts, administered by WageWorks, and
- Health Savings Account, administered by HealthEquity.

The Plans are required by law to maintain the privacy of your health information and to provide you with notice of their legal duties and privacy practices with respect to your health information. If you have any questions about any part of this Notice or if you want more information about the Plans’ privacy practices, please contact:

Director, Human Resource Services
Lehigh University Human Resources
306 South New Street, Suite 437
Bethlehem, PA 18015
Phone: 610-758-3900

How the Plans May Use or Disclose Your Health Information

The following categories describe the ways that we (the Lehigh University Benefits Staff) may use and disclose your health information. For each category of uses and disclosures, we will explain what we mean and present examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

1. **Payment Functions.** We may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits. For example, payment functions may include confirmation of eligibility and demographic information to ensure accurate processing of enrollment changes.
2. **Health Care Operations.** We may use and disclose health information about you to carry out necessary insurance-related activities. For example, such activities may include submitting claims for stop-loss coverage; auditing claims payments; and planning, management, and general administration of the benefits plans.
3. **Required by Law.** As required by law, we may use or disclose your health information. For example, we may disclose your health information to a law enforcement official for purposes such as complying with a court order or subpoena and other law enforcement purposes; we may disclose your health information in the course of any administrative or judicial proceeding; or we may disclose your health information for military, national security, and government benefits purposes.
4. **Health Oversight Activities.** We may disclose your health information to health agencies in the course of audits, investigations, or other proceedings related to oversight of the health care system. For example, we will report medical plan enrollment information to the Medicare: Coordination of Benefits IRS/SSA/CMS Data Match Project.
5. **Worker’s Compensation.** We may disclose your health information as necessary to comply with worker’s compensation or similar laws.

When the Plans May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Policies, we will not use or disclose your health information without written authorization from you. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose health information about you for the reasons covered by your written authorization, though we will be unable to take back any disclosures we have already made with your permission.

Statement of Your Health Information Rights

1. **Right to Request Restrictions.** You have the right to request restrictions on certain uses and disclosures of your health information. The Plans are not required to agree to the restrictions that you request. If you would like to make a request for restrictions, you must submit your request in writing to:

Director, Human Resource Services
Lehigh University Human Resources
306 South New Street, Suite 437
Bethlehem, PA 18015

2. **Right to Request Confidential Communications.** You have the right to receive your health information through a reasonable means or at an alternative location. There are two standard locations used for distribution of plan information. If you are an employee of the University, most information about the plans will be sent to your campus address. On occasion, information may be distributed through the U.S. Postal Service. The standard location for the U.S. Postal Service delivery of plan communications will be your home address, as listed in Lehigh's records. If you are not a current employee of Lehigh University, our standard location for sending plan information to you is your home address, as listed in Lehigh's records. To request an alternative means of receiving confidential communications, you must submit your request in writing to:

Director, Human Resource Services
Lehigh University Human Resources
306 South New Street, Suite 437
Bethlehem, PA 18015

We are not required to agree to your request.

3. **Right to Inspect and Copy.** You have the right to inspect and copy health information about you that may be used to make decisions about your plan benefits. To inspect and copy such information, you must submit your request in writing to:

Director, Human Resource Services
Lehigh University Human Resources
306 South New Street, Suite 437
Bethlehem, PA 18015

If you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request.

4. **Right to Request Amendment.** You have the right to request that the Plans amend your health information that you believe is incorrect or incomplete. We are not required to change your health information and, if your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To request an amendment, you must also provide a reason for your request in writing to:

Director, Human Resource Services
Lehigh University Human Resources
306 South New Street, Suite 437
Bethlehem, PA 18015

5. **Right to Accounting of Disclosures.** You have the right to receive a list or "accounting of disclosures" of your health information made by us, except that we do not have to account for disclosures made for purposes of payment functions or health care operation, or those made to you. To request this accounting, you must submit your request in writing to:

Director, Human Resource Services
Lehigh University Human Resources
306 South New Street, Suite 437
Bethlehem, PA 18015

Your request should specify a time period of up to six years and may not include dates before April 14, 2003. The Plans will provide, on request, one list per 12-month period free of charge; we may charge you for additional lists.

6. **Right to Paper Copy.** 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:

Director, Human Resource Services
Lehigh University Human Resources
306 South New Street, Suite 437
Bethlehem, PA 18015
Phone: 610-758-3900

Changes to this Notice of Privacy Practices

The Plans reserve the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that it maintains. We will promptly revise our Notice and distribute it to you whenever we make material changes to the Notice. Until such time, the Plans are required by law to comply with the current version of this Notice.

Complaints

Complaints about this Notice of Privacy Practices or about how we handle your health information should be directed to:

Vice President for Finance and Administration
Lehigh University
27 Memorial Drive West
Bethlehem, PA 18015
Phone: 610-758-3178

The Plans will not retaliate against you in any way for filing a complaint. All complaints about the Privacy Practices described in this Notice must be submitted in writing. If you believe your privacy rights have been violated, you may also file a complaint with the Secretary of the Department of Health and Human Services.

Effective Date of This Notice: April 14, 2003; Updated October 21, 2019



Summary of Benefits and Coverage
Appendix 1

⚠ The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage: about health care coverage, contact Capital Blue Cross at 1-800-216-9741 or www.capbluecross.com; about prescription drug coverage, contact Express Scripts at 1-866-383-7420 or www.express-scripts.com; and about vision coverage, contact Davis Vision at 1-800-999-5431 or www.davisvision.com. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.ccio.cms.gov or call 1-888-428-2566 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>\$1,400 individual / \$2,800 family participating providers; \$2,500 individual / \$5,000 family non-participating providers. Deductible applies to all services, including prescription drug, before any copayment or coinsurance are applied.</p>	<p>Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Network preventive services.</p>	<p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>For participating providers \$6,900 individual / \$13,800 family; for non-participating providers \$0 individual combined out-of-pocket limit for medical and prescription drug.</p>	<p>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Pre-authorization penalties, premiums, balance billing charges, vision care costs, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>

<p>Will you pay less if you use a network provider?</p>	<p>Yes. For a list of participating providers, see www.capbluexcross.com or call 1-800-962-2242. See www.davisvision.com or call 1-800-999-5431 for vision care participating providers.</p>	<p>This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without a referral.</p>

*For more information about preauthorization, see www.capbluexcross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements.



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	30% coinsurance	None
	Specialist visit	20% coinsurance	30% coinsurance	None
	Preventive care/screening/immunization	No charge	Mandated screening and immunizations 30% coinsurance ; Routine Physical exams; Not covered	Deductible does not apply to services at participating providers . You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance for lab and 20% coinsurance for tests. 20% coinsurance for outpatient radiology.	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com or call 1-866-383-7420.	Generic drugs	10% coinsurance (retail and mail order)	10% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Preferred brand drugs	20% coinsurance (retail and mail order)	20% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Non-preferred brand drugs	30% coinsurance (retail and mail order)	30% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Specialty drugs	20% coinsurance for preferred brand drugs and 30% coinsurance For non-preferred brand drugs	Not covered	Some drugs may require purchase through Accredo Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	Services at non-participating ambulatory surgical facilities 30% coinsurance .

*For more information about preauthorization, see [www.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements](#).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Physician/surgeon fees	20% coinsurance	30% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance	None
	Inpatient services	20% coinsurance	30% coinsurance	None
If you are pregnant	Office visits	20% coinsurance	30% coinsurance	Depending on the type of services, a copayment , coinsurance , or deductible may apply.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	
	Home health care	20% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Rehabilitation services	20% coinsurance	30% coinsurance	90 visit limit *See preauthorization schedule attached to your certificate of coverage.
	Habilitation services	20% coinsurance	30% coinsurance	None
	Skilled nursing care	20% coinsurance	30% coinsurance	None
	Durable medical equipment	20% coinsurance	30% coinsurance	100 day limit
	Hospice services	20% coinsurance	30% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
If your child needs dental or eye care	Children's eye exam	No charge	Full cost less \$32	Limited to one exam per year
	Children's glasses	No charge for standard lenses and select frames; Amount over \$60 for provider frames	Full cost less \$55 for standard lenses and any frame	Limited to one pair of glasses per year
More information about participating providers and vision care benefits are available at www.davisvision.com or call 1-800-999-5431.	Children's dental check-up	Not covered	Not covered	None

*For more information about preauthorization, see www.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements.

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Bariatric Surgery (unless medically necessary)
- Cosmetic Surgery
- Dental care
- Hearing aids
- Long-term care
- Routine foot care (unless medically necessary)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan document](#).)

- Chiropractic Care
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: for health care coverage, contact Capital Blue Cross at 1-800-216-9741 or www.capbluecross.com; for prescription drug coverage, contact Express Scripts at 1-866-383-7420 or www.express-scripts.com; and for vision coverage, contact Davis Vision at 1-800-999-5431 or www.davisvision.com, or the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

—————To see examples of how this plan might cover costs for a sample medical situation, see the next section.—————

*For more information about preauthorization, see www.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) **\$1400**
- [Specialist](#) [*cost sharing*] **\$40**
- [Hospital \(facility\)](#) [*cost sharing*] **20%**
- [Other](#) [*cost sharing*] **20%**

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost **\$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,400
Copayments	\$0
Coinsurance	\$2,523
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,983

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) **\$1400**
- [Specialist](#) [*cost sharing*] **\$40**
- [Hospital \(facility\)](#) [*cost sharing*] **20%**
- [Other](#) [*cost sharing*] **20%**

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost **\$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,400
Copayments	\$0
Coinsurance	\$1,369
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,829

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) **\$1400**
- [Specialist](#) [*cost sharing*] **\$40**
- [Hospital \(facility\)](#) [*cost sharing*] **20%**
- [Other](#) [*cost sharing*] **20%**

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost **\$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,400
Copayments	\$0
Coinsurance	\$385
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,785

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

⚠ The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage: about health care coverage, contact Capital Blue Cross at 1-800-216-9741 or www.capbluecross.com; about prescription drug coverage, contact Express Scripts at 1-866-383-7420 or www.express-scripts.com; and about vision coverage, contact Davis Vision at 1-800-999-5431 or www.davisvision.com. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.ccio.cms.gov or call 1-888-428-2566 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>\$200/individual/\$600/family participating providers; \$500/individual non-participating providers.</p>	<p>Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Network preventive services.</p>	<p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>For participating providers \$4,000 individual / \$8,000 family; for non-participating providers \$0 individual combined out-of-pocket limit for medical and prescription drug.</p>	<p>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Pre-authorization penalties, premiums, balance billing charges, vision care costs, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. For a list of participating providers, see www.capbluecross.com or call 1-800-962-2242. See www.davisvision.com or call 1-800-999-5431 for vision care participating providers.</p>	<p>This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</p>

Do you need a [referral](#) to see a [specialist](#)?

No.

You can see the [specialist](#) you choose without a [referral](#).

*For more information about preauthorization, see www.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements.



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copayment /visit	30% coinsurance	None
	Specialist visit	\$40 copayment /visit	30% coinsurance	None
	Preventive care/screening/immunization	No charge	Mandated screening and immunizations 30% coinsurance ; Routine physical exams ; Not covered	Deductible does not apply to services at participating providers . You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance for lab and 20% coinsurance for tests. 20% coinsurance for outpatient radiology.	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com or call 1-866-383-7420.	Generic drugs	10% coinsurance (retail and mail order)	10% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Preferred brand drugs	20% coinsurance (retail and mail order)	20% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Non-preferred brand drugs	30% coinsurance (retail and mail order)	30% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Specialty drugs	20% coinsurance for preferred brand drugs and 30% coinsurance For non-preferred brand drugs	Not covered	Some drugs may require purchase through Accredo Specialty Pharmacy.

*For more information about preauthorization, see www.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	Services at non-participating ambulatory surgical facilities 30% coinsurance .
	Physician/surgeon fees	20% coinsurance	30% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
If you need immediate medical attention	Emergency room care	\$100 copayment/visit	\$100 copayment/visit	Deductible does not apply. Copayment waived if admitted inpatient.
	Emergency medical transportation	20% coinsurance	30% coinsurance	Deductible does not apply.
	Urgent care	\$40 copayment/visit	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copayment/visit	30% coinsurance	None
	Inpatient services	20% coinsurance	30% coinsurance	None
	Office visits	\$40 copayment/visit	30% coinsurance	None
If you are pregnant	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	90 visit limit *See preauthorization schedule attached to your certificate of coverage.
	Home health care	20% coinsurance	30% coinsurance	None
If you need help recovering or have other special health needs	Rehabilitation services	20% coinsurance	30% coinsurance	None
	Habilitation services	20% coinsurance	30% coinsurance	None
	Skilled nursing care	20% coinsurance	30% coinsurance	100 day limit
	Durable medical equipment	20% coinsurance	30% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
If your child needs dental or eye care -- More information about participating providers and vision	Hospice services	20% coinsurance	30% coinsurance	None
	Children's eye exam	No charge	Full cost less \$32	Limited to one exam per year
	Children's glasses	No charge for standard lenses and select frames; Amount over \$60 for provider frames	Full cost less \$55 for standard lenses and any frame	Limited to one pair of glasses per year

*For more information about preauthorization, see www.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
care benefits are available at www.davisvision.com or call 1-800-999-5431.	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)
<ul style="list-style-type: none"> Acupuncture Bariatric Surgery (unless medically necessary) Cosmetic Surgery

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
<ul style="list-style-type: none"> Chiropractic Care Infertility treatment

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: for health care coverage, contact Capital Blue Cross at 1-800-216-9741 or www.capbluecross.com; for prescription drug coverage, contact Express Scripts at 1-866-383-7420 or www.express-scripts.com; and for vision coverage, contact Davis Vision at 1-800-999-5431 or www.davisvision.com, or the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a plan through the [Marketplace](#).

Language Access Services:

*For more information about preauthorization, see www.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements.

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next section.*—————

*For more information about preauthorization, see www.capbluexcross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$200
- [Specialist](#) [[cost sharing](#)] \$40
- Hospital (facility) [[cost sharing](#)] 20%
- Other [[cost sharing](#)] 20%

This EXAMPLE event includes services like:
 Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost \$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$50
Coinsurance	\$2,490
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,800

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$200
- [Specialist](#) [[cost sharing](#)] \$40
- Hospital (facility) [[cost sharing](#)] 20%
- Other [[cost sharing](#)] 20%

This EXAMPLE event includes services like:
 Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost \$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$280
Coinsurance	\$1,160
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,700

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$200
- [Specialist](#) [[cost sharing](#)] \$40
- Hospital (facility) [[cost sharing](#)] 20%
- Other [[cost sharing](#)] 20%

This EXAMPLE event includes services like:
 Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost \$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$120
Coinsurance	\$330
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$650

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

⚠ The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage: about health care coverage, contact Capital Blue Cross at 1-800-216-9741 or www.capbluecross.com; about prescription drug coverage, contact Express Scripts at 1-866-383-7420 or www.express-scripts.com; about mental/behavioral health or substance abuse, contact Integrated Behavioral Health at 1-800-395-1616 or www.ibhcorp.com; and about vision coverage, contact Davis Vision at 1-800-999-5431 or www.davisvision.com. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.ccio.cms.gov or call 1-888-428-2566 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>\$0/individual participating providers; \$500/individual non-participating providers.</p>	<p>Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Emergency services or emergency medical transportation, and network preventive services.</p>	<p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>For participating providers \$4,000 individual / \$8,000 family; for non-participating providers \$0 individual combined out-of-pocket limit for medical and prescription drug.</p>	<p>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Pre-authorization penalties, premiums, balance billing charges, vision care costs, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. For a list of participating providers, see www.capbluecross.com or call 1-800-962-2242. Call IBH at 1-800-395-1616 for mental/behavioral health or substance abuse</p>	<p>This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be</p>

	<p>providers. See www.davisvision.com or call 1-800-999-5431 for vision care participating providers.</p>	<p>aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without a referral.</p>

*For more information about preauthorization, see www.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements.



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copayment /visit	20% coinsurance	None
	Specialist visit	\$40 copayment /visit	20% coinsurance	None
	Preventive care/screening/immunization	No charge	Mandated screening and immunizations 20% coinsurance ; Routine Physical exams; Not covered	Deductible does not apply to services at participating providers . You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance for lab and 10% coinsurance for tests. 10% coinsurance for outpatient radiology.	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com or call 1-866-383-7420.	Generic drugs	10% coinsurance (retail and mail order)	10% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Preferred brand drugs	20% coinsurance (retail and mail order)	20% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Non-preferred brand drugs	30% coinsurance (retail and mail order)	30% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Specialty drugs	20% coinsurance for preferred brand drugs and 30% coinsurance For non-preferred brand drugs	Not covered	Some drugs may require purchase through Accredo Specialty Pharmacy.
	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	Services at non-participating ambulatory surgical facilities 30% coinsurance .

*For more information about preauthorization, see [www.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements](#).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Physician/surgeon fees	10% coinsurance	20% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
	Emergency room care	\$100 copayment/visit	\$100 copayment/visit	Copayment waived if admitted inpatient.
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
If you have a hospital stay	Urgent care	\$40 copayment/visit	20% coinsurance	None
	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copayment/visit	20% coinsurance	Some services require pre-certification.
	Inpatient services	10% coinsurance	20% coinsurance	Pre-certification required. 50% co-insurance for services provided without pre-authorization.
	Office visits	\$40 copayment/visit	20% coinsurance	Depending on the type of services, a copayment , coinsurance , or deductible may apply.
If you are pregnant	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	
	Home health care	10% coinsurance	20% coinsurance	50 visit limit *See preauthorization schedule attached to your certificate of coverage.
If you need help recovering or have other special health needs	Rehabilitation services	10% coinsurance	20% coinsurance	30 visit limit
	Habilitation services	10% coinsurance	20% coinsurance	30 visit limit
	Skilled nursing care	10% coinsurance	20% coinsurance	100 day limit
	Durable medical equipment	10% coinsurance	20% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
	Hospice services	10% coinsurance	20% coinsurance	None
If your child needs dental or eye care -- More information about participating providers and vision care benefits are available at www.davisvision.com or call 1-800-999-5431.	Children's eye exam	No charge	Full cost less \$32	Limited to one exam per year
	Children's glasses	No charge for standard lenses and select frames; Amount over \$60 for provider frames	Full cost less \$55 for standard lenses and any frame	Limited to one pair of glasses per year
	Children's dental check-up	Not covered	Not covered	None

*For more information about preauthorization, see www.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements.

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Bariatric Surgery (unless medically necessary)
- Cosmetic Surgery
- Dental care
- Hearing aids
- Long-term care
- Routine foot care (unless medically necessary)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan document](#).)

- Chiropractic Care
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: for health care coverage, contact Capital Blue Cross at 1-800-216-9741 or www.capbluecross.com; for prescription drug coverage, contact Express Scripts at 1-866-383-7420 or www.express-scripts.com; for mental/behavioral health or substance abuse, contact Integrated Behavioral Health at 1-800-395-1616 or www.ihhcorp.com; and for vision coverage, contact Davis Vision at 1-800-999-5431 or www.davisvision.com, or the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next section.

*For more information about preauthorization, see www.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's overall deductible](#) \$0
- [Specialist \[cost sharing\]](#) \$40
- [Hospital \(facility\) \[cost sharing\]](#) 10%
- [Other \[cost sharing\]](#) 10%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost \$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$50
Coinsurance	\$1,250
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,360

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's overall deductible](#) \$0
- [Specialist \[cost sharing\]](#) \$40
- [Hospital \(facility\) \[cost sharing\]](#) 10%
- [Other \[cost sharing\]](#) 10%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost \$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$280
Coinsurance	\$970
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,310

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's overall deductible](#) \$0
- [Specialist \[cost sharing\]](#) \$40
- [Hospital \(facility\) \[cost sharing\]](#) 10%
- [Other \[cost sharing\]](#) 10%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost \$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$120
Coinsurance	\$160
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$280

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

⚠ The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage: about health care coverage, contact Capital Blue Cross at 1-800-216-9741 or www.capbluecross.com; about prescription drug coverage, contact Express Scripts at 1-866-383-7420 or www.express-scripts.com; about mental/behavioral health or substance abuse, contact Integrated Behavioral Health at 1-800-395-1616 or www.ibhcorp.com; and about vision coverage, contact Davis Vision at 1-800-999-5431 or www.davisvision.com. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.ccio.cms.gov or call 1-888-428-2566 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Not applicable.	This plan does not have an overall deductible .
Are there services covered before you meet your deductible?	No.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$4,000 individual / \$8,000 family combined out-of-pocket limit for network medical and prescription drug .	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums , balance billing charges, vision care costs, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider?	Yes. For a list of participating providers , see www.capbluecross.com or call 1-800-962-2242. Call IBH at 1-800-395-1616 for mental/behavioral health or substance abuse providers. See www.davisvision.com or call 1-800-999-5431 for vision care participating providers.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copayment /visit	Not covered	Additional \$10 copayment /visit required after hours.
	Specialist visit	\$40 copayment /visit	Not covered	None
If you have a test	Preventive care/screening/immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
	Diagnostic test (x-ray, blood work)	No charge for lab or tests	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com or call 1-866-383-7420.	Imaging (CT/PET scans, MRIs)	No charge	Not covered	*See preauthorization schedule attached to your certificate of coverage.
	Generic drugs	10% coinsurance (retail and mail order)	10% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Preferred brand drugs	20% coinsurance (retail and mail order)	20% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Non-preferred brand drugs	30% coinsurance (retail and mail order)	30% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Specialty drugs	20% coinsurance for preferred brand drugs and 30% coinsurance For non-preferred brand drugs	Not covered	Some drugs may require purchase through Accredo Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	*See preauthorization schedule attached to your certificate of coverage.

*For more information about preauthorization, see www.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	\$100 copayment/visit	\$100 copayment/visit	Copayment waived if admitted inpatient.
	Emergency medical transportation	No charge	No charge	None
	Urgent care	\$40 copayment/visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 copayment/service	Not covered	*See preauthorization schedule attached to your certificate of coverage.
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copayment/visit	Not covered	Some services require pre-certification.
	Inpatient services	\$200 copayment/service	Not covered	Pre-certification required. 50% co-insurance for services provided without pre-authorization.
If you are pregnant	Office visits	\$40 copayment/visit	Not covered	Depending on the type of services, a copayment , coinsurance , or deductible may apply.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	100 visit limit *See preauthorization schedule attached to your certificate of coverage.
	Rehabilitation services	No charge	Not covered	30 visit limit
	Habilitation services	No charge	Not covered	30 visit limit
	Skilled nursing care	No charge	Not covered	60 day limit. Skilled nursing limit combined with acute inpatient rehabilitation limit.
	Durable medical equipment	No charge	Not covered	*See preauthorization schedule attached to your certificate of coverage.
If your child needs dental or eye care -- More information about participating providers and vision care benefits are available at www.davisvision.com or call 1-800-999-5431.	Hospice services	No charge	Not covered	None
	Children's eye exam	No charge	Full cost less \$32	Limited to one exam per year
	Children's glasses	No charge for standard lenses and select frames; Amount over \$60 for provider frames	Full cost less \$55 for standard lenses and any frame	Limited to one pair of glasses per year
	Children's dental check-up	Not covered	Not covered	None

*For more information about preauthorization, see www.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements.

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Bariatric Surgery (unless medically necessary)
- Cosmetic Surgery
- Dental care
- Hearing aids
- Long-term care
- Routine foot care (unless medically necessary)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan document](#).)

- Chiropractic Care
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: for health care coverage, contact Capital Blue Cross at 1-800-216-9741 or www.capbluecross.com; for prescription drug coverage, contact Express Scripts at 1-866-383-7420 or www.express-scripts.com; for mental/behavioral health or substance abuse, contact Integrated Behavioral Health at 1-800-395-1616 or www.ihhcorp.com; and for vision coverage, contact Davis Vision at 1-800-999-5431 or www.davisvision.com, or the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's overall deductible](#) \$0
- [Specialist \[cost sharing\]](#) \$40
- [Hospital \(facility\) \[cost sharing\]](#) 0%
- [Other \[cost sharing\]](#) 0%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost \$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$
Copayments	\$250
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$310

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's overall deductible](#) \$0
- [Specialist \[cost sharing\]](#) \$40
- [Hospital \(facility\) \[cost sharing\]](#) 0%
- [Other \[cost sharing\]](#) 0%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost \$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$280
Coinsurance	\$780
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,120

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's overall deductible](#) \$0
- [Specialist \[cost sharing\]](#) \$40
- [Hospital \(facility\) \[cost sharing\]](#) 0%
- [Other \[cost sharing\]](#) 0%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost \$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$120
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$120

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Plan Design Details
Appendix 2

BENEFIT HIGHLIGHTS

HDHP PPO PLAN

Lehigh University

This information is not a contract, but highlights some of the benefits available to you and is not intended to be a complete list or description of available services. Benefits are subject to the exclusions and limitations contained in your Certificate of Coverage (also known as "benefit booklet"). Refer to your benefit booklet for complete details.

YOUR MEDICAL PLAN SUMMARY OF COST SHARING		
	Member Responsibilities	
	If provider is participating	If provider is nonparticipating
Deductible (per benefit period) Deductible is combined to include medical and prescription drug benefits for participating providers. If you enroll in a family plan, the overall family deductible must be met before the plan begins to pay.	\$1,400 per member \$2,800 per family	\$2,500 per member \$5,000 per family
Coinsurance (percentage you pay after your deductible is met)	20% coinsurance	30% coinsurance
Out-of-Pocket Maximum (The most you pay per benefit period, after which benefits are paid at 100%. This includes deductible, copayments and coinsurance for medical including ER and prescription drug for participating providers only.)	\$6,900 per member \$13,800 per family	Unlimited
Office Visit / Urgent Care / Emergency Room Copayments		
Virtual Visits (performed through our Virtual Care tool)	\$10 copayment per visit after deductible	Not covered
Office Visits (performed by a family practitioner, general practitioner, internist, pediatrician or participating retail clinic)	20% coinsurance after deductible	30% coinsurance after deductible
Specialist Office Visits	20% coinsurance after deductible	30% coinsurance after deductible
Urgent Care Services	20% coinsurance after deductible	30% coinsurance after deductible
Emergency Room	20% coinsurance after deductible	
Preventive Care		
Pediatric and Adult Preventive Care	No charge, waive deductible	Not covered
Screening Gynecological Exam and Pap Smear (one per benefit period)	No charge, waive deductible	30% coinsurance, waive deductible
Screening Mammogram (one per benefit period)	No charge, waive deductible	30% coinsurance, waive deductible
Diagnostic Mammogram	20% coinsurance after deductible	30% coinsurance after deductible
Facility / Surgical Services		
Inpatient Hospital Room and Board	20% coinsurance after deductible	30% coinsurance after deductible
Acute Inpatient Rehabilitation (60 days per benefit period)	20% coinsurance after deductible	30% coinsurance after deductible
Skilled Nursing Facility (120 days per benefit period)	20% coinsurance after deductible	30% coinsurance after deductible
Maternity Services and Newborn Care	20% coinsurance after deductible	30% coinsurance after deductible
Surgical Procedure and Anesthesia (professional charges)	20% coinsurance after deductible	30% coinsurance after deductible
Outpatient Surgery at Ambulatory Surgical Center (facility charge only)	20% coinsurance after deductible	Not covered
Outpatient Surgery at Acute Care Hospital (facility charge only)	20% coinsurance after deductible	30% coinsurance after deductible
Diagnostic Services		
High Tech Imaging (such as MRI, CT, PET)	20% coinsurance after deductible	30% coinsurance after deductible
Radiology (other than high tech imaging)	20% coinsurance after deductible	30% coinsurance after deductible
Independent Laboratory	20% coinsurance after deductible	30% coinsurance after deductible
Facility-owned Laboratory (i.e. Health System owned)	20% coinsurance after deductible	30% coinsurance after deductible
Therapy Services (Rehabilitative and Habilitative Services)		
Physical Therapy	20% coinsurance after deductible	30% coinsurance after deductible
Occupational Therapy	20% coinsurance after deductible	30% coinsurance after deductible
Speech Therapy	20% coinsurance after deductible	30% coinsurance after deductible
Respiratory Therapy	20% coinsurance after deductible	30% coinsurance after deductible
Manipulation Therapy	20% coinsurance after deductible	30% coinsurance after deductible
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH Inpatient Services	20% coinsurance after deductible	30% coinsurance after deductible
MH Outpatient Services	20% coinsurance after deductible	30% coinsurance after deductible
SUD Detoxification Inpatient	20% coinsurance after deductible	30% coinsurance after deductible
SUD Rehabilitation Outpatient	20% coinsurance after deductible	30% coinsurance after deductible
Additional Services		
Home Health Care Services (90 visits per benefit period)	20% coinsurance after deductible	30% coinsurance after deductible
Durable Medical Equipment and Supplies	20% coinsurance after deductible	30% coinsurance after deductible
Prosthetic Appliances	20% coinsurance after deductible	30% coinsurance after deductible
Orthotic Devices	20% coinsurance after deductible	30% coinsurance after deductible

Benefits are underwritten by Capital Advantage Assurance Company®, a subsidiary of Capital BlueCross. An independent licensee of the BlueCross BlueShield Association.

Deductibles, coinsurance and copayments under this program are separate from any deductibles, coinsurance and copayments required under any other health benefits coverage you may have. Participating providers agree to accept our allowance as payment in full—often less than their normal charge. If you visit a nonparticipating provide, you are responsible for paying the deductible, coinsurance and the difference between the nonparticipating provider's charges and the allowed amount. Nonparticipating Providers may balance bill the member. Some nonparticipating facility providers are not covered. In certain situations, a facility fee may be associated with an outpatient visit to a professional provider. Members should consult with the provider of the services to determine whether a facility fee may apply to that provider. An additional cost sharing amount may apply to the facility fee.

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Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.

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YOUR MEDICAL PLAN SUMMARY OF COST SHARING		
	Member Responsibilities	
	If provider is participating	If provider is nonparticipating
Deductible (per benefit period)	\$200 per member \$600 per family	\$500 per member
Coinsurance (percentage you pay after your deductible is met)	20% coinsurance	30% coinsurance
Out-of-Pocket Maximum (The most you pay per benefit period, after which benefits are paid at 100%. This includes deductible, copayments and coinsurance for medical including ER and prescription drug, for participating providers only.)	\$4,000 per member \$8,000 per family	Unlimited
Office Visit / Urgent Care / Emergency Room Copayments		
Virtual Visits (performed through our Virtual Care tool)	\$10 copayment per visit	Not covered
Office Visits (performed by a family practitioner, general practitioner, internist, pediatrician or participating retail clinic)	\$25 copayment per visit	30% coinsurance after deductible
Specialist Office Visits	\$40 copayment per visit	30% coinsurance after deductible
Urgent Care Services	\$40 copayment per visit	30% coinsurance after deductible
Emergency Room	\$100 copayment per visit, waived if admitted	
Preventive Care		
Pediatric and Adult Preventive Care	No charge, waive deductible	Not covered
Screening Gynecological Exam and Pap Smear (one per benefit period)	No charge, waive deductible	30% coinsurance, waive deductible
Screening Mammogram (one per benefit period)	No charge, waive deductible	30% coinsurance, waive deductible
Diagnostic Mammogram	20% coinsurance after deductible	30% coinsurance after deductible
Facility / Surgical Services		
Inpatient Hospital Room and Board	20% coinsurance after deductible	30% coinsurance after deductible
Acute Inpatient Rehabilitation	20% coinsurance after deductible	30% coinsurance after deductible
Skilled Nursing Facility (100 days per benefit period)	20% coinsurance after deductible	30% coinsurance after deductible
Maternity Services and Newborn Care (professional charges)	20% coinsurance after deductible	30% coinsurance after deductible
Surgical Procedure and Anesthesia (professional charges)	20% coinsurance after deductible	30% coinsurance after deductible
Outpatient Surgery at Ambulatory Surgical Center (facility charge only)	20% coinsurance after deductible	30% coinsurance after deductible
Outpatient Surgery at Acute Care Hospital (facility charge only)	20% coinsurance after deductible	30% coinsurance after deductible
Diagnostic Services		
High Tech Imaging (such as MRI, CT, PET)	20% coinsurance after deductible	30% coinsurance after deductible
Radiology (other than high tech imaging)	20% coinsurance after deductible	30% coinsurance after deductible
Independent Laboratory	20% coinsurance after deductible	30% coinsurance after deductible
Facility-owned Laboratory (i.e. Health System owned)	20% coinsurance after deductible	30% coinsurance after deductible
Therapy Services (Rehabilitative and Habilitative Services)		
Physical Therapy	20% coinsurance after deductible	30% coinsurance after deductible
Occupational Therapy	20% coinsurance after deductible	30% coinsurance after deductible
Speech Therapy	20% coinsurance after deductible	30% coinsurance after deductible
Respiratory Therapy	20% coinsurance after deductible	30% coinsurance after deductible
Manipulation Therapy (20% coinsurance after deductible	30% coinsurance after deductible
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH Inpatient Services	20% coinsurance after deductible	30% coinsurance after deductible
MH Outpatient Services	\$25 copayment per visit	30% coinsurance after deductible
SUD Detoxification Inpatient	20% coinsurance after deductible	30% coinsurance after deductible
SUD Rehabilitation Outpatient	\$25 copayment per visit	30% coinsurance after deductible
Additional Services		
Home Health Care Services (90 visits per benefit period)	20% coinsurance after deductible	30% coinsurance after deductible
Durable Medical Equipment and Supplies	20% coinsurance after deductible	30% coinsurance after deductible
Prosthetic Appliances	20% coinsurance after deductible	30% coinsurance after deductible
Orthotic Devices	20% coinsurance after deductible	30% coinsurance after deductible

Benefits are underwritten by Capital Advantage Assurance Company®, a subsidiary of Capital BlueCross. An independent licensee of the BlueCross BlueShield Association.

Deductibles, coinsurance and copayments under this program are separate from any deductibles, coinsurance and copayments required under any other health benefits coverage you may have. Participating providers agree to accept our allowance as payment in full—often less than their normal charge. If you visit a nonparticipating provider, you are responsible for paying the deductible, coinsurance and the difference between the nonparticipating provider' charges and the allowed amount. Nonparticipating Providers may balance bill the member. Some nonparticipating facility providers are not covered. In certain situations, a facility fee may be associated with an outpatient visit to a professional provider. Members should consult with the provider of the services to determine whether a facility fee may apply to that provider. An additional cost sharing amount may apply to the facility fee.

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BENEFIT HIGHLIGHTS
PPO Plus Plan
Lehigh University

This information is not a contract, but highlights some of the benefits available to you and is not intended to be a complete list or description of available services. Benefits are subject to the exclusions and limitations contained in your Certificate of Coverage (also known as "benefit booklet"). Refer to your benefit booklet for complete details.

YOUR MEDICAL PLAN SUMMARY OF COST SHARING		
	Member Responsibilities	
	If provider is participating	If provider is nonparticipating
Deductible (per benefit period)	Not Applicable	\$500 per member
Coinsurance (percentage you pay after your deductible is met)	10% coinsurance	20% coinsurance
Out-of-Pocket Maximum (The most you pay per benefit period, after which benefits are paid at 100%. This includes deductible, copayments and coinsurance for medical including ER and prescription drug, for participating providers only.)	\$4,000 per member \$8,000 per family	Unlimited
Office Visit / Urgent Care / Emergency Room Copayments		
Virtual Visits (performed through our Virtual Care tool)	\$10 copayment per visit	Not covered
Office Visits (performed by a family practitioner, general practitioner, internist, pediatrician or participating retail clinic)	\$25 copayment per visit	20% coinsurance after deductible
Specialist Office Visits	\$40 copayment per visit	20% coinsurance after deductible
Urgent Care Services	\$40 copayment per visit	20% coinsurance after deductible
Emergency Room	\$100 copayment per visit, waived if admitted	
Preventive Care		
Pediatric and Adult Preventive Care	No charge	Not covered
Screening Gynecological Exam and Pap Smear (one per benefit period)	No charge	20% coinsurance, waive deductible
Screening Mammogram (one per benefit period)	No charge	20% coinsurance, waive deductible
Diagnostic Mammogram	10% coinsurance	20% coinsurance after deductible
Facility / Surgical Services		
Inpatient Hospital Room and Board	10% coinsurance	20% coinsurance after deductible
Acute Inpatient Rehabilitation	10% coinsurance	20% coinsurance after deductible
Skilled Nursing Facility (120 days per benefit period)	10% coinsurance	20% coinsurance after deductible
Maternity Services and Newborn Care (professional charges)	10% coinsurance	20% coinsurance after deductible
Surgical Procedure and Anesthesia (professional charges)	10% coinsurance	20% coinsurance after deductible
Outpatient Surgery at Ambulatory Surgical Center (facility charge only)	10% coinsurance	20% coinsurance after deductible
Outpatient Surgery at Acute Care Hospital (facility charge only)	10% coinsurance	20% coinsurance after deductible
Diagnostic Services		
High Tech Imaging (such as MRI, CT, PET)	10% coinsurance	20% coinsurance after deductible
Radiology (other than high tech imaging)	10% coinsurance	20% coinsurance after deductible
Independent Laboratory	10% coinsurance	20% coinsurance after deductible
Facility-owned Laboratory (i.e. Health System owned)	10% coinsurance	20% coinsurance after deductible
Therapy Services (Rehabilitative and Habilitative Services)		
Physical Therapy (30 visits per benefit period per condition)	10% coinsurance	20% coinsurance after deductible
Occupational Therapy (30 visits per benefit period)	10% coinsurance	20% coinsurance after deductible
Speech Therapy (30 visits per benefit period)	10% coinsurance	20% coinsurance after deductible
Respiratory Therapy	10% coinsurance	20% coinsurance after deductible
Manipulation Therapy	10% coinsurance	20% coinsurance after deductible
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH Inpatient Services	COVERAGE PROVIDED UNDER A SEPARATE BEHAVIORIAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY	
MH Outpatient Services		
SUD Detoxification Inpatient		
SUD Rehabilitation Outpatient		
Additional Services		
Home Health Care Services (90 visits per benefit period)	10% coinsurance	20% coinsurance after deductible
Durable Medical Equipment and Supplies	10% coinsurance	20% coinsurance after deductible
Prosthetic Appliances	10% coinsurance	20% coinsurance after deductible
Orthotic Devices	10% coinsurance	20% coinsurance after deductible

Benefits are underwritten by Capital Advantage Assurance Company®, a subsidiary of Capital BlueCross. An independent licensee of the BlueCross BlueShield Association.

Deductibles, coinsurance and copayments under this program are separate from any deductibles, coinsurance and copayments required under any other health benefits coverage you may have. Participating providers agree to accept our allowance as payment in full—often less than their normal charge. If you visit a nonparticipating provider, you are responsible for paying the deductible, coinsurance and the difference between the nonparticipating provider' charges and the allowed amount. Nonparticipating Providers may balance bill the member. Some nonparticipating facility providers are not covered. In certain situations, a facility fee may be associated with an outpatient visit to a professional provider. Members should consult with the provider of the services to determine whether a facility fee may apply to that provider. An additional cost sharing amount may apply to the facility fee.

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BENEFIT HIGHLIGHTS

HMO PLAN

Lehigh University

This information is not a contract, but highlights some of the benefits available to you and is not intended to be a complete list or description of available services. Benefits are subject to the exclusions and limitations contained in your Certificate of Coverage (also known as "benefit booklet"). Refer to your benefit booklet for complete details.

YOUR MEDICAL PLAN SUMMARY OF COST SHARING	
	Member Responsibilities
 Deductible (per benefit period) Deductible is combine to include medical and prescription drug benefits for participating providers.	Not Applicable
 Coinsurance (percentage you pay after your deductible is met)	No member coinsurance
 Out-of-Pocket Maximum (The most you pay per benefit period, after which benefits are paid at 100%. This includes deductible, copayments and coinsurance for medical including ER, prescription drug, pediatric dental, and pediatric vision for participating providers only.)	\$4,000 per member \$8,000 per family
Office Visit / Urgent Care / Emergency Room Copayments	
 Virtual Visits (performed through our Virtual Care tool)	\$10 copayment per visit
Office Visits (performed by a family practitioner, general practitioner, internist, pediatrician or participating retail clinic)	\$25 copayment per visit
Specialist Office Visits	\$40 copayment per visit
Urgent Care Services	\$40 copayment per visit
Emergency Room	\$100 copayment per visit, waived if admitted
Preventive Care	
Pediatric and Adult Preventive Care	No charge
Screening Gynecological Exam and Pap Smear (one per benefit period)	No charge (no referral necessary)
Screening Mammogram (one per benefit period)	No charge (no referral necessary)
Diagnostic Mammogram (one per benefit period)	No charge
Facility / Surgical Services	
Inpatient Hospital Room and Board	\$200 copayment per admission
Acute Inpatient Rehabilitation (60 days per benefit period combined)	\$200 copayment per admission
Skilled Nursing Facility	\$200 copayment per admission
Maternity Services and Newborn Care	\$200 copayment per admission
Surgical Procedure and Anesthesia (professional charges)	No charge
 Outpatient Surgery at Ambulatory Surgical Center (facility charge only)	No charge
Outpatient Surgery at Acute Care Hospital (facility charge only)	No charge
Diagnostic Services	
High Tech Imaging (such as MRI, CT, PET)	No charge
Radiology (other than high tech imaging)	No charge
 Independent Laboratory	No charge
Facility-owned Laboratory (i.e. Health System owned)	No charge
Therapy Services (Rehabilitative and Habilitative Services)	
Physical Therapy (30 visits per benefit period)	No charge
Occupational Therapy (30 visits per benefit period)	No charge
Speech Therapy (rehabilitative and habilitative, 30 visits each per benefit period)	No charge
Respiratory/Pulmonary Therapy (30 rehabilitative visits per benefit period)	No charge
Manipulation Therapy (30 visits per benefit period)	No charge
Mental Health (MH) and Substance Use Disorder Services (SUD)	
MH Inpatient Services	COVERAGE PROVIDED UNDER A SEPARATE BEHAVIORAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY
MH Outpatient Services	
SUD Detoxification Inpatient	
SUD Rehabilitation Outpatient	
Additional Services	
Home Health Care Services (100 visits per benefit period)	No charge
Durable Medical Equipment and Supplies	No charge
Prosthetic Appliances	No charge
Orthotic Devices	No charge

Benefits are underwritten by Keystone Health Plan® Central, a subsidiary of Capital BlueCross. Independent licensee of the Blue Cross and Blue Shield Association.

All services must be received from Participating Providers within Keystone's Approved Service Area unless Preauthorized by Keystone, or except in cases requiring (1) Emergency Service, Urgent Care and follow-up care under the BlueCard Program while outside Keystone's Approved Service Area; or (2) Guest Membership Benefits under the Away From Home Care Program while outside Keystone's approved Service Area.

*Certain preventive contraceptives are required to be covered at no cost to you when filled at a participating pharmacy with a valid prescription in accordance with Preventive Health Guidelines.

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Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.

SERVICES REQUIRING PREAUTHORIZATION

Members should present their *identification card* to their health care *provider* when medical services or items are requested. When members use a *participating provider* (including a BlueCard facility *participating provider* providing **inpatient services**), the *participating provider* will be responsible for obtaining the *preauthorization*. If members use a *non-participating provider* or a BlueCard *participating provider* providing **non-inpatient services**, the *non-participating provider* or BlueCard *participating provider* may call for *preauthorization* on the *member's* behalf; however, it is ultimately the *member's* responsibility to obtain *preauthorization*. Providers and members should call Capital's Utilization Management Department toll-free at **1-800-730-7219** to obtain the necessary *preauthorization*.

Providers/Members should request *Preauthorization* of non-urgent admissions and services well in advance of the scheduled date of service (15 days). *Investigational* or experimental procedures are not usually covered benefits. Members should consult their *Certificate of Coverage or Contract*, *Capital BlueCross' Medical Policies*, or contact Customer Service at the number listed on the back of their health plan identification card to confirm *coverage*. *Participating providers* and *members* have full access to Capital's medical policies and may request *preauthorization* for experimental or *investigational* services/items if there are unique *member* circumstances.

Capital only pays for services and items that are considered *medically necessary*. Providers and members can reference Capital's medical policies for questions regarding *medical necessity*. Final determination of *coverage* is subject to the *member's benefits* and eligibility on the date of service.

PREAUTHORIZATION OF MEDICAL SERVICES INVOLVING URGENT CARE

If the *member's* request for *preauthorization* involves *urgent care*, the *member* or the *member's provider* should advise Capital of the urgent medical circumstances when the *member* or the *member's provider* submits the request to Capital's Clinical Management Department. Capital will respond to the *member* and the *member's provider* no later than seventy-two (72) hours after Capital's Utilization Management Department receives the *preauthorization* request.

FAILURE TO OBTAIN PREAUTHORIZATION

Failure to obtain *preauthorization* for a service could result in a payment reduction or denial for the *provider* and *benefit* reduction or denial for the *member*, based on the *provider's* contract and the *member's* Certificate of Coverage or Contract. Services or items provided without *preauthorization* may also be subject to retrospective *medical necessity* review.

If the *member* presents his/her *ID card* to a *participating provider* in the 21-county area and the *participating provider* fails to obtain or follow *preauthorization* requirements, payment for services will be denied and the provider may not bill the *member*.

The table that follows is a partial listing of the *preauthorization* requirements for services and procedures.

The attached list provides categories of services for which *preauthorization* is required, as well as specific examples of such services. This list is not all inclusive. Capital may from time to time remove *preauthorization* requirements for *benefits* under certain dollar thresholds. For a listing of services currently requiring *preauthorization*, including any threshold requirements, members and providers may consult capbluecross.com.

Category	Details	Comments
Inpatient Admissions	<ul style="list-style-type: none"> • Acute care • Long-term acute care • Non-routine maternity admissions and newborns requiring continued hospitalization after the mother is discharged • Skilled nursing facilities • Rehabilitation hospitals • Behavioral Health (mental health care/ substance use disorder) 	<p><i>Preauthorization</i> requirements do not apply to services provided by a <i>hospital</i> emergency room <i>provider</i>. If an <i>inpatient</i> admission results from an emergency room visit, notification must occur within two (2) business days of the admission. All such services will be reviewed and must meet <i>medical necessity</i> criteria from the first hour of admission. Failure to notify <i>Capital</i> of an admission may result in an administrative denial.</p> <p>Non-routine maternity admissions, including preterm labor and maternity complications, require notification within two (2) business days of the date of admission.</p>
Observation Care Admissions	<ul style="list-style-type: none"> • Notification is required for all observation stays expected to exceed 48 hours. • All observation care must meet medical necessity criteria from the first hour of admission. 	<p>Admissions to observation status require notification within two (2) business days.</p> <p>Failure to notify <i>Capital</i> of an admission may result in an administrative denial.</p>
Diagnostic Services	<ul style="list-style-type: none"> • Genetic disorder testing except: standard chromosomal tests, such as Down Syndrome, Trisomy, and Fragile X, and state mandated newborn genetic testing. • High tech imaging such as but not limited to: Cardiac nuclear medicine studies including nuclear cardiac stress tests, CT (computerized tomography) scans, MRA (magnetic resonance angiography), MRI (magnetic resonance imaging), PET (positron emission tomography) scans, and SPECT (single proton emission computerized tomography) scans. 	<p>Diagnostic services do not require <i>preauthorization</i> when emergently performed during an emergency room visit, observation stay, or <i>inpatient</i> admission.</p>
Durable Medical Equipment (DME), Prosthetic, Appliances, Orthotic Devices, Implants		<p><i>Members</i> and <i>providers</i> may view a listing of services currently requiring <i>preauthorization</i> at capbluecross.com.</p>

Category	Details	Comments
Office Surgical Procedures When Performed in a Facility*	<ul style="list-style-type: none"> • Aspiration and/or injection of a joint • Colposcopy • Treatment of warts • Excision of a cyst of the eyelid (chalazion) • Excision of a nail (partial or complete) • Excision of external thrombosed hemorrhoids; • Injection of a ligament or tendon; • Eye injections (intraocular) • Oral Surgery • Pain management (including trigger point injections, stellate ganglion blocks, peripheral nerve blocks, and intercostal nerve blocks) • Proctosigmoidoscopy/flexible Sigmoidoscopy; • Removal of partial or complete bony impacted teeth (if a benefit); • Repair of lacerations, including suturing (2.5 cm or less); • Vasectomy • Wound care and dressings (including outpatient burn care) 	<p>The items listed are examples of services considered safe to perform in a professional <i>provider's</i> office. <i>Medical necessity</i> review is required when office procedures are performed in a facility setting. <i>Members</i> and <i>providers</i> may view a listing of services currently requiring <i>preauthorization</i> when performed in a facility at capbluecross.com.</p>
Outpatient Procedures/ Surgery	<ul style="list-style-type: none"> • Weight loss surgery (Bariatric) • Meniscal transplants, allografts and collagen meniscus implants (knee) • Ovarian and Iliac Vein Embolization • Photodynamic therapy • Radioembolization for primary and metastatic tumors of the liver • Radiofrequency ablation of tumors • Transcatheter aortic valve replacement • Valvuloplasty 	<p>The items listed are examples of outpatient procedures that may be reviewed for <i>medical necessity</i> and or place of service. <i>Members</i> and <i>providers</i> may view a listing of services currently requiring <i>preauthorization</i> at capbluecross.com.</p>
Therapy Services	<ul style="list-style-type: none"> • Hyperbaric oxygen therapy (non-emergency) • Occupational therapy • Physical therapy • Pulmonary rehabilitation programs 	
Transplant Surgeries	Evaluation and services related to transplants	<i>Preauthorization</i> will include referral assistance to the Blue Distinction Centers for Transplant network if appropriate.

Category	Details	Comments
Reconstructive or Cosmetic Services and Items	<ul style="list-style-type: none"> • Removal of excess fat tissue (Abdominoplasty/Panniculectomy and other removal of fat tissue such as Suction Assisted Lipectomy) • Breast Procedures <ul style="list-style-type: none"> ♦ Breast Enhancement (Augmentation) ♦ Breast Reduction ♦ Mastectomy (Breast removal or reduction) for Gynecomastia ♦ Breast Lift (Mastopexy) ♦ Removal of Breast implants • Correction of protruding ears (Otoplasty) • Repair of nasal/septal defects (Rhinoplasty/Septoplasty) • Skin related procedures <ul style="list-style-type: none"> ♦ Acne surgery ♦ Dermabrasion ♦ Hair removal (Electrolysis/Epilation) ♦ Face Lift (Rhytidectomy) ♦ Removal of excess tissue around the eyes (Blepharoplasty/Brow Ptosis Repair) ♦ Mohs Surgery when performed on two separate dates of service by the same provider • Treatment of Varicose Veins and Venous Insufficiency 	
Medical Injectables		<i>Members and providers may view a listing of services currently requiring preauthorization at capbluecross.com.</i>
Investigational and Experimental procedures, devices, therapies, and pharmaceuticals		<i>Investigational or experimental procedures are not usually covered benefits. Members and providers may request preauthorization for experimental or investigational services/items if there are unique member circumstances.</i>
New to market procedures, devices, therapies, and pharmaceuticals		<i>Preauthorization is required during the first two (2) years after a procedure, device, therapy or pharmaceutical enters the market. Members and providers may view a listing of services currently requiring preauthorization at capbluecross.com.</i>
Select Outpatient Behavioral Health Services	<ul style="list-style-type: none"> • Transcranial Magnetic Stimulation (TMS) • Partial Hospitalization • Substance Use Disorder Intensive Outpatient Programs 	<i>The items listed are examples of outpatient procedures that may be reviewed for <i>medical necessity</i> and or place of service. Members and providers may view a listing of services currently requiring preauthorization at capbluecross.com.</i>

Category	Details	Comments
Other Services	<ul style="list-style-type: none"> • Bio-engineered skin or biological wound care products • Category IDE trials (Investigational Device Exemption) • Clinical trials (including cancer related trials) • Enhanced external counterpulsation (EECP) • Home health care • Home infusion therapy • Eye injections (Intravitreal angiogenesis inhibitors) • Laser treatment of skin lesions • Non-emergency air and ground ambulance transports • Radiofrequency ablation for pain management • Facility based sleep studies for diagnosis and medical Management of obstructive sleep apnea • Enteral feeding supplies and services 	
Pain Management	Interventional Pain Management <ul style="list-style-type: none"> • Joint injections 	Members and providers may view a listing of services currently requiring preauthorization at capbluecross.com .
Oncology Services	Radiation therapy and related treatment planning and procedures performed for planning (such as but not limited to IMRT, proton beam, neutron beam, brachytherapy, 3D conform, SRS, SBRT, gamma knife, EBRT, IORT, IGRT, and hyperthermia treatments.)	<i>Members and providers may view a listing of services currently requiring preauthorization at capbluecross.com.</i>
Select Cardiac Services		<i>Members and providers may view a listing of services currently requiring preauthorization at capbluecross.com.</i>

PLEASE NOTE: This listing identifies those services that require *preauthorization* only as of the date it was printed. This listing is subject to change. *Members* should call *Capital* at 1-800-730-7219 (TTY: 711) with questions regarding the *preauthorization* of a particular service.

For HMO and Gatekeeper PPO *members*, all care rendered by *non participating providers* requires *preauthorization*. This includes care that falls under the Continuity of Care provision of the Certificate of Coverage or Contract.

This information highlights the standard Preauthorization Program. *Members* should refer to their *Certificate of Coverage* or Contract for the specific terms, conditions, exclusions and limitations relating to their *coverage*.

Managed Behavioral Health in PPO Plus and Keystone Plans
Lehigh University Benefit Plan Summary for *Keystone Health Plan 2020*

Service	IBH Network	Non-Network	Pre-Certification
Inpatient Psychiatric Care Out of pocket network only	100% , after \$200 copay per admission. Individual \$4,000 Family \$8,000	No benefit	Required through IBH
Mental Health (MH)- Outpatient Office Visits –Individual, Family, Group Counseling Out of pocket network only	\$25 co-pay Individual \$4,000 Family \$8,000	No benefit	Some services require Pre-Certification.
Inpatient Chemical Dependence (CD)/Substance Abuse Out of pocket network only	100% , after \$200 copay per admission. Individual \$4,000 Family \$8,000	No benefit	Required through IBH
Chemical Dependence (CD)/Substance Abuse - Outpatient Office Visits –Individual, Family, Group Counseling Out of pocket network only	\$25 co-pay Individual \$4,000 Family \$8,000	No benefit	Some services require Pre-Certification.

- Only inpatient services pre-certified by IBH and provided by network providers are covered. There is no benefit for non-network providers or for services not pre-certified.
- Treatment must be provided by a psychiatrist, psychologist, therapist or clinical social worker who is licensed to practice independently at the master’s level or above.
- Laboratory work must be prescribed by a psychiatrist.
- Treatment must be delivered in a goal-oriented manner that produces observable and measurable improvement in the patient’s condition.
- Autism disorder treatment up to the 2020 cap permitted by Pennsylvania Act 62.

Lehigh University Benefit Plan Summary for *PPO Plus 2020*

Service	IBH Network	Non-Network	Pre-Certification
Inpatient Psychiatric Care Out of pocket network only	IBH pays 90% of allowable charges. Individual \$4,000 Family \$8,000	80% of IBH allowable after \$500 deductible (combined MH, CD, and medical)	Required through IBH for both network and non-network 50% penalty for services provided by non-network providers w/o pre-authorization
Mental Health (MH)- Outpatient Office Visits –Individual, Family, Group Counseling Out of pocket network only	\$25 co-pay Individual \$4,000 Family \$8,000	80% of IBH allowable after \$500 deductible (combined MH, CD, and medical)	Some services require Pre-Certification.
Inpatient Chemical Dependence (CD)/Substance Abuse Out of pocket network only	IBH pays 90% of allowable charges Individual \$4,000 Family \$8,000	80% of IBH allowable after \$500 deductible (combined MH, CD, and medical)	Required through IBH for both network and non-network 50% penalty for services provided by non-network providers w/o pre-authorization
Chemical Dependence (CD)/ Substance Abuse - Outpatient Office Visits –Individual, Family, Group Counseling Out of pocket network only	\$25 co-pay Individual \$4,000 Family \$8,000	80% of IBH allowable after \$500 deductible (combined MH, CD, and medical)	Some services require Pre-Certification.

- Treatment must be provided by a psychiatrist, psychologist, therapist or clinical social worker who is licensed to practice independently at the master’s level or above.
- Laboratory work must be prescribed by a psychiatrist.
- Treatment must be delivered in a goal-oriented manner that produces observable and measurable improvement in the patient’s condition.
- Autism disorder treatment up to the 2020 cap permitted by Pennsylvania Act 62.

A Managed Behavioral Health Plan includes mental health and substance abuse treatment benefits. The behavioral health benefit included for this plan is provided by Integrated Behavioral Health (IBH). This plan is compliant with the Mental Health Parity and Equity Act of 2008 (MHPAEA) and Final Rules of 2013.

Plan features include:

- Use of IBH network providers results in lower copays, coinsurance and patient financial responsibility.
- National network of quality providers and facilities selected and credentialed by IBH.
- No need for patient submission of claim forms when IBH network providers are used.
- IBH network providers accept the plan payment as payment in full after the applicable copayment or deductible.
- All mental health services are subject to evidentiary standards of care and medical necessity.
- Some services require prior authorization, call IBH for care coordination.
- If treatment is needed call 800-395-1616 and IBH will provide referrals, case management, care coordination, and benefit questions for your behavioral health plan.

Certain services are still required to be pre-authorized; contact IBH with any questions.

Pre-authorization of all behavioral health services including initial outpatient care with a psychiatrist, psychologist or therapist is highly recommended. Pre-authorization of behavioral health services will insure medical necessity criteria are met and retrospective review will be limited. All care is subject to eligibility, plan definitions, limitations, exclusions, and are payable when determined by IBH as medically necessary and appropriate.

Inpatient and Program based Mental Health Benefits:

To find an in-network facility, contact Integrated Behavioral Health at 800-395-1616. The benefit may allow you to choose services through an out-of-network facility, but you may have to pay a larger portion of the costs, and subject to prior authorization and concurrent review.

Pre-authorization is required for all inpatient, partial hospitalization, residential, and any program based care. You or your provider may call an IBH care manager at 800-395-1616 to obtain preauthorization prior to starting any intensive treatment program.

Outpatient Mental Health Benefits:

All outpatient care falling within outlier categories, requires the provider to submit documentation for review of medical necessity, evidentiary based treatment, and appropriateness of care.

The following outpatient evaluations or treatments require authorization before commencing:

- Psychological testing
- Group therapy

- Outpatient Electroconvulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Or any service determined as an outlier.

The benefit may allow you to choose services through either an IBH network provider or a non-network provider. Non-network providers must be independently licensed and still must follow plan requirements of submitting documentation of evidentiary standards and medically necessary care. Call IBH to determine if a non-network provider is eligible for coverage under your plan.

While there are no treatment visit or hospital day limits in the benefit plan, all claims for treatment (including those delivered before any pre-authorization) are subject to review for medical necessity and appropriateness of care by IBH.

All claims are subject to benefit eligibility as well as plan exclusions and limitations at time of service.

Services Not Included in the Managed Behavioral Health Plan in PPO Plus or Keystone HMO:

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| <ol style="list-style-type: none"> 1. Services performed by the patient on him/herself or performed by immediate family, or an individual residing in the same household, including but not limited to a spouse, child, brother, sister, parent, or the spouse's parent, even if that individual is a qualified provider. 2. Services provided by someone not licensed by the state to treat the condition for which the claim is made and to independently bill fee for service and/or not trained or experienced to treat a specific condition under review. 3. Extended hospital, residential or program related stays that are unrelated to medically necessary and approved treatment. 4. Services furnished by or for the U.S. government, Federal and state funded agency or foreign government, unless payment is legally required. 5. Treatment that is of an experimental or educational nature. Procedures which are experimental, investigational, or unproven. | <ol style="list-style-type: none"> 6. Therapies and technologies whose long-term efficacy or effect is undetermined, or whose efficacy is no greater than that of traditionally accepted standard treatment. 7. Services applied under any government or publicly funded program or law under which the individual is covered. 8. Services for which a third-party is liable. 9. New procedures, services, and medication until they are reviewed for safety and efficacy, through accepted evidentiary review. 10. Services that are primarily to assess or address neurodevelopmental disorders are to be considered as medical conditions and as such not covered under the mental health benefits. With the exception of Attention Deficit/ Hyperactivity disorder, and Tic disorders which are covered by the mental health portion of the plan. 11. Custodial care or supportive counseling, including care for conditions not typically resolved by treatment. 12. Alternative treatment methods that do not meet national standards for behavioral |
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health practice, including but not limited to: regressive therapy, aversion therapy, neurofeedback or neuro-biofeedback, hypnotherapy, acupuncture, acupressure, aromatherapy, massage therapy, reiki, thought-field energy, art or dance therapy.

12. Services not medically necessary. All services must be medically necessary. The fact that a physician or other provider may prescribe, order, recommended, or approve a service or supply does not, in itself, make it medically necessary, even though it is not specifically listed as an exclusion or limitation.

13. Court-ordered treatment. If a participant is currently in a course of treatment that is confirmed as being required by a court, the treatment may be considered only as long as it is medically necessary.

14. Psychological or neuropsychological testing, unless specifically pre-certified by IBH.

15. Inpatient treatment for co-dependency, gambling and sexual addiction.

16. Treatment primarily for chronic pain management or neuropsychological rehabilitation.

17. Treatment primarily for the convenience of the patient or provider.

18. Treatment provided primarily for medical or other research.

19. Charges for services, supplies or treatments which are primarily educational in nature; charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.

20. Charges primarily for marriage, career, or legal counseling, mediation, or custody related services.

21. Treatment of sexual dysfunction not related to organic disease. Sex therapy.

22. Services provided if covered individual would not legally have to pay for them if the covered individual were not covered by the Plan or any other medical plan, to the extent that exclusion of charges for such services is not prohibited by law or regulation.

23. Evaluation or services not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.

24. Charges for obtaining medical records or completing a treatment report, and late payment charges.

25. Methadone maintenance.

26. Speech and language evaluations or speech therapy.

27. Charges for failure to keep a scheduled visit, charges for completion of a claim form.

28. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance.

30. Expenses for pastoral counseling, marriage therapy, music or art therapy, assertiveness training, social skills training, recreational therapy, stress management, or other supportive therapies.

31. Long-term treatment at a residential treatment facility, or long term rehabilitation therapy.

32. Smoking cessation programs not covered under the medical plan.

33. Therapeutic foster care, group home, halfway or three-quarter houses, residential/therapeutic schools, camps.

34. Any treatment or condition excluded by the medical Plan.

How Managed Behavioral Health Plan Claims Are Paid:

Network services require no claim forms. IBH will pay your provider directly. You are responsible for paying coinsurance, copay, or deductible that may apply.

If you use a non-network provider, either you or the provider must submit a claim form and you are responsible for paying the balance of the provider's outpatient or inpatient mental health or substance abuse charges, after the IBH payment of the non-network benefit based on the IBH allowable rate. The IBH allowable rate is the rate for the IBH fee schedule for specific network services. Remember if you use non-network providers, your financial responsibility, the amount you pay, for non-network mental health or substance abuse care is higher and is based on the IBH allowable rate. Claims may be mailed to:

Integrated Behavioral Health
Claims Department
P.O. 30018
Laguna Niguel, CA 92607-0018

How to File a Managed Behavioral Health Plan Appeal:

For purposes of the appeal procedure, a mental health or substance abuse claim appeal includes any request for benefits or authorization that is denied either in part or in whole. You or your provider may appeal a claim or other adverse benefit decision directly to IBH. The appeal must be submitted to:

Integrated Behavioral Health
Quality Management—Appeals
P.O. Box 30018
Laguna Niguel, CA 92607-0018

Appeals Process:

Policy: Integrated Behavioral Health shall offer an appeals process for both members and providers. Such policy shall include reasonable efforts to resolve concerns and disagreements prior to a formal appeal process through collegial and non-adversarial means. The appeals process is consistent with ERISA guidelines.

Procedures: IBH provides an appeal process for members, providers and employers/health plans hereinafter referred to as claimant. This appeal process is available for any adverse benefit decision and/or when disagreements occur regarding decisions or potential decisions about authorizations for proposed treatment, claims payments, or treatment reviews. When such adverse benefit decisions or disagreements occur, the member, provider or employer/health plan may request reconsideration by phone or mail. A Senior Care Manager or supervisor

responds to this Request for Reconsideration immediately. The response is communicated by phone and mail. Facsimile is used when issues are urgent.

Should this reconsideration process fail to satisfy the issue, the claimant may submit a formal appeal for review. This Level 1 Appeal may be a written request or telephonic. It is responded to within the timeframes outlined below for the particular type of claim. A clinical person, with appropriate expertise, and other than the care manager who effected the denial must conduct the appeal review. Such clinician may not be supervised by the initial reviewer. The response is communicated by phone and mail. Facsimile is used when issues are urgent.

External Review Option: If the appealing party continues to be dissatisfied, a second level appeal can be requested in writing or telephonically and is conducted by an external clinical person with appropriate expertise. This decision is also provided within the timeframes outlined below for the particular type of claim. The providers and members are informed by mail or facsimile, depending on the urgency.

All protected health information shall be managed within HIPAA regulations and within other federal law and regulations specific to confidentiality of behavioral health medical data.

Timeframes: *Expedited/Urgent Care Claims*

Initial Claim Response Timeframe:	48 Hours
Request Missing Info from Claimant:	24 Hours
Claimant to Provide Missing Info:	48 Hours
Claimant to Request Appeal:	180 days
Appeal Response Timeframe:	72 Hours

Pre-Service Health Care Claims

Initial Claim Response Timeframe:	15 Days
Extension (Proper Notice/Delay Beyond Plan Control):	15 Days
Request Missing Info from Claimant:	5 Days
Claimant to Provide Missing Info:	50 Days
Claimant to Request Appeal:	180 Days
Appeal Response Timeframe:	30 Days

Post-Service Health Care Claim

Initial Claim Response Timeframe:	30 Days
Extension (Proper Notice/Delay Beyond Plan Control):	15 Days
Request Missing Info from Claimant:	30 Days
Claimant to Provide Missing Info:	50 Days
Claimant to Request Appeal:	180 Days

Appeal Response Timeframe: 60 Days

Additional Claimant Rights:

The claimant is entitled to receive, free of charge, and have access to all relevant documents and information relied upon in making the claim determination.

Once you have completed all mandatory appeals, you and your plan may have other voluntary alternative dispute resolution options. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Under ERISA Section 502(a)(1)(B), you have the right to bring a civil action. This right can be exercised when all required reviews of your claims, including the appeal process, have been completed, your claim was not approved, in whole or in part, and you disagree with the outcome.

The above-described Appeal Process is subject to all applicable State and Federal laws and regulations.