LEHIGH UNIVERSITY

2022 Enrollment & Reference Guide for Medical Coverage

This booklet contains all of the information needed to understand your coverage options for 2022.

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.

Contents

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 2022.

The benefit elections you make during Open Enrollment are effective from January 1, 2022 through December 31, 2022.

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 contacting Human Resources at 610-758-3900 or inben@lehigh.edu.

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 contacting the Lehigh BenefitsVIP Service Center at 866-293-9736 or solutions@benefitsvip.com.

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 covererd 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

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 contacting Lehigh BenefitsVIP Service Center at 866-293-9736 or solutions@benefitsvip.com.

Your 2022 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: 2022 will be the final plan year that PPO Plus is offered to employees.***
- ***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 medical and pharmacy expenses will count toward meeting your deductible. **If you cover any dependents, you must meet the entire family deductible before the plan begins reimbursing your medical or prescription drug expenses. One family member, or all family members combined, can satisfy the deductible.**

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

HDHP	PPO
• Lower payroll deductions • Pay more out-of-pocket when receiving care • Higher annual deductible • Lehigh contribution to the HSA	• 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.

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.

INTRODUCING CONSUMERMEDICAL

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

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

For more information visit https://hr.lehigh.edu/consumermedical-expert-medical-opinion-service.

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.

2022 Monthly Medical Premiums

PLAN	Individual	Employee + Spouse/Partner	Employee+ Child	Employee+ Family
University Contribution (All Plans)	$582	$1,200	$1,092	$1,732
HDHP	$37	$140	$119	$206
PPO	$247	$610	$543	$885
PPO Plus	$334	$804	$718	$1,167
Keystone Health Plan (HMO)	$119	$334	$293	$483

Summary of Medical Plan Options

The table below provides a summary comparison for key benefits across the medical plan options available for 2022. 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	$250	$500	$100	$500	$1,400	$2,500	$0
Family	$750	$500 /person	$300	$500 /person	$2,800*	$5,000*	$0
Coinsurance	20%	40%	15%	40%	20%	40%	N/A
Out-of-Pocket Maximum for all medical and prescription drug charges							
Individual	$4,000	No limit	$4,000	No limit	$5,000	No limit	$4,000
Family	$8,000	No limit	$8,000	No limit	$10,000	No limit	$8,000
Physician Services							
Office Visit	$30 copay/visit	40% coinsurance	$30 copay/visit	40% coinsurance	20% coinsurance	40% coinsurance	$30 copay/visit
Specialist Visit	$50 copay/visit	40% coinsurance	$50 copay/visit	40% coinsurance	20% coinsurance	40% coinsurance	$50 copay/visit
Preventive Care (Administered in accordance with Preventive Health Guidelines & PA state mandates)	No charge	Mandated screenings and immunizations: 40% coinsurance; Routine physical exams: Not covered	No charge	Mandated screenings and immunizations: 40% coinsurance; Routine physical exams: Not covered	No charge	Mandated screenings and immunizations: 40% coinsurance; Routine physical exams: Not covered	No charge
Hospital Services							
Inpatient Coverage	20% coinsurance	40% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	$250/admission
Outpatient Hospital	20% coinsurance	40% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	$100 outpatient surgery copay
Emergency Room	$150 copay/service, waived if admitted		$150 copay/visit, waived if admitted		20% coinsurance		$150 copay/visit, waived if admitted
Urgent Care	$50 copay/service	40% coinsurance	$50 copay/service	40% coinsurance	20% coinsurance	40% coinsurance	$50 copay/ service
Maternity Services							
Prenatal/ Postpartum Care	20% coinsurance	40% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	No charge
Hospital	20% coinsurance	40% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	$250/admission
Mental Health **							
Inpatient	20% coinsurance	40% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	$250/admission
Outpatient	$30 copay/visit	40% coinsurance	$30 copay/visit	40% coinsurance	20% coinsurance	40% coinsurance	$30 copay/visit
Substance Abuse **							
Inpatient	20% coinsurance	40% coinsurance	15% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	$250/admission
Outpatient	$30 copay/visit	40% coinsurance	$30 copay/visit	40% coinsurance	20% coinsurance	40% coinsurance	$30 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 after deductible is met	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 after deductible is met	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 after deductible is met	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.

** Effective 1/1/2022, managed behavioral (mental) health benefits will be provided through Capital Blue Cross. 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 **2022 Enrollment and Reference Guide** for more information 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 gives covered employees access to board-certified physicians via video consultation on your smartphone, tablet or computer. The Virtual Care app is available in the Google Play and App Stores.You can use Virtual Care if you have a health problem and need urgent care; if you're not sure you need emergency care; or if you're simply traveling and need a doctor's advice. Doctors can diagnose, recommend treatment and even write short-term prescriptions for most non-emergency medical issues. This benefit is included in all medical plans offered by the University. **The copay is $10 for HMO and PPO subscribers, and $64 for HDHP subscribers.** Visit **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 2022 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 2022, $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**, at reduced maximum pricing, so you won't worry about running out
- **24/7 access** to a pharmacist from the privacy of your home
- **Automatic refills** every three months

	Retail	Mail Order
Generic	10% ($25 maximum) per 30-day supply	10% ($62.50 maximum) per 90-day supply
Formulary Brand Name	20% ($50 maximum) per 30-day supply	20% ($125 maximum) per 90-day supply
Non-Formulary Brand Name	30% ($100 maximum) per 30-day supply	30% ($250 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 2022 annual IRS limit of $3,650 for individuals or $7,300 for family coverage (these amounts include Lehigh's contribution); $1,000 additional contribution allowed for employees age 55+.
- **Never pay taxes.** Contributions are made from your paycheck on a before-tax basis, and the money will never be taxed when used for eligible expenses.
- **It's your money.** Unused money can be carried over each year and invested for the future — you can even take it with you if you leave your job. This includes the contribution from Lehigh.
- **Can be paired with a Limited Purpose Flexible Spending Account (LPFSA).** You can use your HSA for eligible medical, dental and vision expenses. You can use your LPFSA for tax savings on eligible dental and vision expenses.
- **Please Note.** HSA contribution limits as well as catch up contribution limits **are based on a calendar year** and should be prorated based on the actual number of months you are covered under the HDHP plan.
- **Important restrictions apply when you become Medicare/Social Security eligible.** Once you are enrolled in any part of Medicare, you will not be eligible to contribute to an HSA. If you are receiving Social Security payments prior to age 65 you will be enrolled in Medicare automatically when you turn 65 and will become ineligible to contribute to an HSA. Taxes and penalties will be applied by the IRS if you continue contributing. **Download this information sheet from HealthEquity for more information. (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 share of the costs of a health care service after meeting your deductible. For example, if the coinsurance amount is 20%, then your medical plan pays 80% of the cost and you pay for the remaining 20% out-of-pocket. When you choose an in-network provider, the coinsurance you pay is significantly lower than for an out-of-network provider.

Co-payment
A fixed amount (for example, $25) you pay for a covered 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 2nd and ends on November 16th. 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 2022.

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. Complete the tasks on your "To Do" list.
4. Click on the "Get Started" 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 contacting the Lehigh BenefitsVIP Service Center at 866-293-9736 or solutions@benefitsvip.com.

When will my changes become effective?

For current employees: The benefit elections you make during Open Enrollment are effective from January 1, 2022 through December 31, 2022.

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 they complete their enrollment in Lehigh Benefits within the first thirty days of employment.

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 $247 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 2022?

- All four medical plans will see a 5% increase in employee premiums. The University contribution to all medical plans has also increased by 5%.
- New deductible added to PPO Plus – Individual deductible of $100, Family deductible of $300.
- 2022 will be the last plan year that PPO Plus will be offered to Lehigh employees.
- Effective 1/1/2022, Managed Behavioral (Mental) Health services will be administered by Capital Blue Cross for all of the medical plans.
- Increase to PPO Deductible – Individual deductible to $250, Family deductible to $750.

See the **Your 2022 Medical Options, Summary of Benefits and Coverage and Plan Design Details** sections of this publication for information about all available plans.

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 contact the Lehigh BenefitsVIP Service Center at 866-293-9736 or solutions@benefitsvip.com.

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.

Where to Go for Help

Contact/Provider	Type of Benefit	Telephone Number	Web Address
BenefitsVIP Service Center	General Lehigh Benefits Questions	866-293-9736	**solutions@benefitsvip.com**
Capital Blue Cross and Keystone Health Plan Central Group #00515044	Medical Insurance	800-216-9741	**www.capbluecross.com**
Capital Blue Cross Managed Behavioral (Mental) Health	Behavioral (Mental) Health Insurance (beginning 1/1/2022)	866-322-1657	**www.capbluecross.com**
Capital Blue Virtual Care	Telehealth	855-818-DOCS	**www.capbluecross.com/virtualcare**
ConsumerMedical	Expert Medical Opinion & Surgery Decision Support	888-361-3944	**www.myconsumermedical.com**
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**
United Concordia Group #250021021	Dental	800-332-0366	**www.ucci.com**
Uprise Health (formerly IBH)	Employee Assistance Program (EAP)	800-395-1616	**www.uprisehealth.com** To access EAP/Work Life resources: User ID: lehigh Password: univ03

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.

Additional Notices

- 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, 2021. Contact your State for more information on eligibility –

ALABAMA- Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: **http://myalhipp.com/** Phone: 1-855-692-5447	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 Health Insurance Buy-In Program (HIBI): **https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program** HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – 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://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/ hipp/index.html** Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: **http://myarhipp.com/** Phone: 1-855-MyARHIPP (855-692-7447)	Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp** Phone: 678-564-1162 ext 2131
CALIFORNIA	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program **http://dhcs.ca.gov/hipp** Phone: 916-445-8322 Email: **hipp@dhcs.ca.gov**	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: **https://www.in.gov/medicaid/** Phone 1-800-457-4584

IOWA – Medicaid and CHIP (HAWKI)	NEBRASKA – Medicaid
Medicaid Website: **https://dhs.iowa.gov/ime/members** Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp** HIPP Phone: 1-888-346-9562	Website: **http://www.ACCESSNebraska.ne.gov** Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha 402-595-1178
KANSAS – Medicaid	**NEVADA – Medicaid**
Website: **https://www.kancare.ks.gov/** Phone: 1-800-792-4884	Medicaid Website: **http://dhcfp.nv.gov/** Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx** Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: **https://kidshealth.ky.gov/Pages/index.aspx** Phone: 1-877-524-4718 Kentucky Medicaid Website: **https://chfs.ky.gov**	Website: **https://www.dhhs.nh.gov/oii/hipp.htm** Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: **www.medicaid.la.gov or www.ldh.la.gov/lahipp** Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	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: **https://www.maine.gov/dhhs/ofi/applications-forms-** Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: **https://www.maine.gov/dhhs/ofi/applications-forms** Phone: 1-800-977-6740. TTY: Maine relay 711	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/info-details/masshealth-premium-assistance-pa** 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/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.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

PENNSYLVANIA – Medicaid	VERMONT– Medicaid
Website: **https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HI PP-Program.aspx** Phone: 1-800-692-7462	Website: **http://www.greenmountaincare.org/** Phone: 1-800-250-8427
RHODE ISLAND – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: **http://www.eohhs.ri.gov/** Phone: 855-697-4347 or 401-462-0311 (Direct RIte Share Line)	Websites: **https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp** Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
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
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/badger-careplus/p-10095.htm** 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://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/** Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

US Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-EBSA (3272)

US Department of Health and Human Services
Centers for Medicare and Medicaid Services
www.cms.hhs.gov
1-877-2323, Menu Option 4, Ext 61565

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

Creditable Coverage Disclosure Notice

Important Notice from Lehigh University About
Your Prescription Drug Coverage and Medicare
October 1, 2021

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 1, 2021
Name of Entity/Sender: Lehigh University
Contact – Position/Office: Director of Benefits
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
- 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/Health Equity, 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 of Benefits
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 of Benefits
   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 of Benefits
   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 of Benefits
   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 of Benefits
   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 of Benefits
   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 of Benefits
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 7, 2021

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.cciio.cms.gov or call 1-888-428-2566 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$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.	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.
Are there services covered before you meet your deductible?	Yes. Network preventive services.	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?	For participating providers $5,000 individual / $10,000 family; for non-participating providers $0 individual combined out-of-pocket limit for 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?	Pre-authorization penalties, 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. 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?	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	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	Mandated screening and immunizations 40% 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.	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% 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	40% 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)	
	Physician/surgeon fees	20% coinsurance	40% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	90 visit limit *See preauthorization schedule attached to your certificate of coverage.
	Rehabilitation services	20% coinsurance	40% coinsurance	30 visit limit
	Habilitation services	20% coinsurance	40% coinsurance	30 visit limit
	Skilled nursing care	20% coinsurance	40% coinsurance	100 day limit
	Durable medical equipment	20% coinsurance	40% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
	Hospice services	20% coinsurance	40% 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; 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**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid,CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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:

To talk to an interpreter in your language at no cost, call 800.962.2242 (TTY: 711).

Para hablar con un intérprete de forma gratuita, llame al 800.962.2242 (TTY: 711).

欲免费用本国语言洽询传译员，请拨电话 800.962.2242 (TTY: 711).

Để nói chuyện với thông dịch viên bằng ngôn ngữ của quý vị không phải mất phí, xin gọi 800.962.2242 (TTY: 711).

Для бесплатного разговора с переводчиком на своем языке, позвоните по тел.: 800.962.2242 (TTY: 711).

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

Fa koschdefrei schwetze mit me dolmetscher in deinre Schrooch, ruf 800.962.2242 uff (TTY: 711).

무료 전화 통역 서비스 800.962.2242 (TTY: 711).

Per parlare con un interprete nella vostra lingua gratis, chiami 800.962.2242 (TTY: 711)

Pour parler à un interpréter dans votre langue sans charges, téléphoner à 800.962.2242 (TTY: 711).

Um in Ihrer Sprache gebührenfrei mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800.962.2242 an (TTY: 711).

દુભાષીયા જોડે વાત કરવા, 800.962.2242 (TTY: 711) પર ફોન કરો.

Aby porozmawiac z tlumaczem w jezyku polskim, prosze zadzwonic na numer darmowy telefonu 800.962.2242 (TTY: 711)

Pou pale avèk yon entèprèt nan lang ou grastis, rele nan 800.962.2242 (TTY: 711).

ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ សូមហៅទៅកាន់ 800.962.2242 (TTY: 711)

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]*	20%
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	$2523
What isn't covered	
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]*	20%
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
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,824**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1400
Specialist *[cost sharing]*	20%
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$0
Coinsurance	$385
What isn't covered	
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; about mental/behavioral health or substance abuse, 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.cciio.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. 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	$30 copayment/visit	Not covered	Additional $10 copayment/visit required after hours.
	Specialist visit	$50 copayment/visit	Not covered	None
	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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for lab or tests	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	*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)	$100 copayment Acute Care Hospital and Ambulatory Surgical Center	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	$150 copayment/visit	$150 copayment/visit	Copayment waived if admitted inpatient.
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$50 copayment/visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 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	$30 copayment/visit	Not covered	Some services require pre-certification.
	Inpatient services	$250 copayment/service	Not covered	Pre-certification required. 50% co-insurance for services provided without pre-authorization.
If you are pregnant	Office visits	$50 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	90 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	100 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.
	Hospice services	No charge	Not covered	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.ibhcorp.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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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:

To talk to an interpreter in your language at no cost, call 800.962.2242 (TTY: 711).

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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]*	$50
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	$0
Copayments	$310
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$370**

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]*	$50
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	$340
Coinsurance	$780
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,175**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist *[cost sharing]*	$50
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$350
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$350**

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.cciio.cms.gov or call 1-888-428-2566 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250/individual/$750/family participating providers; $500/individual non-participating providers.	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.
Are there services covered before you meet your deductible?	Yes. Network preventive services.	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?	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.	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?	Pre-authorization penalties, 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. 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?	No.	You can see the specialist you choose without a referral.

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	$30 copayment/visit	40% coinsurance	None
	Specialist visit	$50 copayment/visit	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	Mandated screening and immunizations 40% 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.	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% 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	40% coinsurance	Services at non-participating ambulatory surgical facilities 40% coinsurance.

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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)	
	Physician/surgeon fees	20% coinsurance	40% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
If you need immediate medical attention	Emergency room care	$150 copayment/visit	$150 copayment/visit	Deductible does not apply. Copayment waived if admitted inpatient.
	Emergency medical transportation	20% coinsurance	40% coinsurance	Deductible does not apply.
	Urgent care	$50 copayment/visit	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copayment/visit	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	$50 copayment/visit	40% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	90 visit limit *See preauthorization schedule attached to your certificate of coverage.
	Rehabilitation services	20% coinsurance	40% coinsurance	30 visit limit
	Habilitation services	20% coinsurance	40% coinsurance	30 visit limit
	Skilled nursing care	20% coinsurance	40% coinsurance	100 day limit
	Durable medical equipment	20% coinsurance	40% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
	Hospice services	20% coinsurance	40% 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

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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**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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.

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

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Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$250
Specialist *[cost sharing]*	$50
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	$250
Copayments	$60
Coinsurance	$2,484
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,854**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$250
Specialist *[cost sharing]*	$50
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	$250
Copayments	$340
Coinsurance	$1,156
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,801**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$250
Specialist *[cost sharing]*	$50
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$150
Coinsurance	$326
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$726**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	$100/individual/$300/family participating providers; $500/individual non-participating providers.	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.
Are there services covered before you meet your deductible?	Yes. Emergency services or emergency medical transportation, and network preventive services.	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?	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.	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?	Pre-authorization penalties, 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. 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?	No.	You can see the specialist you choose without a referral.

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	$30 copayment/visit	40% coinsurance	None
	Specialist visit	$50 copayment/visit	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	Mandated screening and immunizations 40% 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)	15% coinsurance for lab and 15% coinsurance for tests. 15% coinsurance for outpatient radiology.	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance	40% 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)	15% coinsurance	40% coinsurance	Services at non-participating ambulatory surgical facilities 40% 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)	
	Physician/surgeon fees	15% coinsurance	40% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
If you need immediate medical attention	Emergency room care	$150 copayment/visit	$150 copayment/visit	Copayment waived if admitted inpatient.
	Emergency medical transportation	15% coinsurance	15% coinsurance	None
	Urgent care	$50 copayment/visit	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	40% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
	Physician/surgeon fees	15% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copayment/visit	40% coinsurance	Some services require pre-certification.
	Inpatient services	15% coinsurance	40% coinsurance	Pre-certification required. 50% co-insurance for services provided without pre-authorization.
If you are pregnant	Office visits	$50 copayment/visit	40% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	15% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	15% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	40% coinsurance	90 visit limit *See preauthorization schedule attached to your certificate of coverage.
	Rehabilitation services	15% coinsurance	40% coinsurance	30 visit limit
	Habilitation services	15% coinsurance	40% coinsurance	30 visit limit
	Skilled nursing care	15% coinsurance	40% coinsurance	100 day limit
	Durable medical equipment	15% coinsurance	40% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
	Hospice services	15% coinsurance	40% 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.ibhcorp.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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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:

To talk to an interpreter in your language at no cost, call 800.962.2242 (TTY: 711).

Para hablar con un intérprete de forma gratuita, llame al 800.962.2242 (TTY: 711).

欲免费用本国语言洽询传译员，请拨电话 800.962.2242 (TTY: 711).

Để nói chuyện với thông dịch viên bằng ngôn ngữ của quý vị không phải mất phí, xin gọi 800.962.2242 (TTY: 711).

Для бесплатного разговора с переводчиком на своем языке, позвоните по тел.: 800.962.2242 (TTY:

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

711).

Fa koschdefrei schwetze mit me dolmetscher in deinre Schrooch, ruf 800.962.2242 uff (TTY: 711).

무료 전화 통역 서비스 800.962.2242 (TTY: 711).

Per parlare con un interprete nella vostra lingua gratis, chiami 800.962.2242 (TTY: 711)

Pour parler à un interpréter dans votre langue sans charges, téléphoner à 800.962.2242 (TTY: 711).

Um in Ihrer Sprache gebührenfrei mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800.962.2242 an (TTY: 711).

ગુજરાતીમા જોડે વાત કરવા, 800.962.2242 (TTY: 711) પર ફોન કરો.

Aby porozmawiac z tlumaczem w jezyku polskim, prosze zadzwonic na numer darmowy telefonu 800.962.2242 (TTY: 711)

Pou pale avèk yon entèprèt nan lang ou grastis, rele nan 800.962.2242 (TTY: 711).

ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ សូមហៅទៅកាន់ 800.962.2242 (TTY: 711)

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	$100
Specialist *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	15%
Other *[cost sharing]*	15%

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	$100
Copayments	$60
Coinsurance	$1,860
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,080**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$100
Specialist *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	15%
Other *[cost sharing]*	15%

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	$100
Copayments	$340
Coinsurance	$1,060
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,555**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$100
Specialist *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	15%
Other *[cost sharing]*	15%

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$150
Coinsurance	$245
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$495**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Design Details
Appendix 2

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BENEFIT HIGHLIGHTS

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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 Benefits Booklet (also known as "Certificate of Coverage"). Refer to your Benefits Booklet for complete details.

YOUR MEDICAL PLAN SUMMARY OF COST SHARING		
	Member Responsibilities	
	If provider is in-network	**If provider is out-of-network**
Deductible (per benefit period) Deductible is combined to include medical and prescription drug benefits for in-network 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	40% 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 in-network providers only.)	$5,000 per member $10,000 per family	Unlimited
Office Visit / Urgent Care / Emergency Room Copayments		
Virtual Care (non-specialist) Visits – delivered via the Capital Blue Cross Virtual Care platform	$10 copayment per visit after deductible	Not covered
Virtual Care (managed behavioral health) Visits – delivered via the Capital Blue Cross Virtual Care platform	$30 copayment per visit after deductible	Not covered
Office Visits and Consultations (In-person & Telehealth) - performed by a family practitioner, general practitioner, internist, pediatrician or in-network retail clinic	20% coinsurance after deductible	40% coinsurance after deductible
Specialist Office Visits (In-person & Telehealth)	20% coinsurance after deductible	40% coinsurance after deductible
Urgent Care Services	20% coinsurance after deductible	40% 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	40% coinsurance, waive deductible
Screening Mammogram (one per benefit period)	No charge, waive deductible	40% coinsurance, waive deductible
Diagnostic Mammogram	20% coinsurance after deductible	40% coinsurance after deductible
Facility / Surgical Services		
Inpatient Hospital Room and Board	20% coinsurance after deductible	40% coinsurance after deductible
Acute Inpatient Rehabilitation (60 days per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Skilled Nursing Facility (100 days per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Maternity Services and Newborn Care	20% coinsurance after deductible	40% coinsurance after deductible
Surgical Procedure and Anesthesia (professional charges)	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Surgery at Ambulatory Surgical Center (facility charge only)	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Surgery at Acute Care Hospital (facility charge only)	20% coinsurance after deductible	40% coinsurance after deductible
Diagnostic Services		
High Tech Imaging (such as MRI, CT, PET)	20% coinsurance after deductible	40% coinsurance after deductible
Radiology (other than high tech imaging)	20% coinsurance after deductible	40% coinsurance after deductible
Independent Laboratory	20% coinsurance after deductible	40% coinsurance after deductible
Facility-owned Laboratory (i.e. Health System owned)	20% coinsurance after deductible	40% coinsurance after deductible
Therapy Services (Rehabilitative and Habilitative Services)		
Physical Therapy (30 visits per benefit period per condition)	20% coinsurance after deductible	40% coinsurance after deductible
Occupational Therapy (30 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Speech Therapy (30 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Respiratory Therapy (30 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Manipulation Therapy (30 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH Inpatient Services	20% coinsurance after deductible	40% coinsurance after deductible
MH Outpatient Services	20% coinsurance after deductible	40% coinsurance after deductible
SUD Detoxification Inpatient	20% coinsurance after deductible	40% coinsurance after deductible
SUD Rehabilitation Outpatient	20% coinsurance after deductible	40% coinsurance after deductible
Additional Services		
Home Health Care Services (90 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Durable Medical Equipment and Supplies	20% coinsurance after deductible	40% coinsurance after deductible

Prosthetic Appliances	20% coinsurance after deductible	40% coinsurance after deductible
Orthotic Devices	20% coinsurance after deductible	40% coinsurance after deductible

Benefits are underwritten by Capital Advantage Assurance Company®, a subsidiary of Capital Blue Cross. An independent licensee of the Blue Cross Blue Shield 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. In-network providers agree to accept our allowance as payment in full—often less than their normal charge. If you visit a out-of-network provide, you are responsible for paying the deductible, coinsurance and the difference between the out-of-network provider's charges and the allowed amount. Out-of-network Providers may balance bill the member. Some out-of-network 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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Keystone HEALTH PLAN CENTRAL
A Capital Blue Cross Company
Independent Licensee of the Blue Cross Blue Shield Association

BENEFIT HIGHLIGHTS

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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 Benefits Booklet (also known as "Certificate of Coverage"). Refer to your Benefits 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 in-network 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 and prescription drugs for in-network providers only.)	$4,000 per member $8,000 per family
Office Visit / Urgent Care / Emergency Room Copayments	
Virtual Care (non-specialist) Visits – delivered via the Capital BlueCross Virtual Care platform	$10 copayment per visit
Virtual Care (managed behavioral health) Visits – delivered via the Capital BlueCross Virtual Care platform	$30 copayment per visit
Office Visits and Consultations (In-person & Telehealth) -performed by a family practitioner, general practitioner, internist, pediatrician or in-network retail clinic	$30 copayment per visit
Specialist Office Visits (In-person & Telehealth)	$50 copayment per visit
Urgent Care Services	$50 copayment per visit
Emergency Room	$150 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	$250 copayment per admission
Acute Inpatient Rehabilitation (60 days per benefit period)	$250 copayment per admission
Skilled Nursing Facility (100 days per benefit period)	$250 copayment per admission
Maternity Services and Newborn Care	$250 copayment per admission
Surgical Procedure and Anesthesia (professional charges)	No charge
Outpatient Surgery at Ambulatory Surgical Center (facility charge only)	$100 copayment per admission
Outpatient Surgery at Acute Care Hospital (facility charge only)	$100 copayment per admission
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 per condition)	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	$250 copayment per admission
MH Outpatient Services	$30 copayment per visit
SUD Detoxification Inpatient	$250 copayment per admission
SUD Rehabilitation Outpatient	$30 copayment per visit
Additional Services	
Home Health Care Services (90 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 Blue Cross. Independent licensee of the Blue Cross and Blue Shield Association.

All services must be received from In-network 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.


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BENEFIT HIGHLIGHTS

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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 Benefits Booklet (also known as "Certificate of Coverage"). Refer to your Benefits Booklet for complete details.

YOUR MEDICAL PLAN SUMMARY OF COST SHARING		
	Member Responsibilities	
	If provider is in-network	**If provider is out-of-network**
Deductible (per benefit period)	$250 per member $750 per family	$500 per member
Coinsurance (percentage you pay after your deductible is met)	20% coinsurance	40% 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 in-network providers only.)	$4,000 per member $8,000 per family	Unlimited
Office Visit / Urgent Care / Emergency Room Copayments		
Virtual Care (non-specialist) Visits – delivered via the Capital Blue Cross Virtual Care platform	$10 copayment per visit	Not covered
Virtual Care (managed behavioral health) Visits – delivered via the Capital Blue Cross Virtual Care platform	$30 copayment per visit	Not covered
Office Visits and Consultations (In-person & Telehealth) - performed by a family practitioner, general practitioner, internist, pediatrician or in-network retail clinic	$30 copayment per visit	40% coinsurance after deductible
Specialist Office Visits (In-person & Telehealth)	$50 copayment per visit	40% coinsurance after deductible
Urgent Care Services	$50 copayment per visit	40% coinsurance after deductible
Emergency Room	$150 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	40% coinsurance, waive deductible
Screening Mammogram (one per benefit period)	No charge, waive deductible	40% coinsurance, waive deductible
Diagnostic Mammogram	20% coinsurance after deductible	40% coinsurance after deductible
Facility / Surgical Services		
Inpatient Hospital Room and Board	20% coinsurance after deductible	40% coinsurance after deductible
Acute Inpatient Rehabilitation (60 days per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Skilled Nursing Facility (100 days per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Maternity Services and Newborn Care	20% coinsurance after deductible	40% coinsurance after deductible
Surgical Procedure and Anesthesia (professional charges)	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Surgery at Ambulatory Surgical Center (facility charge only)	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Surgery at Acute Care Hospital (facility charge only)	20% coinsurance after deductible	40% coinsurance after deductible
Diagnostic Services		
High Tech Imaging (such as MRI, CT, PET)	20% coinsurance after deductible	40% coinsurance after deductible
Radiology (other than high tech imaging)	20% coinsurance after deductible	40% coinsurance after deductible
Independent Laboratory	20% coinsurance after deductible	40% coinsurance after deductible
Facility-owned Laboratory (i.e. Health System owned)	20% coinsurance after deductible	40% coinsurance after deductible
Therapy Services (Rehabilitative and Habilitative Services)		
Physical Therapy (30 visits per benefit period per condition)	20% coinsurance after deductible	40% coinsurance after deductible
Occupational Therapy (30 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Speech Therapy (30 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Respiratory Therapy (30 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Manipulation Therapy (30 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH Inpatient Services	20% coinsurance after deductible	40% coinsurance after deductible
MH Outpatient Services	$30 copayment per visit	40% coinsurance after deductible
SUD Detoxification Inpatient	20% coinsurance after deductible	40% coinsurance after deductible
SUD Rehabilitation Outpatient	$30 copayment per visit	40% coinsurance after deductible
Additional Services		
Home Health Care Services (90 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Durable Medical Equipment and Supplies	20% coinsurance after deductible	40% coinsurance after deductible
Prosthetic Appliances	20% coinsurance after deductible	40% coinsurance after deductible
Orthotic Devices	20% coinsurance after deductible	40% coinsurance after deductible

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. In-network providers agree to accept our allowance as payment in full—often less than their normal charge. If you visit a out-of-network provider, you are responsible for paying the deductible, coinsurance and the difference between the out-of-network provider' charges and the allowed amount. Out-of-network Providers may balance bill the member. Some out-of-network 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

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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 Benefits Booklet (also known as "Certificate of Coverage"). Refer to your Benefits Booklet for complete details.

YOUR MEDICAL PLAN SUMMARY OF COST SHARING		
	Member Responsibilities	
	If provider is in-network	**If provider is out-of-network**
Deductible (per benefit period)	$100 per member $300 per family	$500 per member
Coinsurance (percentage you pay after your deductible is met)	15% coinsurance	40% 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 in-network providers only.)	$4,000 per member $8,000 per family	Unlimited
Office Visit / Urgent Care / Emergency Room Copayments		
Virtual Care (non-specialist) Visits – delivered via the Capital Blue Cross Virtual Care platform	$10 copayment per visit	Not covered
Virtual Care (specialist) Visits – delivered via the Capital Blue Cross Virtual Care platform	$30 copayment per visit	Not covered
Office Visits and Consultations (In-person & Telehealth) - performed by a family practitioner, general practitioner, internist, pediatrician or in-network retail clinic	$30 copayment per visit	40% coinsurance after deductible
Specialist Office Visits (In-person & Telehealth)	$50 copayment per visit	40% coinsurance after deductible
Urgent Care Services	$50 copayment per visit	40% coinsurance after deductible
Emergency Room	$150 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	40% coinsurance, waive deductible
Screening Mammogram (one per benefit period)	No charge, waive deductible	40% coinsurance, waive deductible
Diagnostic Mammogram	15% coinsurance after deductible	40% coinsurance after deductible
Facility / Surgical Services		
Inpatient Hospital Room and Board	15% coinsurance after deductible	40% coinsurance after deductible
Acute Inpatient Rehabilitation (60 days per benefit period)	15% coinsurance after deductible	40% coinsurance after deductible
Skilled Nursing Facility (100 days per benefit period)	15% coinsurance after deductible	40% coinsurance after deductible
Maternity Services and Newborn Care	15% coinsurance after deductible	40% coinsurance after deductible
Surgical Procedure and Anesthesia (professional charges)	15% coinsurance after deductible	40% coinsurance after deductible
Outpatient Surgery at Ambulatory Surgical Center (facility charge only)	15% coinsurance after deductible	40% coinsurance after deductible
Outpatient Surgery at Acute Care Hospital (facility charge only)	15% coinsurance after deductible	40% coinsurance after deductible
Diagnostic Services		
High Tech Imaging (such as MRI, CT, PET)	15% coinsurance after deductible	40% coinsurance after deductible
Radiology (other than high tech imaging)	15% coinsurance after deductible	40% coinsurance after deductible
Independent Laboratory	15% coinsurance after deductible	40% coinsurance after deductible
Facility-owned Laboratory (i.e. Health System owned)	15% coinsurance after deductible	40% coinsurance after deductible
Therapy Services (Rehabilitative and Habilitative Services)		
Physical Therapy (30 visits per benefit period per condition)	15% coinsurance after deductible	40% coinsurance after deductible
Occupational Therapy (30 visits per benefit period)	15% coinsurance after deductible	40% coinsurance after deductible
Speech Therapy (30 visits per benefit period)	15% coinsurance after deductible	40% coinsurance after deductible
Respiratory Therapy (30 visits per benefit period)	15% coinsurance after deductible	40% coinsurance after deductible
Manipulation Therapy (30 visits per benefit period)	15% coinsurance after deductible	40% coinsurance after deductible
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH Inpatient Services	15% coinsurance after deductible	40% coinsurance after deductible
MH Outpatient Services	$30 copayment per visit	40% coinsurance after deductible
SUD Detoxification Inpatient	15% coinsurance after deductible	40% coinsurance after deductible
SUD Rehabilitation Outpatient	$30 copayment per visit	40% coinsurance after deductible
Additional Services		
Home Health Care Services (90 visits per benefit period)	15% coinsurance after deductible	40% coinsurance after deductible
Durable Medical Equipment and Supplies	15% coinsurance after deductible	40% coinsurance after deductible
Prosthetic Appliances	15% coinsurance after deductible	40% coinsurance after deductible
Orthotic Devices	15% coinsurance after deductible	40% coinsurance after deductible

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. In-network providers agree to accept our allowance as payment in full—often less than their normal charge. If you visit a out-of-network provider, you are responsible for paying the deductible, coinsurance and the difference between the out-of-network provider' charges and the allowed amount. Out-of-network Providers may balance bill the member. Some out-of-network 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.

Voice activated paper.

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

High Blood Pressure (HBP)	Every 3-5 years for adults age 19-39 with BP<130/85 who have no other risk factors. Annually for adults age 40 and older, and annually for all adults at increased risk for HBP.
HIV Test	Routine one-time testing of adults age 19-65 at unknown risk for HIV infection. Periodic repeat testing (at least annually) of all high-risk adults age 19 and older.
Latent Tuberculosis (TB) Infection Test	At least one-time testing of adults age 19 and older at high risk. Periodic repeat testing of adults with continued high risk for TB infection.
Low-dose CT Scan for Lung Cancer	Annual testing until smoke-free for 15 years for high-risk adults 50-80 years of age.
Obesity/Weight Loss Interventions	Age 19 and older: Every visit (BMI of 30 or greater: Intensive Multicomponent Behavioral Therapy (IBT) counseling available).
STI counseling	Age 19 and older for high-risk adults: Moderate and Intensive Behavioral Therapy (IBT) counseling available.
Skin Cancer Prevention Counseling	Counseling to minimize exposure to ultraviolet (UV) radiation for adults age 19-24 with fair skin.
Syphilis Test	Test all high-risk adults age 19 and older; suggested testing is every 1-3 years.
Tobacco Use Assessment/ Counseling and Cessation Interventions	Age 19 and older: 2 cessation attempts per year (each attempt includes a maximum of 4 counseling visits of at least 10 minutes per session); FDA-approved tobacco cessation medications[5]; individualize risk in pregnant women.

IMMUNIZATIONS**	
COVID-19[6]	Age 19 and older: Based on vaccine availability, refer to the CDC for dosing recommendations.
Haemophilus Influenza Type B (Hib)	Age 19 and older: Based on individual risk or healthcare provider recommendation, one or three doses depending on indication.
Hepatitis A (HepA)	Age 19 and older: Based on individual risk or healthcare provider recommendation, two or three doses.
Hepatitis B (HepB)	Age 19 and older: Based on individual risk or healthcare provider recommendation, two or three doses.
Human Papillomavirus (9vHPV)	Age 19-26: Two or three doses, depending on age at series initiation. Age 27-45: Based on healthcare provider recommendation.
Influenza	Age 19 and older: One dose annually during influenza season.
Measles/Mumps/Rubella (MMR)	Age 19 and older: Based on indication (born 1957 or later) or healthcare provider recommendation, one or two doses.
Meningococcal A, C, W, Y (MenACWY)	Age 19 and older: Based on individual risk or healthcare provider recommendation: One or two doses depending on indication, then booster every 5 years if risk remains.
Meningococcal B (MenB)	Age 19 and older: Based on individual risk or healthcare provider recommendation: Two or three doses depending on indication, then booster every 2-3 years if risk remains.
Pneumococcal (conjugate) (PCV13)	Age 19-64: One dose. Based on individual risk, serial administration with PPSV23 may be indicated. Age 65 and older: Based on individual risk and healthcare provider recommendation.
Pneumococcal (polysaccharide) (PPSV23)	Age 65 and older: One or two doses depending on indication. One dose at least 5 years after PPSV23. Age 19-64: Based on individual risk or healthcare provider recommendation.
Tetanus/Diphtheria/Pertussis (Td or Tdap)	Age 19 and older: One dose of Tdap, then Td or Tdap booster every 10 years.
Varicella/Chickenpox (VAR)	Beginning at age 19: One or two doses (born 1980 or later) based upon past immunization or medical history.
Zoster (Shingles)	Beginning at age 50: Two doses.

[1] Coverage is provided without cost-share for all FDA-approved generic contraceptive methods and all FDA-approved contraceptives without a generic equivalent. See the Rx Preventive Coverage List at capitalbluecross.com for details. Coverage includes clinical services, including patient education and counseling, needed for provision of the contraceptive method. If an individual's provider recommends a particular service or FDA-approved item based on a determination of medical necessity with respect to that individual, the service or item is covered without cost-sharing.

[2] CT Colonography is listed as an alternative to a flexible sigmoidoscopy and colonoscopy, with the same schedule overlap prohibition as found in footnote #3.

[3] Only one endoscopic procedure is covered at a time, without overlap of the recommended schedules.

[4] For guaiac-based testing (gFOBT), six stool samples are obtained (2 samples on each of 3 consecutive stools, while on appropriate diet, collected at home). For immunoassay testing (FIT), specific manufacturer's instructions are followed.

[5] Refer to the most recent Formulary located on the Capital Blue Cross web site at capitalbluecross.com.

[6] COVID-19 vaccine availability is dependent on government distribution during the public health emergency (PHE). Refer to the CDC for the most up-to-date information on COVID-19 vaccines.

Schedule for Maternity

SCREENINGS/PROCEDURES*

The recommended services listed below are considered preventive care (including prenatal visits) for pregnant women. You may receive the following screenings and procedures at no member cost share:

- Anemia screening (CBC)
- Anxiety/Depression Screening (prenatal/postpartum)
- Breastfeeding Support/Counseling/Supplies
- Gestational Diabetes Screening (prenatal/postpartum)
- Hepatitis B Screening (at the first prenatal visit)
- HIV Screening
- Low-dose Aspirin Therapy (after 12 weeks of gestation for preeclampsia in high-risk women)
- Preeclampsia screening
- Rh Blood Typing
- Rh Antibody Testing for Rh-negative Women
- Rubella Titer
- Syphilis screening
- Tobacco Use Assessment, Counseling and Cessation Interventions
- Asymptomatic Urine Bacteria Screening
- Other preventive services may be available as determined by your healthcare provider

* Services that need to be performed more frequently than stated due to specific health needs of the member and that would be considered medically necessary may be eligible for coverage when submitted with the appropriate diagnosis and procedure(s) and are covered under the core medical benefit. If a clinician determines that a patient requires more than one well-woman visit annually to obtain all necessary recommended preventive services, the additional visits will be provided without cost-sharing. Occupational, school and other "administrative" exams are not covered.
** Refer to the guidelines set forth by the Centers for Disease Control and Prevention (CDC) for additional immunization information.

Schedule for Children: Birth through the end of the month child turns 19 years old

GENERAL HEALTHCARE

Routine History and Physical Examination – Recommended Initial/Interval of Service:
Newborn, 3-5 days, by 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, and 30 months; and 3 years to 19 years annually.

Exams may include:

- Blood pressure (risk assessment up to 2½ years)
- Body mass index (BMI; beginning at 2 years of age)
- Developmental milestones surveillance (except at time of developmental screening)
- Head circumference (through 24 months)
- Height/length and weight
- Newborn evaluation (including gonorrhea prophylactic topical eye medication)
- Weight for length (through 18 months)
- Anticipatory guidance for age-appropriate issues including:
  - Growth and development, breastfeeding/nutrition/support/counseling/supplies, obesity prevention, physical activity and psychosocial/behavioral health
  - Safety, unintentional injuries, firearms, poisoning, media access
  - Contraceptive methods/counseling (females)
  - Tobacco products, use/education
  - Oral health risk assessment/dental care/fluoride supplementation (> 6 months)[1]
  - Fluoride varnish painting of primary teeth (to age 5 years)
  - Folic Acid (childbearing age)

	Newborn	9-12 months	1 year	2 years	3 years	4 years	5 years	6 years	7 years	8 years	9 years	10 years	11 years	12 years	13 years	14 years	15 years	16 years	17 years	18 years	19 years
SCREENINGS/PROCEDURES*																					
Alcohol, Tobacco and Drug Use Assessment (CRAFFT)													✔	✔	✔	✔	✔	✔	✔	✔	✔
Alcohol use screening/counseling																				✔	✔
Anemia screening			✔	Assess risk at all other well child visits																	
Anxiety/Depression Screening (PHQ-2)														✔	✔	✔	✔	✔	✔	✔	✔

	Newborn	9-12 months	1 year	2 years	3 years	4 years	5 years	6 years	7 years	8 years	9 years	10 years	11 years	12 years	13 years	14 years	15 years	16 years	17 years	18 years	19 years
SCREENINGS/PROCEDURES*																					
Autism Spectrum Disorder Screening	At 18 months			✔																	
Chlamydia Test	For sexually active females: suggested testing interval is 1-3 years.																				
Developmental Screening		✔	✔	✔	At 9 months, 18 months and 2½ years																
Domestic/Interpersonal/ Intimate Partner Violence	At least annually for adolescents of childbearing age, 11 years of age and older; provide or refer services as determined by your healthcare provider.																				
Gonorrhea Test	For sexually active females: suggested testing interval is 1-3 years.																				
Hearing Screening/ Risk Assessment	Between 3-5 days through 3 years; repeat at 7 and 9																				
Hearing Test (objective method)	✔					✔	✔	✔		✔		✔	Once between ages 11-14, 15-17 and 18+								
Hepatitis B Test	Beginning at 11 years (children who have not been vaccinated for hepatitis B virus (HBV) infection/other high risk); Periodic repeat testing of children with continued high risk for HBV infection.																				
Hepatitis C Test	One-time testing beginning at age 18 years. Periodic repeat testing with continued high risk for HCV infection.																			✔	✔
High Blood Pressure (HBP)					✔	Beginning at 3 years or younger for at risk: at every well-child visit. Confirm HBP outside office by Ambulatory Blood Pressure Monitoring (ABPM) before treating.															
HIV Screening/Risk Assessment													✔	✔	✔	✔	✔	✔	✔	✔	✔
HIV Test	Routine one-time testing between 15-18 years old. If indicated by high-risk assessment testing may begin earlier. Periodic repeat testing (at least annually) of all high-risk children.																				
Lead Screening Test/Risk Assessment	Screening Test: 12 to 24 months (at risk) 2; Risk Assessment at 6, 9, 12, 18, 24 months and 3-6 years.																				
Lipid Screening/ Risk Assessment				✔		✔		✔		✔				✔	✔	✔	✔	✔	✔		
Lipid Test	Once between 9-11 years (younger if risk is assessed as high) and once between 17-19 years.																				
Maternal Depression Screening	By 1 month, 2 month, 4 month and 6 months																				
Newborn Bilirubin Screening	✔																				
Newborn Blood Screen *(as mandated by the PA Department of Health)*	✔																				
Newborn Critical Congenital Heart Defect Screening	✔																				
Obesity								✔	Beginning at 6 years: at every well-child visit. Offer/refer to intensive counseling and behavioral interventions.												
STI Counseling	Beginning at 11 years (at risk, sexually active): offer Intensive Behavioral Therapy (IBT) counseling.												✔								
STI Screening													✔	✔	✔	✔	✔	✔	✔	✔	✔
Skin Cancer Prevention Counseling	Beginning at 6 months, counseling to minimize exposure to ultraviolet (UV) radiation for children with fair skin.																				
Syphilis Test	For high-risk children; suggested testing interval is 1-3 years.																				
Tobacco Smoking Screening and Cessation	Beginning at age 18: two (2) cessation attempts per year (each attempt includes a maximum of 4 counseling visits); FDA-approved tobacco cessation medications[3]																			✔	✔
Tuberculin Test	Assess risk at every well child visit.																				
Vision Risk Assessment	Up to 2½ years								✔		✔		✔		✔	✔		✔	✔	✔	✔
Vision Test (objective method)					✔	✔	✔	✔		✔		✔		✔			✔				
	Optional annual instrument-based testing may be used between 1-5 years of age and between 6-19 years of age in uncooperative children.																				

IMMUNIZATIONS**	
COVID-19[4]	Based on vaccine availability, refer to the CDC for age and dosing recommendations.
Diphtheria/Tetanus/Pertussis (DTaP)	2 months, 4 months, 6 months, 15–18 months, 4–6 years.
Haemophilus Influenza Type B (Hib)	2 months, 4 months, 6 months (4 dose), 12–15 months, and 5–18 years for those at high-risk.
Hepatitis A (HepA)	12–23 months (2 doses).
Hepatitis B (HepB)	Birth, 1–2 months, 6–18 months.
Human Papillomavirus (HPV)	11–12 years (2 doses) and 9–10 years for those at high-risk or individualization for those not at high-risk.
Influenza[4]	6 months–18 years; annually during flu season.
Measles/Mumps/Rubella (MMR)	12–15 months, 4-6 years.
Meningococcal (MenACWY-D/MenACWY-CRM)	11–12 years, 16 years; 2 months–18 years for those at high-risk.
Meningococcal B (MenB)	10–18 years for those at high-risk; 16-18 years not at high-risk based on healthcare provider recommendation.
Pneumococcal (conjugate) (PCV13)	2 months, 4 months, 6 months, 12–15 months and 5–18 years for those at high-risk.
Pneumococcal (polysaccharide) (PPSV23)	2–18 years (1 or 2 doses) for those at high-risk.
Polio (IPV)	2 months, 4 months, 6–18 months, 4–6 years.
Rotavirus (RV)	2 months, 4 months, 6 months (3 doses) for specific vaccines.
Tetanus/Reduced Diphtheria/Pertussis (Tdap)	11–12 years.
Varicella/Chickenpox (VAR)	12–15 months, 4–6 years.

[1] Fluoride supplementation pertains only to children who reside in communities with inadequate water fluoride.
[2] Encourage all PA-CHIP Members to undergo blood lead level testing before age 2 years. If not previously tested, test between the ages of 3 and 6 years old.
[3] Refer to the most recent Formulary located on the Capital Blue Cross web site at capitalbluecross.com.
[4] COVID-19 vaccine availability is dependent on government distribution during the public health emergency (PHE). Refer to the CDC for the most up-to-date information on COVID-19 vaccines.
[5] Children aged 6 months to 8 years who are receiving influenza vaccines for the first time should receive 2 separate doses (> 4 weeks apart), both of which are covered.

* Services that need to be performed more frequently than stated due to specific health needs of the member and that would be considered medically necessary may be eligible for coverage when submitted with the appropriate diagnosis and procedure(s) and are covered under the core medical benefit. If a clinician determines that a patient requires more than one well-woman visit annually to obtain all necessary recommended preventive services, the additional visits will be provided without cost-sharing. Occupational, school and other "administrative" exams are not covered.

** Refer to the guidelines set forth by the Centers for Disease Control and Prevention (CDC) for additional immunization information including catch-up vaccinations if necessary.

This preventive schedule is periodically updated to reflect current recommendations from the U.S. Preventive Services Task Force (USPSTF); Health Resources and Services Administration (HRSA), National Institutes of Health (NIH); NIH Consensus Development Conference Statement, March 27–29, 2000; Advisory Committee on Immunization Practices (ACIP); Centers for Disease Control and Prevention (CDC); American Diabetes Association (ADA); American Cancer Society (ACS); Eighth Joint National Committee (JNC 8); U.S. Food and Drug Administration (FDA), American Academy of Pediatrics (AAP), Women's Preventive Services Initiative (WPSI).

Category	Details	Comments
***Inpatient* Admissions**	• 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)	*Preauthorization* requirements do not apply to services provided by a *hospital* emergency room *provider*. If an *inpatient* admission results from an emergency room visit, notification must occur within 2 business days of the admission. All such services will be reviewed and must meet *medical necessity* criteria from the first hour of admission. Failure to notify us of an admission may result in an administrative denial. Non-routine maternity admissions, including preterm labor and maternity complications, require notification within 2 business days of the date of admission.
Observation Care Admissions	• 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.	Admissions to observation status require notification within 2 business days. Failure to notify us of an admission may result in an administrative denial.
Diagnostic Services	• 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.	Diagnostic services do not require *preauthorization* when emergently performed during an emergency room visit, observation stay, or *inpatient* admission.
Durable Medical Equipment (DME), Prosthetic, Appliances, Orthotic Devices, Implants		*Members* and *providers* may view a listing of services currently requiring *preauthorization* at the Single Source Preauthorization List.

Category	Details	Comments
Office Surgical Procedures When Performed in a Facility*	• 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)	The items listed are examples of services considered safe to perform in a professional *provider's* office. *Medical necessity* review is required when office procedures are performed in a facility setting. *Members* and *providers* may view a listing of services currently requiring *preauthorization* when performed in a facility at the Single Source Preauthorization List.
Outpatient Procedures/ Surgery	• 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	The items listed are examples of outpatient procedures that may be reviewed for *medical necessity* and or place of service. *Members* and *providers* may view a listing of services currently requiring *preauthorization* at the Single Source Preauthorization List.
Rehabilitative Therapy Services	• Hyperbaric oxygen therapy (non-emergency) • Occupational therapy • Physical therapy • Pulmonary rehabilitation programs	
Transplant Surgeries	Evaluation and services related to transplants	*Preauthorization* will include referral assistance to the Blue Distinction Centers for Transplant network if appropriate.

Category	Details	Comments

Reconstructive or Cosmetic Services and Items	• Removal of excess fat tissue (Abdominoplasty/Panniculectomy and other removal of fat tissue such as Suction Assisted Lipectomy)
	• Breast Procedures
	  ◆ 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
	  ◆ 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		*Members* and *providers* may view a listing of services currently requiring *preauthorization* at the Single Source Preauthorization List.
Investigational and Experimental procedures, devices, therapies, and pharmaceuticals		*Investigational* or experimental procedures are not usually covered benefits. *Members* and *providers* may request *preauthorization* for experimental or *investigational* services/items if included on the listing of services requiring authorization.
New to market procedures, devices, therapies, and pharmaceuticals		*Preauthorization* is required during the first 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 the Single Source Preauthorization List.
Select Outpatient Behavioral Health Services	• Transcranial Magnetic Stimulation (TMS) • Partial Hospitalization • Intensive Outpatient Programs	The items listed are examples of outpatient procedures that may be reviewed for *medical necessity* and or place of service. *Members* and *providers* may view a listing of services currently requiring *preauthorization* at the Single Source Preauthorization List.

Category	Details	Comments
Other Services	• Bio-engineered skin or biological wound care products • Category IDE trials (Investigational Device Exemption) • Enhanced external counterpulsation (EECP) • Home health care • Eye injections (Intravitreal angiogenesis inhibitors) • Laser treatment of skin lesions • Non-emergency air 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 • Joint injections	Members and providers may view a listing of services currently requiring preauthorization at the Single Source Preauthorization List.
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.)	*Members* and *providers* may view a listing of services currently requiring *preauthorization* at the Single Source Preauthorization List.
Select Cardiac Services		*Members* and *providers* may view a listing of services currently requiring *preauthorization* at the Single Source Preauthorization List.
Gene Therapy		*Members* and *providers* may view a listing of services currently requiring *preauthorization* at the Single Source Preauthorization List.

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 us 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 *out-of-network providers* requires *preauthorization*. This includes care that falls under the Continuity of Care provision of the Benefits Booklet or Contract.

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