

2027
EMPLOYEE BENEFIT GUIDE

MEDICAL COVERAGE ONLY

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

This Flexible Benefits Enrollment & Reference Guide provides details about the benefits available to you through Lehigh for 2027:

- Medical (including Prescription Drug and Vision)

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

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

- Change plans
- Add or delete dependents from your coverage
- Change coverage levels
- Enroll in a Healthcare or Dependent Care Flexible Spending Account (FSA)
- Elect to contribute to the Health Savings Account (HSA) if you enroll in the High Deductible Health Plan (HDHP) option for 2027

The benefit elections you make during Open Enrollment are effective from January 1, 2027 through December 31, 2027.

NAVIGATION ICONS

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

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

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

Medical benefits are available to new staff members on the first of the month following their first work day. For new faculty members, benefits are available beginning on their first work day. However, their coverage does not begin until enrollment selections are completed online in Lehigh Benefits.

***If you choose to have your spouse or partner covered by Lehigh's medical insurance plan, you will be charged a $125/month surcharge until you complete a Spousal Surcharge Waiver request and HR approves it.** The request must be submitted each year, and is provided during the online enrollment process. Learn more about eligibility and submitting your election on the Lehigh Benefits site or contact HR at **610.758.3900** or **inben@ lehigh.edu**.



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DON'T MISS YOUR CHANCE TO ENROLL!

- If you are a current employee: Enrollment for 2027 benefits is November 2-16, 2026 for coverage effective January 1, 2027.
  - If you do nothing during Open Enrollment, your current elections will continue in 2027 with one exception: Flexible spending accounts and employee HSA contributions must be renewed.
- If you are a new hire: New employees (both faculty and staff members) must enroll within 30 days of your first day of work.
  - Coverage for faculty members is effective as of their first day of work provided they complete their enrollment in Lehigh Benefits within the first 30 days of employment.
  - Coverage for staff members is effective on the first of the month following their start date, provided they complete their enrollment in Lehigh Benefits within the first 30 days of employment.
  - If you miss your enrollment period deadline, you will be assigned Lehigh's default benefit coverage of PPO individual coverage at a monthly cost of $316. No dependents will be enrolled in medical coverage.

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

ENROLLMENT IS EASY

Enroll on the Web

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

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

OR USE THE APP

- Download **Benefitplace** (the Benefitfocus app) from The App Store or the Google Play Store
- Log in by using the ID **lehighbenefits** on the initial screen, then sign in with your Lehigh ID and password.

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

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

CHANGING YOUR COVERAGE DURING THE YEAR

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

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

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

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

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

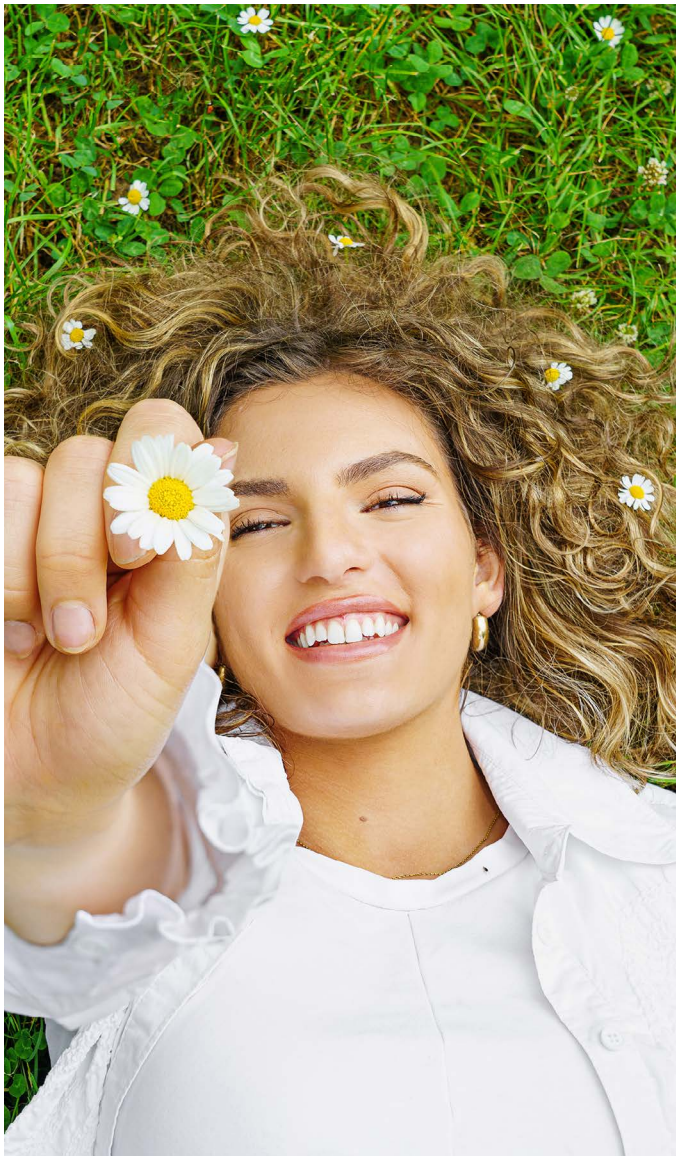


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WHAT HAPPENS TO YOUR COVERAGE IF YOU LEAVE LEHIGH?

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

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



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

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

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

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

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

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

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

EMERGENCY ROOM CARE
Care received in an emergency room.

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

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

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

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

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

YOUR THREE MEDICAL INSURANCE OPTIONS INCLUDE:

Capital Blue Cross Preferred Provider Organization (PPO) plans.

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

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

THE PPO PLAN

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

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

THE HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

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

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

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

THE KEYSTONE HMO

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

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

CLICK HERE for Medical Plan SBC

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

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all GLP-1 medications for all indications will be covered at $150 copay per 30-day supply.

PPO PLAN - NATIONAL NETWORK

	In-Network	Out-of-Network
Annual Deductible	Individual: $1,000 / Family: $2,000	Individual: $1,500 / Family: $1,500 pp
Coinsurance Level *(after deductible)*	20%	40%
Out-of-Pocket Maximum *(including deductible)*	Individual: $5,000 / Family: $10,000	No limit / No limit
Preventive Care *Administered in accordance with Preventive Health Guidelines & PA state mandates)*	Covered 100%	Mandated screenings and immunizations: 40% coinsurance; Routine physical exams: Not covered
Physician's Office Services *All visits for treatment of illness and injury*		
Primary physician office visit	$30 copay per visit	40% coinsurance
Specialist physician office visit	$50 copay per visit	40% coinsurance
Emergency Room Treatment	$250 copay per visit Waived if admitted	$250 copay per visit Waived if admitted
Urgent Care Center	$50 copay per visit	40% coinsurance
Inpatient Hospital Care	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
Maternity *Prenatal / Postpartum Care*	20% coinsurance	40% coinsurance
Maternity *Hospital*	20% coinsurance	40% coinsurance
Mental Health and Substance Abuse Services**		
Inpatient rehabilitation	20% coinsurance	40% coinsurance
Outpatient Rehabilitation and office visits	$30 copay per visit	40% coinsurance
Prescriptions	**Prices are maximums*	
Retail (30-day) Generic/Brand/Brand Non-Formulary	$30/$60/$120	Coinsurance plus amount over Express Scripts allowable amount
Retail (90-day) Generic/Brand/Brand Non-Formulary	$90/$180/$360	
Mail Order (90-day) Generic/Brand/Brand Non-Formulary	$90/$180/$360	

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

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

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

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

HDHP PLAN - NATIONAL NETWORK

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

**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.*

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HealthEquity

HEALTH SAVINGS ACCOUNT (HSA)

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

- **Money from Lehigh.** Lehigh will contribute up to $600 per year to your HSA when you enroll in employee only coverage, and up to $1,200 per year to your account for any other level of coverage. Note, this contribution will be made per pay period and will be prorated based on the date your coverage begins. You must open an HSA in order to receive the Lehigh contribution.
- **Works like a bank account.** Use the money to pay for eligible healthcare expenses — use your HSA debit card to pay when you receive care or reimburse yourself for payments you've made (up to the available balance in the account).
- **You can save.** You decide how much to save and can change that amount at any time. Contribute up to the 2027 annual IRS limit of $4,500 for individuals or $9,000 for family coverage (these amounts include Lehigh's contribution); $1,000 additional contribution allowed for employees age 55+.
- **Never pay taxes.** Contributions are made from your paycheck on a before-tax basis, and the money will never be taxed when used for eligible expenses.
- **It's your money.** Unused money can be carried over each year and invested for the future — you can even take it with you if you leave your job. This includes the contribution from Lehigh.
- **Can be paired with a Limited Purpose Flexible Spending Account (LPFSA).** You can use your HSA for eligible medical, dental and vision expenses. You can use your LPFSA for tax savings on eligible dental and vision expenses.
- **Please Note.** HSA contribution limits as well as catch up contribution limits are based on a calendar year and should be prorated based on the actual number of months you are covered under the HDHP plan.
- **Important restrictions apply when you become Medicare/Social Security eligible.** Once you are enrolled in any part of Medicare, you will not be eligible to contribute to an HSA. If you are receiving Social Security payments prior to age 65 you will be enrolled in Medicare automatically when you turn 65 and will become ineligible to contribute to an HSA. Taxes and penalties will be applied by the IRS if you continue contributing. Download this **information sheet** from HealthEquity for more information.

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

CLICK HERE for HSA eligible expenses

TIERS	2027 LEHIGH ANNUAL HSA CONTRIBUTION		2027 EMPLOYEE HSA MAXIMUM CONTRIBUTION		2027 FEDERAL HSA MAXIMUM ANNUAL CONTRIBUTION
Individual Coverage	$600	+	$3,900	=	$4,500
Family Coverage	$1,200	+	$7,800	=	$9,000

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

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

KEYSTONE HMO PLAN - 21 COUNTY / LEHIGH VALLEY

	In-Network
Annual Deductible	Individual: $300 / Family: $600
Coinsurance Level *(after deductible)*	N/A
Out-Of-Pocket Maximum *(including deductible)*	Individual: $4,000 / Family: $8,000
Preventive Care *Administered in accordance with Preventive Health Guidelines & PA state mandates)*	Covered 100%
Physician's Office Services *All visits for treatment of illness and injury*	
Primary physician office visit	$30 copay per visit
Specialist physician office visit	$50 copay per visit
Emergency Room Treatment	$250 copay per visit. Waived if admitted.
Urgent Care Center	$50 copay per visit
Inpatient Hospital Care	$250/admission
Outpatient Hospital	$100 outpatient surgery copay
Maternity *Prenatal/Postpartum Care*	No charge
Maternity *Hospital*	$250/admission
Mental Health and Substance Abuse Services**	
Inpatient Rehabilitation	$250/admission
Outpatient Rehabilitation and Office Visits	$30 copay per visit
Prescriptions	**Prices are maximums*
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****Care from out-of-network providers is not covered, other than in an emergency, as determined by Capital Blue Cross.*
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Preventive care is any covered medical service or supply that is received in the absence of symptoms or a diagnosed medical condition. Preventive care includes preventive services such as physical examinations, certain immunizations, and screening tests.

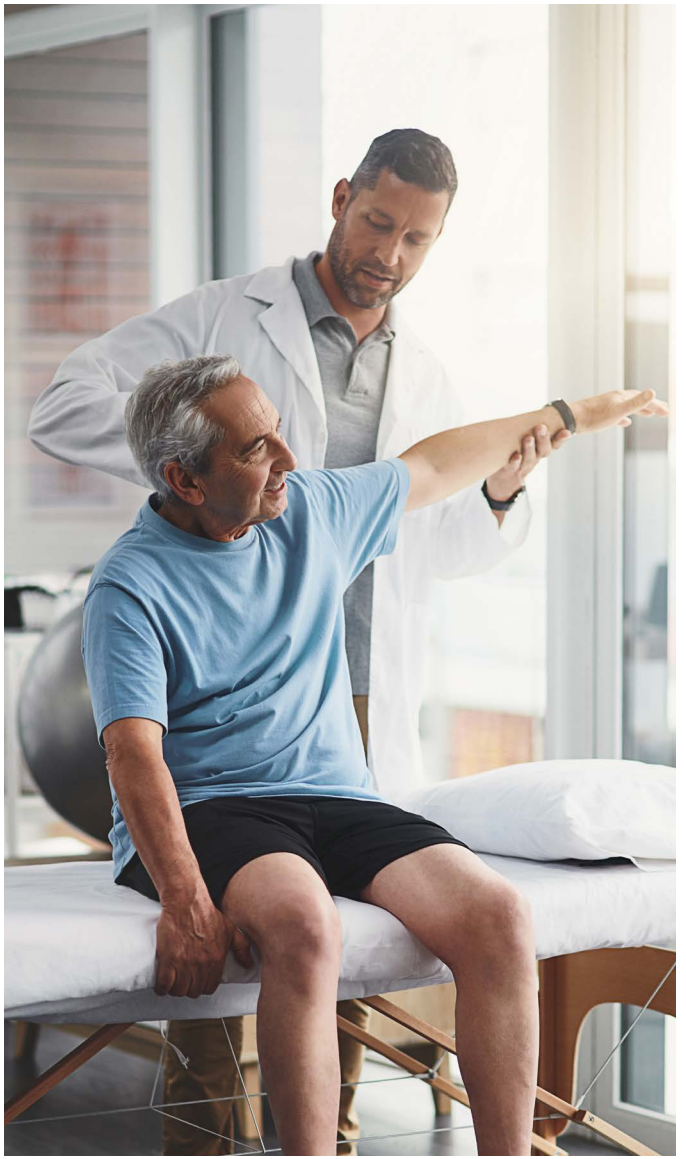
Federal laws covering medical, dental and/or vision preventive care change often. Check to see what's covered at **healthcare.gov/preventive-care-benefits**.

IN-NETWORK PREVENTIVE CARE

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

Preventive services are divided into three groups:

- Adults
- Maternity
- Children



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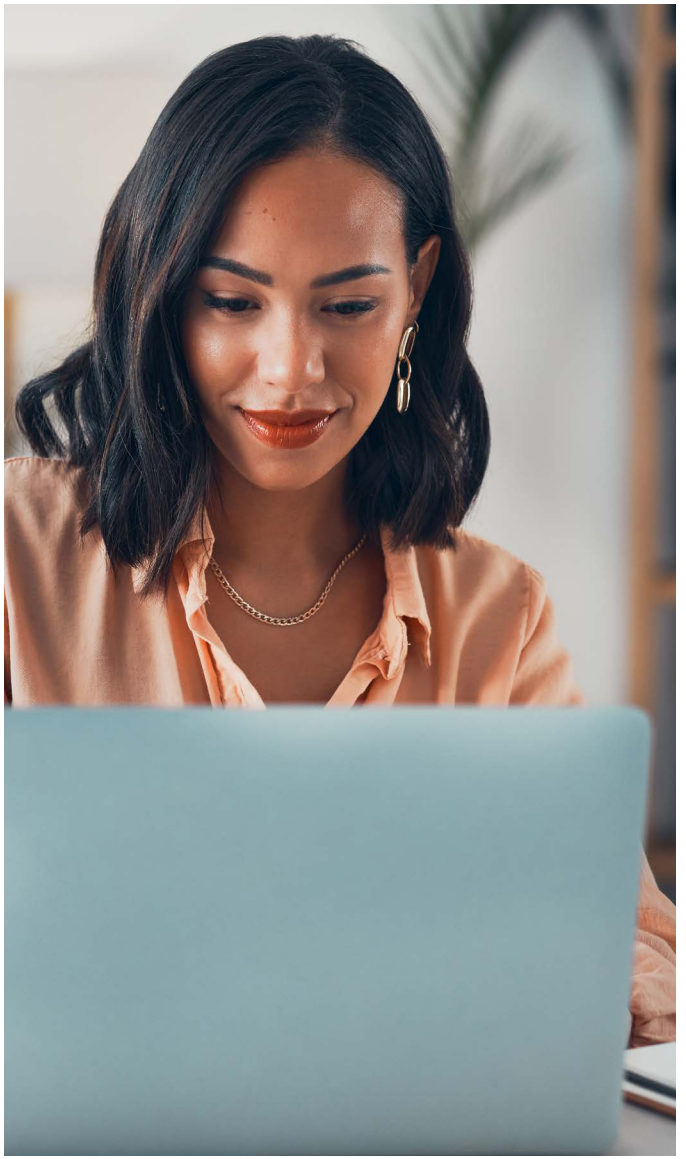
CAPITAL BLUE CROSS VIRTUAL CARE

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 for non-specialist visits through VirtualCare is $10 for HMO and PPO subscribers, and $70 for HDHP subscribers (prior to meeting your deductible).

VirtualCare visits with specialists are $30 copays for HMO/PPO, and pricing varies for HDHP subscribers prior to meeting your deductible. Contact Capital Blue Cross for additional information.

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



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EXPRESS SCRIPTS®

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

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

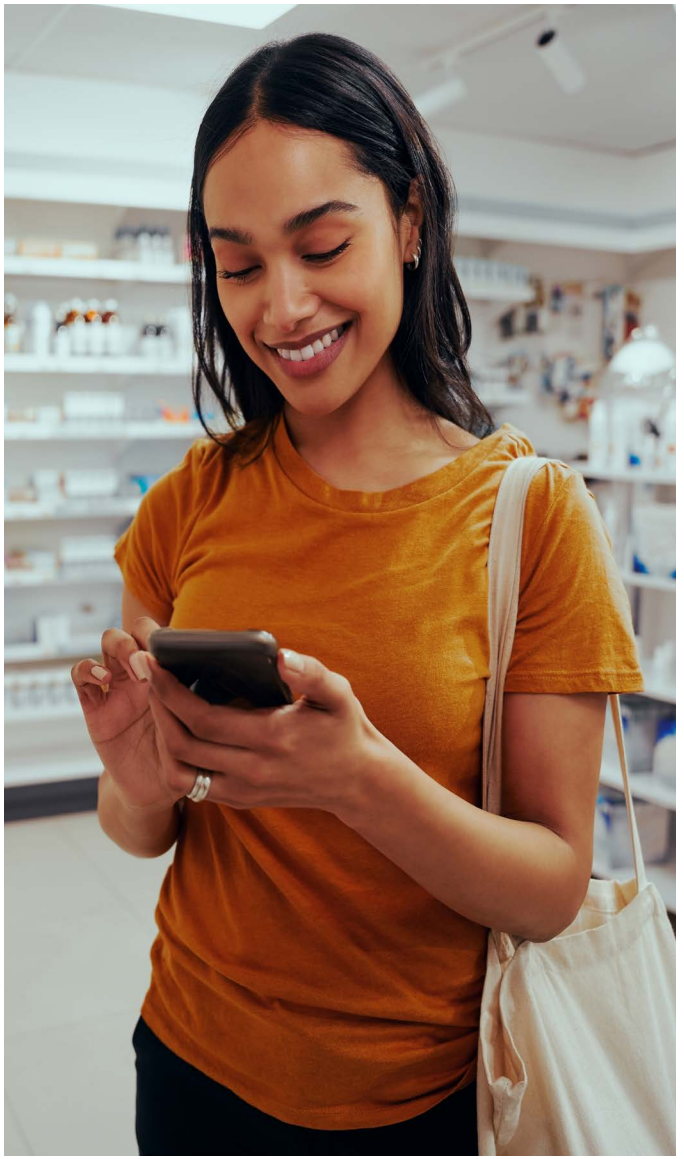
	RETAIL	MAIL ORDER
Generic*	20% ($30 maximum) per 30-day supply	20% ($90 maximum) per 90-day supply
Formulary Brand Name*	25% ($60 maximum) per 30-day supply	25% ($180maximum) per 90-day supply
Non-Formulary Brand Name*	35% ($120 maximum) per 30-day supply	35% ($360 maximum) per 90-day supply

On the HDHP plan, all prescription expenses are full cost until the deductible is satisfied.

FILLING YOUR PRESCRIPTIONS BY MAIL ORDER COULD SAVE YOU MONEY

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

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



MEDICAL
PPO
HIGH DEDUCTIBLE HEALTH PLAN
HEALTH SAVINGS ACCOUNT
KEYSTONE HMO
PREVENTIVE CARE
VIRTUAL CARE
PRESCRIPTION DRUG PLAN
VISION

DavisVision

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

	In-Network	Out-of-Network: Reimbursement to You
Eye Exams	$0 copay	$32
Lenses		
Single Vision	$0	$25
Bifocal	$0	$36
Trifocal	$0	$46
Post Cataract	$0	up to $72
Non-standard (i.e., no line bifocals, tints, coatings)	Fixed Costs	No Additional Benefit
Contact Lenses (Every 12 months)		
Prescription Evaluation and Fitting	$0	Daily Wear: $20 Extended Wear: $30
Contact Lenses	Amount over $100, less 15% discount on overage	Specialty: $48 Disposable: $75
Medically Necessary Contact Lenses (w/prior approval)	$0	Lenses (w/prior approval) $0 up to $225
Frames	All providers: $0 for Davis fashion selection frames up to $100. Non-Davis frames: At Visionworks- amount over $150 for non-Davis frames, less 20% discount on overage. At other providers - amount over $100, less 20% discount on overage.	$30

FIND A VISION PROVIDER

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

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

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

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

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

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)
QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

SPECIAL ENROLLMENT RIGHTS (HIPAA)
If you have previously declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

SPECIAL ENROLLMENT RIGHTS CHIPRA – CHILDREN'S HEALTH INSURANCE PLAN
You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:
You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
You become eligible for a CHIP premium assistant subsidy under state Medicaid or CHIP (Children's Health Insurance Program). You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.
COVERAGE EXTENSION RIGHTS UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA) If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

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

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

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

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

PREMIUM ASSISTANCE UNDER MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)
If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage

DOCUMENTATION AND DATES FOR QUALIFYING LIFE EVENTS

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

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

PPO PLAN

MONTHLY CONTRIBUTIONS		University Contribution
Employee	$316	$868
Employee Plus Spouse/Partner	$783	$1,786
Employee Plus Child(ren)	$697	$1,624
Employee Plus Family	$1,136	$2,578

HDHP PLAN

MONTHLY CONTRIBUTIONS		University Contribution
Employee	$47	$868
Employee Plus Spouse/Partner	$181	$1,786
Employee Plus Child(ren)	$152	$1,624
Employee Plus Family	$265	$2,578

KEYSTONE HMO

MONTHLY CONTRIBUTIONS		University Contribution
Employee	$152	$868
Employee Plus Spouse/Partner	$429	$1,786
Employee Plus Child(ren)	$376	$1,624
Employee Plus Family	$622	$2,578

BENEFIT CARRIER CONTACT INFORMATION

PROVIDER	BENEFIT	TELEPHONE	WEB ADDRESS
Alight	Expert Medical Opinion & Surgery Decision Support	888.361.3944	mymedicalally.alight.com
BenefitsVIP Service Center	General Lehigh Benefits Questions	866.293.9736	solutions@benefitsvip.com
Capital Blue Cross & Keystone Health Plan Central Group #00515044	Medical Insurance	800.216.9741	capbluecross.com
Capital Blue Virtual Care	Telehealth	855.818.3627	capbluecross.com/virtualcare
Davis Vision Group #LHU	Vision Insurance	877.923.2847 | 800.999.5431	davisvision.com Control code: 5167 Your ID number is your LIN
Express Scripts Group #LEHIGHU	Prescription Plan	866.383.7420	express-scripts.com Create an account for full access. Your ID number is your LIN

HOW TO CHOOSE YOUR MEDICAL PLAN

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

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

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

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

1. How much coverage do I need?

- See how the services you'll likely need in 2027 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 2027, $600 individual/$1,200 family)
- You can also contribute through pre-tax payroll deductions
- Money carries over year to year — build tax-free savings to pay for eligible health expenses, now or in the future
  - Additional restrictions apply

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

HSA EXPENSES

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

ELIGIBLE HSA EXPENSES:

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

INELIGIBLE HSA EXPENSES:

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