

# Lehigh Select Products – Plan Year 2011

	Lehigh Select Plan 1 - 96105			Lehigh Select Plan 2 - 96107			Lehigh Select Plan 3 - 96108			Lehigh Select Plan 4 - 96109			Lehigh Select Plan 7 - 96111			Lehigh Select Plan 6 - 96110			Lehigh Select Plan 8 - 96112			Lehigh Select Plan 9 - 96113			Lehigh Select Plan 10 - 96106					
Benefits	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3			
Contract Year Deductible – Individual* <i>(Does not apply to OOP maximum)</i>	None	\$250	\$500	None	\$500	\$1,000	\$250	\$1,000	\$2,000	\$500	\$750	\$1,250	None	\$1,000	\$2,000	\$1,000	\$2,000	\$4,000	\$2,000	\$3,000	\$4,000	3,000	\$4,000	\$5,000	\$4,000	\$5,000	\$6,000			
Coinsurance	0%	10%	30%	10%	20%	30%	20%	30%	40%	0%	10%	20%	0%	0%	30%	0%	0%	20%	0%	10%	20%	0%	10%	30%	0%	10%	20%			
Out-of-Pocket Maximum – Individual*	None	\$1,500	\$3,000	\$1,000	\$1,500	\$3,000	\$1,000	\$1,500	\$3,000	None	\$1,500	\$3,000	None	None	\$4,000	None	None	\$5,000	None	\$3,000	\$4,000	None	\$4,000	\$5,000	None	\$5,000	\$6,000			
Lifetime Maximum*	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited			
Hospital Services																														
Inpatient Copay	None	\$250 per admission	30% after deductible	\$250 per admission	\$500 per admission	30% after deductible	\$500 per admission	\$750 per admission	40% after deductible	None	\$100 per admission	20% after deductible	None	\$100 per admission	30% after deductible	\$250 per admission	\$500 per admission	20% after deductible	\$250 per admission	\$500 per admission	20% after deductible	\$250 per admission	\$500 per admission	30% after deductible	\$250 per admission	\$500 per admission	20% after deductible			
Outpatient Services																														
Office Visits, Primary Preventive Care (PCP or Specialist)	\$10/\$20	\$20/\$30	30% after deductible	\$10/\$20	\$30	30% after deductible	\$15/\$30	\$40	40% after deductible	\$15/\$30	\$25/\$40	20% after deductible	\$15/\$25	\$20/\$30	30% after deductible	\$15/\$30	\$25/\$40	20% after deductible	\$15/\$30	\$15/\$30	20% after deductible	\$15/\$30	\$15/\$30	30% after deductible	\$15/\$30	\$15/\$30	20% after deductible			
Preventative Copay	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0			
Chiropractic Care – 20 visits maximum per contract year (X-rays subject to deductible)	\$20	\$20	30% after deductible	\$20	\$20	30% after deductible	\$30	\$30	40% after deductible	\$30	\$30	20% after deductible	\$25	\$25	30% after deductible	\$30	\$30	20% after deductible	\$30	\$30	20% after deductible	\$30	\$30	30% after deductible	\$30	\$30	30% after deductible	\$30	\$30	20% after deductible
EAP – Employee Assistance Program**	2 visits at 0%	Not covered	Not covered	2 visits at 0%	Not covered	Not covered	2 visits at 0%	Not covered	Not covered	2 visits at 0%	Not covered	Not covered	2 visits at 0%	Not covered	Not covered	2 visits at 0%	Not covered	Not covered	2 visits at 0%	Not covered	Not covered	2 visits at 0%	Not covered	Not covered	2 visits at 0%	Not covered	Not covered			
Emergency																														
Emergency Room Care	\$100 (waived if admitted)	\$100 (waived if admitted)	\$100 (waived if admitted)	\$125 (waived if admitted)	\$125 (waived if admitted)	\$125 (waived if admitted)	\$125 (waived if admitted)	\$125 (waived if admitted)	\$125 (waived if admitted)	\$100 (waived if admitted)	\$100 (waived if admitted)	\$100 (waived if admitted)	\$100 (waived if admitted)	\$100 (waived if admitted)	\$100 (waived if admitted)	\$125 (waived if admitted)	\$125 (waived if admitted)	\$125 (waived if admitted)	\$100 (waived if admitted)	\$100 (waived if admitted)	\$100 (waived if admitted)	\$100 (waived if admitted)	\$100 (waived if admitted)	\$100 (waived if admitted)	\$100 (waived if admitted)	\$100 (waived if admitted)	\$100 (waived if admitted)			

**Notes Regarding All Plans**

\* Unless Otherwise indicated, the family deductible is two times (2x) the single deductible. Family out-of-pocket maximum is two times (2x) the single out-of-pocket maximum.

\*\* Employee Assistance Program provided by Preferred EAP and sponsored by Valley Preferred.

– Deductibles, fixed dollar copays, and certain services DO NOT apply to out-of-pocket maximum.

**Provided for demonstration purposes only.** Actual benefits, cost sharing provisions, limitations, and exclusions are set forth in the certificate of insurance issued to members.

**This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you have any questions call us at 800-788-7895 in central and eastern Pennsylvania.**

**Prescription Drug Plan – Retail**

Rx Plans Available	Tier 1A	Tier 1	Tier 2	Tier 3
\$3/\$10/\$20/\$45	\$3	\$10	\$20	\$45
\$3/\$10/\$25/\$50	\$3	\$10	\$25	\$50
\$3/\$10/\$35/\$60	\$3	\$10	\$35	\$60
\$3/\$15/\$30/\$55	\$3	\$15	\$30	\$55
\$3/\$15/\$35/\$60	\$3	\$15	\$35	\$60
\$3/\$20/\$40/\$70	\$3	\$20	\$40	\$70
Mail Order	2	2	2.5	3

**Prescription Drug Tier Level Descriptions**

**Tier 1A:** Includes common antibiotics, pain relievers, acid reducers, anti-depressants, blood pressure and cholesterol lowering drugs, and more.

**Tier 1:** Includes more generic and a few selected OTC (over-the-counter) drugs.

**Tier 2:** Formulary brand-name drugs.

**Tier 3:** Nonformulary brand-name, and a few nonformulary generic drugs. These drugs may have a lower cost alternative on Tier 1 or Tier 2.