Liberty Advantage Employee Health Plan			
Plan Name	Plan A1 Platinum: 100905A1		
Network	LRMC	Memorial Health Plan (MHP)	
Deductibles/Coins.	$500 - 90%	$1,500 - 80%/50%	
Prescription (Rx)	$10/25/50		
	IN	IN	OUT
Calendar Year Deductible	$500	$1,500	$3,000
Family Deductible	$1,000	$3,000	$6,000
Lifetime Maximum Benefit	Unlimited		
Coinsurance after Deductible	90%	80%	50%
Individual Out of Pocket Max	$3,000		Unlimited
Family Out of Pocket Max	$6,000		Unlimited
Preventive Care Services	No Cost	No cost	Deductible then 50%
Office Visits (labs/X-rays) Walk-in Clinic	$10 co-pay	$25 co-pay	Deductible then 50%
Specialty Doctor Office Visits	$30 co-pay	$45 co-pay	Deductible then 50%
Surgery (physician office)	Deductible then 10%	Deductible then 20%	Deductible then 50%
Maternity (Prenatal/delivery)	Deductible then 10%	Deductible then 20%	Deductible then 50%
Emergency Roo0m	$250 copay, then 80%		
Non-Emergency Use	Deductible then 10%	Not covered	
Inpatient Hospital (Co-pay & Coinsurance) Per admittance	Deductible then 10%	Deductible then $200 copay & 20% coins.	Deductible then $600 co-pay & 50%

Outpatient Dialysis Treatment: (In-Network and Out of Network)-100% of the lesser of (i) the Usual, Customary, and Reasonable Outpatient Dialysis Charge as defined in "Outpatient Dialysis Treatment" Section in the Plan Document, (ii) the maximum allowable charge after all applicable deductibles and costsharing; and (iii) such charge as is negotiated between the Plan Administrator and the provider of Outpatient Dialysis Treatment.	**Member pays Deductible then 10% of Usual, Customary and Reasonable Charges**	**Member pays Deductible then 20% of Usual, Customary and Reasonable Charges**	**Member pays Deductible then 50% of Usual, Customary and Reasonable Charges**
Outpatient Labs & X-ray	**No Cost**	**Deductible then 20%**	**Deductible then 50%**
Therapy Services (Speech, PT) 25 visits max per calendar yr.	**Deductible then 10%**	**Deductible then 20%**	**Deductible then 50%**
Mental Health Subst nce Abuse	**Deductible then 10%**	**Deductible then 20%**	**Deductible then 50%**
Urgent Care Center	**NA**	**$75 co-pay**	**Deductible then $75 co-pay, & 50%**
Durable Medical Equip.	**NA**	**Deductible then 20%**	**Deductible then 50%**
Prescriptions Co-pays	**Retail Pharmacy (30-day supply only)**		
Generic	**$10**		**N/A**
Preferred	**$25**		**N/A**
Non-Preferred	**$50**		**N/A**
Specialty Drugs	**20% ($250 copay max)**		**N/A**
	MAIL ORDER (60, 90-day supply)		
Generic	**$25**		**N/A**
Preferred	**$50**		**N/A**
Non-Preferred	**$100**		**N/A**
Specialty Drugs	**20% ($750 copay max per 30-day supply)**		**N/A**