Liberty Advantage Employee Health Plan			
Plan Name	Plan C Silver: 100905C		
Network	LRMC	Memorial Health Plan (MHP)	
Deductibles/Coins.	$1,000 - 85%	$3,000 - 75%/50%	
Prescription (Rx)	$10/30/60		
	IN	IN	OUT
Calendar Year Deductible	$1,000	$3,000	$6,000
Family Deductible	$2,000	$6,000	$12,000
Lifetime Maximum Benefit	Unlimited		
Coinsurance after Deductible	85%	75%	50%
Individual Out of Pocket Max	$5,500		Unlimited
Family Out of Pocket Max	$11,000		Unlimited
Preventive Care Services	No cost	No cost	Deductible then 50%
Office Visits (labs/X-rays) Walkin Clinic	$35 co-pay	$40 co-pay	Deductible then 50%
Specialty Doctor Office Visits	$45 co-pay	$60 co-pay	Deductible then 50%
Surgery (physician' s office)	Deductible then 15%	Deductible then 25%	Deductible then 50%
Maternity (Prenatal/delivery)	Deductible then 15%	Deductible then 25%	Deductible then 50%
Emergency Room	$250 copay, then 80%		
Non-Emergency Use	Deductible then 15%	Not Covered	
Inpatient Hospital (Co-pay & Coinsurance) Per admittance	Deductible then 15%	Deductible then $400 co-pay & 25% Coins.	Deductible then $1200 Coins. & 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 cost-sharing; and (iii) such charge as is negotiated between the Plan Administrator and the provider of Outpatient Dialysis Treatment.	**Member pays Deductible then 15% of Usual, Customary and Reasonable Charge**	**Member pays Deductible then 25% 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 25%**	**Deductible then 50%**
Therapy Services (Speech, PT) 25 visits max per calendar yr.	**NA**	**Deductible then 25%**	**Deductible then 50%**
Mental Health Substance Abuse	**Deductible then 15%**	**Deductible then 25%**	**Deductible then 50%**
Urgent Care Center	**NA**	**$75 co-pay**	**Deductible then $75 co-pay, & 50%**
Durable Medical Equip.	**NA**	**Deductible then 25%**	**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**