Liberty Advantage Employee Health Plan			
Plan Name	**Plan A1 Platinum**		
Network	**LRMC**	**The Care Network (TCN)**	
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 Room	**$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 co-pay & 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 cost-sharing; 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 Substance 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	**Liberty in-house Pharmacy (30-day supply only)**	**Liberty in-house Pharmacy (90-day supply only**	**Retail Pharmacy (30-day supply only)**
Generic	**$5**	**$15**	**$10**
Preferred	**$10**	**$30**	**$25**
Non-Preferred	**$20**	**$60**	**$50**
Specialty Drugs	***See below**	***See below**	***See below**

* **In order to provide a comprehensive and cost-effective prescription drug program for you and your family, Liberty Regional Employee Health Insurance Plan, has contracted with PrudentRx to offer the PrudentRx Co-Pay Program for certain specialty medications. The PrudentRx Co-Pay Program assists members by helping them enroll in manufacturer co-pay assistance programs. If you enroll in the PrudentRx Co-Pay Program, your out-of-pocket cost for prescriptions covered under the PrudentRx Co-Pay Program will be $0. Otherwise, medications in the specialty tier will remain subject to a 30% co-insurance.**

	MAIL ORDER (60, 90-day supply)	
Generic	**$25**	**N/A**
Preferred	**$50**	**N/A**
Non-Preferred	**$100**	**N/A**
Specialty Drugs	**N/A**	**N/A**