Liberty Advantage Employee Health Plan

Plan Name	Plan C Silver		
Network	LRMC	The Care Network (TCN)	
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) Walk-in 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.	Deductible then 15%	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	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	$30
Non-Preferred	$20	$60	$60
Specialty Drugs	20% ($250 copay max.)	20% ($750 Max)	20% ($250 copay Max)
	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