

# LIBERTY PLANS

## 1500/80



### SCHEDULE OF BENEFITS

### YOU PAY

|  |   |  |
|--|---|--|
| <b>Preventive Care Under PPACA</b>   | Charges for preventive care as per PPACA on the effective date of the plan provide for certain benefits to be paid absent of cost sharing.  | No Deductible, No Copay  |
| <b>Teladoc</b>   | The Teladoc program, while not insurance, is a convenient standalone service that provides access by web, phone, or mobile app to qualified doctors who can treat many common medical conditions.                                       | No Deductible, No Copay  |
| <b>Professional Outpatient Office Visits</b><br>Primary Care<br>Mental Health & Substance Use Disorder                                       | These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical or medical procedures performed by the physician or for diagnostic services billed separately. | \$30 Copay<br>\$30 Copay   |
| <b>Office Based Diagnostic Tests, Labs &amp; X-Ray</b>   | Includes diagnostic tests performed in a physician's office and billed by such physician or a freestanding non-hospital billed facility only.   | \$30 Copay   |
| <b>Urgent Care / Physician</b>   | Urgent Care copayments do not include charges for diagnostic, surgical, or medical procedures.  | \$30 Copay   |
| <b>Prescription Drug Coverage</b><br>Generics<br>Preferred Brand<br>Non-Preferred Brand<br>Expensive Specialty & Injectables                 | Up to a 34-day supply may be purchased at retail for the listed copay.<br>Up to a 90-day supply may be purchased at retail or by mail order for 2 copays.   | \$10 Copay<br>\$30 Copay<br>\$75 Copay<br>50% up to \$400 Max Copay              |
| <b>EXPENSES ABOVE THIS LINE NOT SUBJECT TO DEDUCTIBLE</b>  |   |  |
| <b>Plan Year Deductible</b><br>Individual<br>Family  | An individual within family coverage will only be required to meet the indicated individual deductible amount before coinsurance benefits begin.  | \$1,500 per Individual<br>\$3,000 per Family                                     |
| <b>Out of Pocket Maximum</b><br>Individual<br>Family   | All in network covered cost sharing including copays, deductible and coinsurance combine to meet this OOP maximum.  | \$7,000 per Individual<br>\$14,000 per Family                                    |
| <b>Outpatient Specialist Office Visits</b>   | See notes for "Professional Outpatient Office Visits".  | 20% after the Deductible   |
| <b>Outpatient Surgical, Diagnostic &amp; Therapeutic Procedures</b><br>Medical Services<br>Facility Charges                                  | Includes outpatient services, such as miscellaneous medical procedures and supplies, diagnostic and therapeutic procedures and surgery at a physician's office, freestanding surgical center or hospital (when approved).               | 20% after the Deductible<br>20% after the Deductible                             |
| <b>Vision</b>  | Any optometrist; member must submit claim for reimbursement. Copay waived for children under 5.   | 20% after the Deductible   |
| <b>Short Term Rehabilitation Services</b>  | Physical, chiropractic, speech and occupational therapy. (Includes therapies performed in a provider's office or other non-hospital billed facility only).  | 20% after the Deductible   |
| <b>Emergency Services</b><br>Hospital Emergency Room<br>Ambulance  | \$250 penalty for non-emergency use of a hospital emergency room.   | 20% after the Deductible<br>20% after the Deductible                             |
| <b>Allergy Testing, Injections &amp; Serum</b>   |   | 20% after the Deductible   |
| <b>Inpatient Hospitalization</b><br>Medical Services & Facility<br>Anesthesiologist & Surgeon Fees<br>Mental Health & Substance Use Disorder |   | 20% after the Deductible<br>20% after the Deductible<br>20% after the Deductible |
| <b>Home Health Care &amp; Skilled Nursing Facilities</b>   |   | 20% after the Deductible   |
| <b>Durable Medical Equipment</b>   |   | 20% after the Deductible   |

PPO Provisions. When receiving care from non-network providers, all benefits are subject to the deductible and 40% coinsurance for the member and an increased out of pocket maximum. Other limits may apply. Maximum Out of Pocket Expenses are increased to \$9,000 for individual and \$18,000 for coverage with dependents. Please refer to the Summary Plan Descriptions (SPD) for details. The SPD is the final determination of all benefits. Out-of-Network benefits are subject to usual and customary limitations.