

Medical Plans

LIBERTY

	Cigna Core PPO		Cigna Buy-Up PPO		Cigna HDHP		Kaiser HMO
General Plan Information	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network
Health Savings Account							
Employer HSA Contribution	Not Applicable		Not Applicable		up to \$500		Not Applicable
Deductible							
Individual Deductible (ded)	\$750	\$2,000	\$250	\$750	\$3,000	\$6,000	\$0
Family Deductible (ded)	\$2,250*	\$6,000*	\$750*	\$2,250*	\$6,000*	\$12,000*	\$0
Out of Pocket Maximum							
Individual	\$3,000	\$10,000	\$2,500	\$5,000	\$4,000	\$10,000	\$1,500
Family	\$6,000	\$20,000	\$5,000	\$10,000	\$8,000	\$20,000	\$3,000
Coinsurance & Copays							
Coinsurance	20%	50%	20%	40%	20%	50%	20%
Physician Visits	\$30 copay	50% after ded	\$20 copay	40% after ded	\$30 copay after ded	50% after ded	\$15 copay
Primary Care	\$30 copay	50% after ded	\$20 copay	40% after ded	\$30 copay after ded	50% after ded	\$15 copay
Specialist	\$30 copay	50% after ded	\$20 copay	40% after ded	\$30 copay after ded	50% after ded	\$15 copay
Telehealth Visit	\$30 copay	N/A	\$20 copay	N/A	\$30 copay after ded	N/A	100%, no copay
Preventative Care Services	100%, no ded	50% after ded	100%, no ded	40% after ded	100%, no ded	50% after ded	100%
Emergency & Ambulatory							
Urgent Care	\$35 copay	50% after ded	\$25 copay	40% after ded	20% after ded	50% after ded	\$15 copay
Emergency Room	\$100 copay, waived if admitted		\$100 copay, waived if admitted		\$100 copay, waived if admitted; after ded		\$100 copay waived if admitted
Hospital Services							
Inpatient	20% after ded	50% after ded	20% after ded	40% after ded	20% after ded	50% after ded	\$250/admission
Outpatient	20% after ded	50% after ded	20% after ded	40% after ded	20% after ded	50% after ded	\$15/procedure
Therapy Visits							
Mental Health/Substance Abuse							
Inpatient	20% after ded	50% after ded	20% after ded	40% after ded	20% after ded	50% after ded	\$250/admission
Outpatient	\$30 copay	50% after ded	\$20 copay	40% after ded	\$30 copay after ded	50% after ded	\$15 copay
Durable Medical Equipment	20% after ded	50% after ded	20% after ded	40% after ded	20% after ded	50% after ded	20% coinsurance
Chiropractic Care	\$30 Copay, 20 visits	Not Covered	\$20 Copay, 20 visits	Not Covered	20% after ded, 20 visits	Not Covered	\$15 Copay, 20 visits

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Prescription Drugs							
Retail	30 days		30 days		30 days		30 days
Generic	\$15 copay	Not Covered	\$15 copay	Not Covered	\$15 copay after ded	Not Covered	\$10
Preferred (Preferred Brand)	\$30 copay		\$30 copay		\$30 copay after ded		\$30
Non-Preferred Brand	\$60 copay		\$60 copay		\$60 copay after ded		\$30
Preferred Specialty	20%, \$250 max		20%, \$250 max		20%, \$250 max after ded		20%, \$250 max
Mail Order	90 days		90 days		90 days		90 days
Preferred (Generic)	\$45 copay	Not Covered	\$45 copay	Not Covered	\$45 copay after ded	Not Covered	\$20
Preferred (Preferred Brand)	\$90 copay		\$90 copay		\$90 copay after ded		\$60
Non-Preferred Brand	\$180 copay		\$180 copay		\$180 copay after ded		\$60
Preferred Specialty	N/A		N/A		N/A		N/A

* Family members are responsible to only meet their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.

The information included in this presentation guide is intended as an overview only. It is not a complete description, nor is it a substitute for the applicable plan documents, Summary Plan Descriptions or insurance contracts. In all cases, the official plan documents govern and are the final authority on the terms of the benefit plans. The company reserves the right to modify, amend or terminate the benefit plans at any time and for any reason. Receiving this document or participating in company benefits is not a guarantee of future or continued employment or benefits.