The Liberty Plan: 2027 Benefit Summary

Nov 6, 2026

This summary describes The Liberty Plan from January 1, 2027, until your Summary Plan Description is issued. It is a summary; the plan document controls.

1. The plan at a glance

	The Liberty Plan
Effective	January 1, 2027; calendar plan year
Funding and administration	Self-funded by Liberty; administered by Nova
Network	None. See any provider you choose
Deductible, individual / family	$200 / $400
After the deductible, the plan pays	90%
Out-of-pocket maximum, individual / family	$6,500 / $13,000
Primary care / specialist visit	$20 / $25 copay
Preventive care	$0
Emergency room	$100 copay (waived if admitted)
Urgent care	$25 copay
Generic prescription	$5 copay
New in 2027	Functional medicine; up to 2 blood tests and up to 4 health coaching sessions a year

2. How the plan works and what you pay

No network. You can see any licensed doctor, hospital or clinic. Every provider is paid under the same benefit level, so there are no in-network or out-of-network penalties.

Reference-based pricing. For each claim, ClaimDOC checks the bill and prices it at a fair amount based on what Medicare pays for the same care. Nova pays that amount, and your share is figured on it. Your Explanation of Benefits (EOB) shows the fair price and what you owe.

If a provider bills you more. A provider may bill the difference between its charge and the fair price. Do not pay it yet and do not ignore it. Send the bill and your EOB to the ClaimDOC advocates, who step in for you.

Your costs

- **Deductible:** $200 for you, $400 for a family. You pay this first for services marked "after deductible." Copay services are not subject to it.
- **Coinsurance:** after the deductible, the plan pays 90% and you pay 10%.
- **Copays:** a flat amount for office visits, urgent care, emergency care, therapy and most prescriptions.
- **Out-of-pocket maximum:** $6,500 for you, $13,000 for a family. It includes your deductible, copays, coinsurance and prescription costs. Once you reach it, the plan pays 100% of covered services for the rest of the year. In a family, each person stops at $6,500, or the family stops at $13,000.
- **Resets** every January 1.

3. Covered services and what you pay

"After deductible" means you pay the first $200 (or the family's $400), then the plan pays 90%. Copay services are not subject to the deductible.

Doctor visits and virtual care

Service	What you pay
Primary care visit	$20 copay
Specialist visit	$25 copay
Surgery in a doctor's office	Same as an office visit
Virtual visit with your own doctor	$20 primary care; $25 specialist
Virtual urgent care	$20 copay [vendor to be announced]
Preventive care, screenings and immunizations, all ages	$0

Hospital, emergency and facility care

Service	What you pay
Inpatient hospital, facility and doctors	10% after deductible
Outpatient facility and professional services (surgeons, radiologists, pathologists, anesthesiologists)	10% after deductible
Emergency room, including ER doctor, lab and radiology	$100 copay; waived if admitted
Urgent care facility	$25 copay
Ambulance, emergency	10% after deductible; mental health and substance use ambulance $0
Skilled nursing, rehabilitation hospital, sub-acute	10% after deductible; 60 days a year

Service	What you pay
Hospice, inpatient and outpatient	10% after deductible
Home health care	10% after deductible; 100 visits a year (not limited for mental health or substance use)

Tests and imaging

Service	What you pay
Laboratory services at an independent lab or outpatient facility	10% after deductible
Lab work done in your doctor's office	Part of the office visit
X-ray and other radiology	10% after deductible
MRI, MRA, CT and PET scans	10% after deductible; pre-approval may be required

Therapy

Service	What you pay
Physical therapy	$20 copay; unlimited visits
Speech, hearing and occupational therapy	$20 copay; unlimited visits
Chiropractic care	$20 copay; 20 visits a year
Acupuncture	$20 copay; 12 visits a year

Mental health and substance use

Service	What you pay
Inpatient, acute and residential	10% after deductible; no annual limit
Outpatient, doctor's office (including therapy and medication management)	$20 copay; no annual limit
Outpatient, other services (partial hospitalization, intensive outpatient, ABA therapy)	10% after deductible; no annual limit

Family planning and other benefits

Service	What you pay
Contraceptive devices and sterilization, women's	$0

Service	What you pay
and men's	
Abortion services	$0
Infertility treatment, including artificial insemination, IVF, GIFT and ZIFT	Covered [limits to be provided]
Breast pump rental (one per birth) and supplies	$0
Durable medical equipment and prosthetics	10% after deductible; no annual limit
Infusion and other medical drugs	$0 in a doctor's office; 10% after deductible at a facility or at home
Organ transplants	Covered as inpatient care [transplant facility and travel details to be provided]
Temporomandibular joint disorder (TMJ)	Case by case, by place of service; excludes appliances and orthodontic treatment

4. Prescription drugs and new 2027 benefits

TrueRx runs your pharmacy benefit. Prescription copays are not subject to the deductible, and what you pay counts toward your out-of-pocket maximum, which is shared with your medical benefits.

Prescription	30-day supply	Notes
Generic	$5 copay	Up to a 90-day supply at three times the copay
Preferred brand	$30 copay [TrueRx to confirm]	Up to a 90-day supply
Non-preferred brand	$60 copay [TrueRx to confirm]	Up to a 90-day supply
Specialty	20% of the cost, up to $250 a fill [TrueRx to confirm]	30-day supply
Preventive and required drugs	$0	Contraceptives and federally required preventive drugs

- **Brand when a generic exists:** you pay the brand copay plus the cost difference, unless your doctor writes "dispense as written."
- **Covered:** insulin, glucose test strips, lancets, needles and pens; self-administered injectables; oral fertility drugs. Infertility injectables are not covered by the pharmacy benefit.
- **Drug programs:** some drugs need prior approval, step therapy or quantity limits. TrueRx will publish the drug list and rules [to be provided before January 1].

New for 2027

Benefit	What is covered
Functional medicine	Covered [eligible practitioners, services and your cost to be provided]
Blood tests	Up to 2 per plan year [which tests and your cost to be provided]
Health coaching	Up to 4 sessions per plan year [provider and your cost to be provided]

5. Using your plan

Emergencies. Go to the nearest emergency room or call 911. You do not need approval first. Call Nova afterward so we can follow up.

Pre-approval. Some services need approval from Nova before you receive them. Your provider normally arranges it. Nova will publish the list [to be provided before January 1].

Your first visit. Show your Nova ID card and ask the office to send the claim to Nova. Pay your copay, not a larger balance. Nominate your regular doctors to ClaimDOC so they hear from ClaimDOC before your visit.

If a provider pushes back. If a provider says it does not take your plan, say that the plan pays claims directly and ask it to send the claim to Nova, then call the ClaimDOC advocates. If a bill is higher than your EOB, send it to ClaimDOC before you pay. Send any collection notice to ClaimDOC the same day.

Care support. Nova offers a 24-hour nurse line, case management and chronic-condition support at no cost to you.

Appeals. If a claim is denied, you may appeal. The denial notice explains how and by when; the plan document sets the process [appeals details to be provided].

Who to call

For	Call
Claims, ID cards, benefits, nurse line	Nova [phone and website]
A provider pushing back, or a bill above your EOB	ClaimDOC advocates [phone]
Prescriptions	TrueRx [phone and website]
Eligibility and enrollment	HR and benefits [name, email, phone]

6. Your 2027 contributions

Monthly amounts per employee. Per paycheck assumes 24 pay periods a year [payroll to confirm].

Coverage	Monthly	Per paycheck
Employee only	$137.87	$68.94
Employee + spouse	$896.38	$448.19
Employee + child(ren)	$758.25	$379.13
Family	$1,516.95	$758.48

7. Important information

- **Limits.** Skilled nursing 60 days a year; home health 100 visits a year; chiropractic 20 visits; acupuncture 12 visits. Therapy and mental health have no annual visit limit.
- **Not covered or limited.** Non-emergency ambulance transportation, such as a ride home from the hospital, is generally not covered. Sterilization reversals are not covered. TMJ appliances and orthodontic treatment are excluded. [Full list of exclusions to be added from the plan document.]
- **Eligibility.** Eligible employees and their dependents, including children to age 26, may enroll. [Waiting period, dependent rules and COBRA to be provided.]
- **Plan year.** January 1 to December 31. Your deductible and out-of-pocket maximum start over each January 1.
- **Changes during the year.** You may change your coverage only at open enrollment or after a qualifying life event such as marriage, birth or adoption, or loss of other coverage.
- **This is a summary.** It is not the plan document or Summary Plan Description, which control if they differ. Liberty may amend or end the plan. Services must be medically necessary and covered under the plan. This summary will be replaced when the Summary Plan Description is issued.

Federal protections. Preventive care is covered at no cost, and the plan follows federal rules on mental health parity and coverage for emergency services.