Medical Cost Share - Freedom Plan
Plan Year 2023

	In-Network	Out-of-Network
Individual Medical Deductible	$0	$5,000
Family Medical Deductible	$0	$15,000
Individual Out-of-Pocket Maximum[1]	$1,000	No Out-of-Pocket Maximum
Family Out-of-Pocket Maximum[1]	$2,000	No Out-of-Pocket Maximum
Co-insurance	10% Co-insurance	50% Co-insurance
Office Visits and Services		
Primary Care Provider (Office Visit & Telehealth Services)	$0 Co-pay per visit	50% Co-insurance+
OB/GYN	$0 Co-pay per visit	50% Co-insurance+
Maternity Office Visit (initial visit only)	$0 Co-pay per visit	50% Co-insurance+
Specialty Care Provider (Office Visit & Telehealth Services)	$10 Co-pay per visit	50% Co-insurance+
Chiropractor	$10 Co-pay per visit	50% Co-insurance+
Office Labs	100% Coverage (some labs may be subject to deductible)	50% Co-insurance+
Diagnostic Services	100% Coverage*	50% Co-insurance+
Major Diagnostic Testing	$25 Co-pay per test	50% Co-insurance+
Wellness & Preventive Care	100% Coverage	50% Co-insurance
After-Hours/Walk-In Clinics	$0 Co-pay per visit	50% Co-insurance+
Urgent Care Centers	$10 Co-pay per visit	50% Co-insurance+
Inpatient Services		
Inpatient Semi-Private Room	$150/day, days 1-3*	50% Co-insurance+
Physician Services	100% Coverage*	50% Co-insurance+
Outpatient Services		
Ambulatory Surgery Unit or Outpatient Surgery	$150 Co-pay*	50% Co-insurance+
Observation Stay	$150/day, days 1-3*	50% Co-insurance+
Physician Services	100% Coverage*	50% Co-insurance+
Lab Services	100% Coverage (some labs may be subject to deductible)	50% Co-insurance+
Major Diagnostic Testing	$25 Co-pay per test*	50% Co-insurance+
Other Hospital Outpatient Services	Up to $25 Co-pay per test*	50% Co-insurance+
Emergency Services		
Emergency Room	$150 Co-pay per visit; waived if admitted within 24 hours*	
Ambulance	10% Co-insurance*	

[1]The In-Network Out-of-Pocket Maximum includes Medical and Prescription Drugs. Exclusions and Limitations are listed in the Certificate of Coverage.

*Benefit is subject to the In-Network Medical Deductible.

+Benefit is subject to the Out-of-Network Medical Deductible.

This Cost Share Schedule does not include all available benefits. Please refer to your Certificate of Coverage for a complete listing of covered services, cost share amounts, exclusions and limitations.

Medical Cost Share - Freedom Plan
Plan Year 2023

	In-Network	Out-of-Network
Durable Medical Equipment		
Durable Medical Equipment	10% Co-insurance*	50% Co-insurance+
Extended Care Services		
Long-Term Acute Care Facility	$50 Co-pay per day*	50% Co-insurance+
Rehabilitation Facility	$50 Co-pay per day*	50% Co-insurance+
Skilled Nursing Facility	$50 Co-pay per day*	50% Co-insurance+
Other Covered Services		
Anti-cancer/Radiation Therapy	10% Co-insurance*	50% Co-insurance+
Cardiac Rehabilitation	10% Co-insurance*	50% Co-insurance+
Diabetes Management	$0 Co-pay per visit	50% Co-insurance+
Dialysis	10% Co-insurance*	50% Co-insurance+
Home Health Care	10% Co-insurance*	Not Covered
Hospice	10% Co-insurance*	Not Covered
Nutritional Counseling	$0 Co-pay per visit	50% Co-insurance+
Outpatient Habilitative Services	$0 Co-pay per visit*	50% Co-insurance+
Outpatient Rehabilitative Services	$0 Co-pay per visit*	50% Co-insurance+
Vision Services		
Vision Exam	$10 Co-pay per visit	50% Co-insurance+
Glasses and Contacts for Children	50% Co-insurance	50% Co-insurance+
Glasses and Contacts for Adults	100% Coverage $100 maximum benefit	50% Co-insurance
Mental Health Services		
Outpatient Mental Health Services (Physician)	$0 Co-pay per visit	50% Co-insurance+
Inpatient Mental Health Services	$150/day, days 1-3*	50% Co-insurance+
Alcohol and Chemical Dependency		
Outpatient Alcohol/Chemical Dependency (Physician)	$0 Co-pay per visit	50% Co-insurance+
Inpatient Alcohol/Chemical Dependency	$150/day, days 1-3*	50% Co-insurance+
Approved Transplant Services		
Approved Transplant Services	Applicable Inpatient or ASU/Outpatient Surgery Co-payment*	Not Covered

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+Benefit is subject to the Out-of-Network Medical Deductible.

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Prescription Drug Cost Share

IN-NETWORK PRESCRIPTION DRUG MEMBER COST SHARE	
Prescription Drug Deductible	$500 Individual; $1,500 Family Applies to Tiers III, IV, and V
Prescription Drug Out-of-Pocket Maximum	Included in the In-Network Out-of-Pocket Maximum
Retail or Mail Order Prescription Drugs*	Co-payment amounts listed below cover a 30-day supply. Retail and Mail Order Prescription Drugs may be available in a 30-day supply for 1 Co-payment, 60-day supply for 2 Co-payments, or 100-day supply for 3 Co-payments.
Tier I Prescription Drugs	
DeSiard Pharmacy Network Pharmacies**	100% Coverage
All Other Pharmacies	$5 Co-payment
Tier II Prescription Drugs	
All Pharmacies	$10 Co-payment
Tier III Prescription Drugs	
All Pharmacies	$25 Co-payment
Tier IV Prescription Drugs	
All Pharmacies	$60 Co-payment
Tier V Prescription Drugs	
All Pharmacies	50% Co-insurance
Tier VI Prescription Drugs	
All Pharmacies	100% Coverage

DIABETIC SUPPLIES AND METERS	
DeSiard Pharmacy Network Pharmacies	100% Coverage
All Other In-Network Pharmacies	Member pays applicable Prescription Drug Tier Cost Share.

There is no Out-of-Network Coverage for Prescription Drugs.

*Quantity limits vary by Prescription Drug. Please refer to your formulary for applicable quantity limits. All Tier V Prescription Drugs are limited to a 30-day supply.

**The DeSiard Pharmacy Network Pharmacies mail order benefit may not be available for some out-of-state members.

Dental Cost Share

Code Category	Eligible Members	In-Network Dental Cost Share	Out-of-Network Dental Cost Share
Preventive	Adults and Children	100% Coverage	100% Coverage
Basic and Major *$1,000 combined Basic and Major benefit maximum for adults.*	Adults and Children	**Children:** 50% Co-insurance **Adults:** 100% Coverage	**Children:** 50% Co-insurance **Adults:** 100% Coverage
Orthodontia	Children Only	50% Co-insurance	50% Co-insurance

- **What levels of coverage are included?**
  - Preventive dental – routine exams and cleanings (2 per calendar year), preventive x-rays (1 set per calendar year). Preventive coverage includes only codes in the Preventive code category.
  - Comprehensive dental – includes fillings, extractions, root canals, crowns, and other specified dental services. Comprehensive coverage includes codes in the Basic and Major categories for adults and children.
  - Orthodontia dental – includes braces and aligners to adjust teeth. Orthodontia coverage is available to children only.

- **Is there a waiting period for dental coverage to become effective?**
  - No. Dental coverage is in effect at your effective date.

- **What is my financial responsibility?**
  - Preventive Dental and Comprehensive Dental services are not subject to any deductible on your plan.
  - In-Network preventive dental services are covered at 100% of the Vantage Allowable.
  - Comprehensive dental member responsibility varies by dental code category. See the chart above for member cost share and the benefit maximum amount.

- **How does Vantage Dental coordinate with other dental supplemental policies?**
  - Standard coordination of benefit rules applies when determining the primary payor. Vantage's coverage is generally primary.
  - It is your responsibility to supply all dental coverage ID cards at the time of service.
  - Vantage will not authorize dental services or return predetermination requests when Vantage is secondary.

- **What covered services require pre-authorization? How do I request pre-authorization?**
  - Preventive and Basic Dental – No pre-authorization required.
  - Major Dental and Orthodontia – Pre-authorization required.
  - All Out-of-Network – Pre-authorization required.
  - Your dental provider may request a pre-authorization for services by contacting Vantage's Dental department.

- **Who do I call for help?**
  - Vantage's Dental department can be reached at (844) 788-1907. They can assist with dental eligibility, benefits, and claim status questions.