

COST SHARE SCHEDULE



OGB MEDICAL HOME HMO PLAN EFFECTIVE JANUARY 1, 2018

MEDICAL MEMBER COST SHARE

In-Network Medical Deductible	\$400 Individual \$800 Individual + 1 family member \$1,200 Family (Individual + 2 or more family members) <i>Retirees prior to 3/1/2015 (with or without Medicare):</i> \$0 Individual \$0 Individual + 1 family member \$0 Family (Individual + 2 or more family members)
Out-of-Network Medical Deductible	\$1,500 Individual \$3,000 Individual + 1 family member \$4,500 Family (Individual + 2 or more family members)
Cost Share after Applicable Medical Deductible	In-Network Benefits: See Below Out-of-Network Benefits: 50% Co-insurance based on the Vantage Allowable, may be balance-billed
In-Network Medical Out-of-Pocket Maximum <i>(includes In-Network Medical Deductible)</i>	\$3,500 Individual \$6,000 Individual + 1 family member \$8,500 Family (Individual + 2 or more family members) <i>Retirees prior to 3/1/2015 (with or without Medicare):</i> \$2,000 Individual \$3,000 Individual + 1 family member \$4,000 Family (Individual + 2 or more family members)
Out-of-Network Out-of-Pocket Maximum	Not applicable.

AFFINITY HEALTH NETWORK (AHN)

This Plan includes a preferred provider network, Affinity Health Network (AHN), which has lower cost share for certain Covered Services as indicated by "AHN" below.

IN-NETWORK PROVIDERS

Physician Office Services

Medical Home Primary Care Provider (AHN MH-PCP)	\$10 AHN MH-PCP office visit Co-payment
Medical Home Primary Care Provider (MH-PCP)	\$20 MH-PCP office visit Co-payment
Chiropractor	\$20 Chiropractor office visit Co-payment
Specialty Care (AHN)	\$35 AHN Specialty Care office visit Co-payment
Specialty Care	\$45 Specialty Care office visit Co-payment
Office Diagnostic Services <i>(excludes Major Diagnostic testing and ultrasounds)</i>	100% coverage
Lab Services	100% coverage
Major Diagnostic Testing and Ultrasounds (AHN)	\$0 AHN Co-payment per test
Major Diagnostic Testing and Ultrasounds	\$50 Co-payment per test

*Covered services that are subject to the In-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. Search for current providers at www.VHP-StateGroup.com or call Member Services at (318) 998-4435 or (844) 536-7104.

In-Network Covered Services:	In-Network Benefit:
Maternity-Related Services	
Office Visit	\$10 AHN or \$20 office visit Co-payment (initial visit only)
Office Diagnostic Services <i>(excludes Major Diagnostic testing and ultrasounds)</i>	100% coverage
Lab Services	100% coverage
Major Diagnostic Testing	\$50 Co-payment per test
Ultrasounds	100% coverage for initial 2 ultrasounds
Wellness & Preventive Care	
Annual Examination	100% coverage
Immunizations & Vaccines	100% coverage
Men's, Women's and Children's Health	100% coverage
Inpatient Hospital Services	
Inpatient Semi-Private Room (AHN)	\$50 AHN Co-payment per day for days 1-3, \$150 max per stay
Inpatient Semi-Private Room	\$100 Co-payment per day for days 1-3, \$300 max per stay
Physician Services	100% coverage*
Outpatient Hospital Services	
Observation Stay (AHN)	\$50 AHN Co-payment per day for days 1-3, \$150 max per stay
Observation Stay	\$100 Co-payment per day for days 1-3, \$300 max per stay
Physician Services	100% coverage*
Ambulatory Surgery (ASU)/Outpatient Surgery (AHN)	\$50 AHN Co-payment
Ambulatory Surgery (ASU)/Outpatient Surgery	\$100 Co-payment
Major Diagnostic Testing and Ultrasounds (AHN)	\$0 AHN Co-payment per test
Major Diagnostic Testing and Ultrasounds	\$50 Co-payment per test
Lab Services	100% coverage
Other Hospital Outpatient Services	100% coverage
Emergency Medical Services	
Emergency Room	\$200 Co-payment per visit (waived if admitted)
Physician Services	100% coverage*
Ambulance	\$50 Co-payment for ground ambulance; \$250 Co-payment for air ambulance
Durable Medical Equipment and Supplies	20% Co-insurance* up to \$5,000 of the Allowable; 100% covered* after first \$5,000
After-Hours/Walk-In Clinics (AHN)	\$10 AHN MH-PCP office visit Co-payment
After-Hours/Walk-In Clinics <i>(Diagnostic services may be subject to Deductible.)</i>	\$20 MH-PCP office visit Co-payment
Urgent Care Services	\$50 Co-payment per visit
Extended Care Facilities	\$100 Co-payment per day for days 1-3, \$300 max per stay
Long-Term Acute Care Facility	
Rehabilitation Facility	
Skilled Nursing Facility	
Extended Care Facilities Physician Services	100% coverage*

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In-Network Covered Services:	In-Network Benefit:
Other Covered Services Allergenic Testing Autism Spectrum Disorders Cardiac Rehabilitation (Office) Cardiac Rehabilitation (Outpatient) Chemotherapy/Radiation Therapy (Office) Chemotherapy/Radiation Therapy (Outpatient) Diabetes Management Dialysis Home Health Care Hospice Nutritional Counseling Occupational and Speech Therapy Physical Therapy	20% Co-insurance* \$10 AHN or \$20 office visit Co-payment \$20 MH-PCP or \$45 Specialty Co-payment \$50 Co-payment \$20 Co-payment 100% coverage* \$10 AHN or \$20 office visit Co-payment 100% coverage* 100% coverage* 100% coverage* \$10 AHN or \$20 office visit Co-payment \$10 AHN or \$20 office visit Co-payment \$10 AHN or \$20 office visit Co-payment
Supplementary Benefits <small>(Alcohol- and Drug-related Injuries; Breast Reduction; Cochlear Implant; Leaving Against Medical Advice; Pain Management; Self-inflicted Injuries)</small>	40% Co-insurance*
Mental Health and Alcohol & Chemical Dependency Services Outpatient Mental Health Services Inpatient Mental Health Services Outpatient Alcohol & Chemical Dependency Inpatient Alcohol & Chemical Dependency Inpatient Physician Services	\$10 AHN or \$20 MH-PCP office visit Co-payment \$100 Co-payment per day for days 1-3, \$300 max per stay \$10 AHN or \$20 MH-PCP office visit Co-payment \$100 Co-payment per day for days 1-3, \$300 max per stay 100% coverage*
Vision Services Routine Vision Exam for Children Routine Vision Exam for Adults Glasses and Contacts	\$35 AHN or \$45 Specialty Care office visit Co-payment \$35 AHN or \$45 Specialty Care office visit Co-payment 50% Co-insurance; \$100 max benefit for adults
Preventive Dental Services Preventive Dental Exam and Cleaning	100% coverage of the Vantage Allowable
Approved Transplant Services	Applicable Inpatient or ASU/Outpatient Surgery Co-payment
Approved Transplant Physician Services	100% coverage*

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PRESCRIPTION DRUG MEMBER COST SHARE

Prescription Drug Deductible

No Prescription Drug Deductible.

In-Network Retail Prescription Drugs

Tier I: Preferred Generic Prescription Drugs	\$5 Co-payment per prescription up to 30-day supply
Tier II: Non-Preferred Generic Prescription Drugs	\$20 Co-payment per prescription up to 30-day supply
Tier III: Preferred Brand Prescription Drugs	\$50 Co-payment per prescription up to 30-day supply
Tier IV: Non-Preferred Brand Prescription Drugs	\$80 Co-payment per prescription up to 30-day supply
Tier V: Specialty Prescription Drugs	\$150 Co-payment per prescription up to 30-day supply
Tier VI: Preventive Prescription Drugs	100% coverage

Mail Order Prescription Drugs:

(Not available for Tier V Specialty Prescription Drugs)

Tier I (Preferred Generic):

*Affinity Health Network – Saint John Pharmacy
Other Pharmacies*

90-day supply for **\$0** AHN Co-payment
Prescription Drug Co-payments apply.
30-day supply for 1 Co-payment
60-day supply for 2 Co-payments
90-day supply for 3 Co-payments

Tiers II, III and IV:

All Pharmacies

30-day supply for 1 Co-payment
60-day supply for 2 Co-payments
90-day supply for 3 Co-payments

Diabetic Supplies and Meters:

*Affinity Health Network – Saint John Pharmacy
All Other Pharmacies*

\$0 Co-payment
Prescription Drug Co-payments apply.

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