Medical Cost Share - Essential Plan
Plan Year 2020

	AHN Providers	In-Network	Out-of-Network
Individual Medical Deductible	$4,500		$5,000
Family Medical Deductible	$13,500		$15,000
Individual Out-of-Pocket Maximum[1]	$8,000		No Out-of-Pocket Maximum
Family Out-of-Pocket Maximum[1]	$16,000		No Out-of-Pocket Maximum
Co-insurance	30% Co-insurance		50% Co-insurance
Office Visits and Services			
Primary Care Provider Office Visit	$30 Co-pay per visit	$40 Co-pay per visit	50% Co-insurance+
Chiropractor	$40 Co-pay per visit		50% Co-insurance+
OB/GYN	$30 Co-pay per visit	$40 Co-pay per visit	50% Co-insurance+
Maternity Office Visit (initial visit only)	$30 Co-pay per visit	$40 Co-pay per visit	50% Co-insurance+
Specialty Care Provider Office Visit	30% Co-insurance*		50% Co-insurance+
Office Labs	100% Coverage (some labs may be subject to deductible)		50% Co-insurance+
Diagnostic Services	30% Co-insurance*		50% Co-insurance+
Major Diagnostic Testing	30% Co-insurance*		50% Co-insurance+
Wellness & Preventive Care	100% Coverage		50% Co-insurance
After-Hours/Walk-In Clinics	$30 Co-pay per visit	$40 Co-pay per visit	50% Co-insurance+
Urgent Care Centers	30% Co-insurance*		50% Co-insurance+
Inpatient Services			
Inpatient Semi-Private Room	30% Co-insurance*		50% Co-insurance+
Physician Services	30% Co-insurance*		50% Co-insurance+
Outpatient Services			
Ambulatory Surgery Unit or Outpatient Surgery	30% Co-insurance*		50% Co-insurance+
Observation Stay	30% Co-insurance*		50% Co-insurance+
Physician Services	30% Co-insurance*		50% Co-insurance+
Lab Services	30% Co-insurance*		50% Co-insurance+
Major Diagnostic Testing	30% Co-insurance*		50% Co-insurance+
Other Hospital Outpatient Services	30% Co-insurance*		50% Co-insurance+
Emergency Services			
Emergency Room	30% Co-insurance*		
Ambulance	30% Co-insurance*		
Durable Medical Equipment			
Durable Medical Equipment	30% Co-insurance*		50% 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.

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Plan Year 2020

Extended Care Services			
Long-Term Acute Care Facility	30% Co-insurance*		50% Co-insurance+
Rehabilitation Facility	30% Co-insurance*		50% Co-insurance+
Skilled Nursing Facility	30% Co-insurance*		50% Co-insurance+
Other Covered Services			
Anti-cancer/Radiation Therapy	30% Co-insurance*		50% Co-insurance+
Cardiac Rehabilitation	30% Co-insurance*		50% Co-insurance+
Diabetes Management	$30 Co-pay per visit	$40 Co-pay per visit	50% Co-insurance+
Dialysis	30% Co-insurance*		50% Co-insurance+
Home Health Care	30% Co-insurance*		Not Covered
Hospice	30% Co-insurance*		Not Covered
Nutritional Counseling	$30 Co-pay per visit	$40 Co-pay per visit	50% Co-insurance+
Outpatient Habilitative Services	30% Co-insurance*		50% Co-insurance+
Outpatient Rehabilitative Services	30% Co-insurance*		50% Co-insurance+
Vision Services			
Routine Vision Exam	30% Co-insurance*		50% Co-insurance+
Glasses and Contacts for Children	50% Co-insurance		50% Co-insurance+
Glasses and Contacts for Adults	50% Co-insurance; $100 max		50% Co-insurance
Mental Health Services			
Outpatient Mental Health Services (Physician)	$30 Co-pay per visit	$40 Co-pay per visit	50% Co-insurance+
Inpatient Mental Health Services	30% Co-insurance*		50% Co-insurance+
Alcohol and Chemical Dependency			
Outpatient Alcohol/Chemical Dependency (Physician)	$30 Co-pay per visit	$40 Co-pay per visit	50% Co-insurance+
Inpatient Alcohol/Chemical Dependency	30% Co-insurance*		50% Co-insurance+
Approved Transplant Services			
Approved Transplant Services	Applicable Inpatient or ASU/Outpatient Surgery Co-insurance*		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	$1,000 Individual; $3,000 Family (applies to Tiers III, IV, and V)
Prescription Drug Out-of-Pocket Maximum	Included in the In-Network Out-of-Pocket Maximum
Cost Share: 30-day supply for 1 Co-payment 60-day supply for 2 Co-payments 90-day supply for 3 Co-payments	**Retail or Mail Order*** **(Co-payment shown is for a 30-day supply)**
Tier I Prescription Drugs	
Affinity Health Network Pharmacies**	100% Coverage
All Other In-Network Pharmacies	$10 Co-payment
Tier II Prescription Drugs	
All In-Network Pharmacies	$30 Co-payment
Tier III Prescription Drugs	
All In-Network Pharmacies	50% Co-insurance
Tier IV Prescription Drugs	
All In-Network Pharmacies	50% Co-insurance
Tier V Prescription Drugs	
Participating In-Network Specialty Pharmacies	50% Co-insurance
Tier VI Prescription Drugs	
All In-Network Pharmacies	100% Coverage

DIABETIC SUPPLIES AND METERS	
Affinity Health Network Pharmacies	100% Coverage
All Other 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.

**This benefit is administered by Saint John Pharmacy and may not be available for some out-of-state members. The mail order benefit is only through Saint John Pharmacy available for a 90-day supply.

Dental Cost Share

Code Category	In-Network Dental Cost Share	Out-of-Network Dental Cost Share
Preventive	100% Coverage	100% Coverage
Basic	50% Co-insurance ***$500 combined Basic and Major Max*** *for adults.*	50% Co-insurance
Major	50% Co-insurance ***$500 combined Basic and Major Max*** *for adults.*	50% Co-insurance
Orthodontia for Children	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)
  - Comprehensive dental – includes fillings, extractions, root canals, crowns, and other specified dental services

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

- **What are the covered dental code categories?**
  - Preventive coverage includes only the Preventive category.
  - Comprehensive coverage includes Basic and Major for adults and children. Orthodontia applies to children only.

- **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 Vantage Allowable amount based on the comprehensive dental category.
  - An Out-of-Network Provider may balance-bill you for any charges over the Vantage Allowable.

- **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. Member Services can assist with eligibility, benefits, and claim status questions as well.