



## Medical Cost Share - Essential Plan Plan Year 2021

	AHN Network	In-Network	Out-of-Network
Individual Medical Deductible	\$6,500		\$8,000
Family Medical Deductible	\$13,000		\$16,000
Individual Out-of-Pocket Maximum <sup>1</sup>	\$8,550		No Out-of-Pocket Maximum
Family Out-of-Pocket Maximum <sup>1</sup>	\$17,100		No Out-of-Pocket Maximum
Co-insurance	50% Co-insurance		50% Co-insurance
<b>Office Visits and Services</b>			
Primary Care Provider Office Visit	\$40 Co-pay per visit	\$50 Co-pay per visit	50% Co-insurance <sup>+</sup>
Chiropractor	\$50 Co-pay per visit		50% Co-insurance <sup>+</sup>
OB/GYN	\$40 Co-pay per visit	\$50 Co-pay per visit	50% Co-insurance <sup>+</sup>
Maternity Office Visit (initial visit only)	\$40 Co-pay per visit	\$50 Co-pay per visit	50% Co-insurance <sup>+</sup>
Specialty Care Provider Office Visit	50% Co-insurance*		50% Co-insurance <sup>+</sup>
Office Labs	100% Coverage (some labs may be subject to deductible)		50% Co-insurance <sup>+</sup>
Diagnostic Services	50% Co-insurance*		50% Co-insurance <sup>+</sup>
Major Diagnostic Testing	50% Co-insurance*		50% Co-insurance <sup>+</sup>
Wellness & Preventive Care	100% Coverage		50% Co-insurance
After-Hours/Walk-In Clinics	\$40 Co-pay per visit	\$50 Co-pay per visit	50% Co-insurance <sup>+</sup>
Urgent Care Centers	50% Co-insurance*		50% Co-insurance <sup>+</sup>
<b>Inpatient Services</b>			
Inpatient Semi-Private Room	50% Co-insurance*		50% Co-insurance <sup>+</sup>
Physician Services	50% Co-insurance*		50% Co-insurance <sup>+</sup>
<b>Outpatient Services</b>			
Ambulatory Surgery Unit or Outpatient Surgery	50% Co-insurance*		50% Co-insurance <sup>+</sup>
Observation Stay	50% Co-insurance*		50% Co-insurance <sup>+</sup>
Physician Services	50% Co-insurance*		50% Co-insurance <sup>+</sup>
Lab Services	50% Co-insurance*		50% Co-insurance <sup>+</sup>
Major Diagnostic Testing	50% Co-insurance*		50% Co-insurance <sup>+</sup>
Other Hospital Outpatient Services	50% Co-insurance*		50% Co-insurance <sup>+</sup>
<b>Emergency Services</b>			
Emergency Room	50% Co-insurance*		
Ambulance	50% Co-insurance*		

<sup>1</sup>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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<b>Durable Medical Equipment</b>			
Durable Medical Equipment	50% Co-insurance*		50% Co-insurance+
<b>Extended Care Services</b>			
Long-Term Acute Care Facility	50% Co-insurance*		50% Co-insurance+
Rehabilitation Facility	50% Co-insurance*		50% Co-insurance+
Skilled Nursing Facility	50% Co-insurance*		50% Co-insurance+
<b>Other Covered Services</b>			
Anti-cancer/Radiation Therapy	50% Co-insurance*		50% Co-insurance+
Cardiac Rehabilitation	50% Co-insurance*		50% Co-insurance+
Diabetes Management	\$40 Co-pay per visit	\$50 Co-pay per visit	50% Co-insurance+
Dialysis	50% Co-insurance*		50% Co-insurance+
Home Health Care	50% Co-insurance*		Not Covered
Hospice	50% Co-insurance*		Not Covered
Nutritional Counseling	\$40 Co-pay per visit	\$50 Co-pay per visit	50% Co-insurance+
Outpatient Habilitative Services	50% Co-insurance*		50% Co-insurance+
Outpatient Rehabilitative Services	50% Co-insurance*		50% Co-insurance+
<b>Vision Services</b>			
Routine Vision Exam	50% 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
<b>Mental Health Services</b>			
Outpatient Mental Health Services (Physician)	\$40 Co-pay per visit	\$50 Co-pay per visit	50% Co-insurance+
Inpatient Mental Health Services	50% Co-insurance*		50% Co-insurance+
<b>Alcohol and Chemical Dependency</b>			
Outpatient Alcohol/Chemical Dependency (Physician)	\$40 Co-pay per visit	\$50 Co-pay per visit	50% Co-insurance+
Inpatient Alcohol/Chemical Dependency	50% Co-insurance*		50% Co-insurance+
<b>Approved Transplant Services</b>			
Approved Transplant Services	50% Co-insurance*		Not Covered

<sup>1</sup>The In-Network Out-of-Pocket Maximum includes Medical and Prescription Drugs. Exclusions and Limitations are listed in the Certificate of Coverage.

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

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# Prescription Drug Cost Share

<b><u>IN-NETWORK PRESCRIPTION DRUG MEMBER COST SHARE</u></b>	
<b>Prescription Drug Deductible</b>	\$1,000 Individual; \$2,000 Family Applies to Tiers III, IV, and V
<b>Prescription Drug Out-of-Pocket Maximum</b>	Included in the In-Network Out-of-Pocket Maximum
<b>Retail or Mail Order Prescription Drugs*</b>	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.
<b>Tier I Prescription Drugs</b>	
Affinity Health Network Pharmacies**	100% Coverage
All Other Pharmacies	\$10 Co-payment
<b>Tier II Prescription Drugs</b>	
All Pharmacies	\$30 Co-payment
<b>Tier III Prescription Drugs</b>	
All Pharmacies	50% Co-insurance
<b>Tier IV Prescription Drugs</b>	
All Pharmacies	50% Co-insurance
<b>Tier V Prescription Drugs</b>	
All Pharmacies	50% Co-insurance
<b>Tier VI Prescription Drugs</b>	
All Pharmacies	100% Coverage

<b><u>DIABETIC SUPPLIES AND METERS</u></b>	
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 mail order benefit is administered by Saint John Pharmacy and is only available for a 100-day supply. The Saint John Pharmacy 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 <i>\$500 combined Basic and Major max for adults.</i>	Adults and Children	50% Co-insurance	50% Co-insurance
Orthodontia for Children	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.
  - 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. They can assist with dental eligibility, benefits, and claim status questions.