# Medical Cost Share - Essential Plan
## Plan Year 2021

| | AHN Network | In-Network | Out-of-Network |
|---|---|---|---|
| Individual Medical Deductible | $1,600 | | $5,000 |
| Family Medical Deductible | $4,800 | | $15,000 |
| Individual Out-of-Pocket Maximum[1] | $7,500 | | No Out-of-Pocket Maximum |
| Family Out-of-Pocket Maximum[1] | $15,000 | | No Out-of-Pocket Maximum |
| Co-insurance | 20% Co-insurance | | 50% Co-insurance |
| **Office Visits and Services** | | | |
| Primary Care Provider Office Visit | $20 Co-pay per visit | $30 Co-pay per visit | 50% Co-insurance+ |
| Chiropractor | $30 Co-pay per visit | | 50% Co-insurance+ |
| OB/GYN | $20 Co-pay per visit | $30 Co-pay per visit | 50% Co-insurance+ |
| Maternity Office Visit (initial visit only) | $20 Co-pay per visit | $30 Co-pay per visit | 50% Co-insurance+ |
| Specialty Care Provider Office Visit | 20% Co-insurance* | | 50% Co-insurance+ |
| Office Labs | 100% Coverage (some labs may be subject to deductible) | | 50% Co-insurance+ |
| Diagnostic Services | 20% Co-insurance* | | 50% Co-insurance+ |
| Major Diagnostic Testing | 20% Co-insurance* | | 50% Co-insurance+ |
| Wellness & Preventive Care | 100% Coverage | | 50% Co-insurance |
| After-Hours/Walk-In Clinics | $20 Co-pay per visit | $30 Co-pay per visit | 50% Co-insurance+ |
| Urgent Care Centers | 20% Co-insurance* | | 50% Co-insurance+ |
| **Inpatient Services** | | | |
| Inpatient Semi-Private Room | 20% Co-insurance* | | 50% Co-insurance+ |
| Physician Services | 20% Co-insurance* | | 50% Co-insurance+ |
| **Outpatient Services** | | | |
| Ambulatory Surgery Unit or Outpatient Surgery | 20% Co-insurance* | | 50% Co-insurance+ |
| Observation Stay | 20% Co-insurance* | | 50% Co-insurance+ |
| Physician Services | 20% Co-insurance* | | 50% Co-insurance+ |
| Lab Services | 20% Co-insurance* | | 50% Co-insurance+ |
| Major Diagnostic Testing | 20% Co-insurance* | | 50% Co-insurance+ |
| Other Hospital Outpatient Services | 20% Co-insurance* | | 50% Co-insurance+ |
| **Emergency Services** | | | |
| Emergency Room | 20% Co-insurance* | | |
| Ambulance | 20% 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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| | | | |
|---|---|---|---|
| **Durable Medical Equipment** | | | |
| Durable Medical Equipment | 20% Co-insurance* | | 50% Co-insurance+ |
| **Extended Care Services** | | | |
| Long-Term Acute Care Facility | 20% Co-insurance* | | 50% Co-insurance+ |
| Rehabilitation Facility | 20% Co-insurance* | | 50% Co-insurance+ |
| Skilled Nursing Facility | 20% Co-insurance* | | 50% Co-insurance+ |
| **Other Covered Services** | | | |
| Anti-cancer/Radiation Therapy | 20% Co-insurance* | | 50% Co-insurance+ |
| Cardiac Rehabilitation | 20% Co-insurance* | | 50% Co-insurance+ |
| Diabetes Management | $20 Co-pay per visit | $30 Co-pay per visit | 50% Co-insurance+ |
| Dialysis | 20% Co-insurance* | | 50% Co-insurance+ |
| Home Health Care | 20% Co-insurance* | | Not Covered |
| Hospice | 20% Co-insurance* | | Not Covered |
| Nutritional Counseling | $20 Co-pay per visit | $30 Co-pay per visit | 50% Co-insurance+ |
| Outpatient Habilitative Services | 20% Co-insurance* | | 50% Co-insurance+ |
| Outpatient Rehabilitative Services | 20% Co-insurance* | | 50% Co-insurance+ |
| **Vision Services** | | | |
| Routine Vision Exam | 20% 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) | $20 Co-pay per visit | $30 Co-pay per visit | 50% Co-insurance+ |
| Inpatient Mental Health Services | 20% Co-insurance* | | 50% Co-insurance+ |
| **Alcohol and Chemical Dependency** | | | |
| Outpatient Alcohol/Chemical Dependency (Physician) | $20 Co-pay per visit | $30 Co-pay per visit | 50% Co-insurance+ |
| Inpatient Alcohol/Chemical Dependency | 20% Co-insurance* | | 50% Co-insurance+ |
| **Approved Transplant Services** | | | |
| Approved Transplant Services | 20% 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** | $600 Individual; $1,800 Family<br>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** | |
| Affinity Health Network Pharmacies** | 100% Coverage |
| All Other Pharmacies | $10 Co-payment |
| **Tier II Prescription Drugs** | |
| All Pharmacies | $30 Co-payment |
| **Tier III Prescription Drugs** | |
| All Pharmacies | 20% Co-insurance |
| **Tier IV Prescription Drugs** | |
| All Pharmacies | 20% Co-insurance |
| **Tier V Prescription Drugs** | |
| All Pharmacies | 50% Co-insurance |
| **Tier VI Prescription Drugs** | |
| All 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 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<br>*$500 combined Basic and Major max for adults.* | 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.