



Medical Cost Share - Essential Plan Plan Year 2021

Members of Federally Recognized Tribes who receive services from Participating Indian Health Service Providers will not have to pay In-Network Deductible, Co-payments or Co-insurance. Such services will be provided at zero cost sharing for these Members. The following Member Cost Sharing will apply to Covered Services received from Providers who are not Participating Indian Health Service Providers.

	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 <small>(some labs may be subject to deductible)</small>		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 [*]		

¹The 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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Prescription Drug Cost Share

<u>IN-NETWORK PRESCRIPTION DRUG MEMBER COST SHARE</u>	
Prescription Drug Deductible	\$600 Individual; \$1,800 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	
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

<u>DIABETIC SUPPLIES AND METERS</u>	
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.