Medical Cost Share - Freedom 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 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]	$8,550		No Out-of-Pocket Maximum
Family Out-of-Pocket Maximum[1]	$17,100		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	$65 Co-pay per visit	$75 Co-pay per visit	50% Co-insurance+
Office Labs	100% Coverage (some labs may be subject to deductible)		50% Co-insurance+
Diagnostic Services	100% Coverage*		50% Co-insurance+
Major Diagnostic Testing	$200 Co-pay per test*	$300 Co-pay per test*	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	$65 Co-pay per visit	$75 Co-pay per visit	50% Co-insurance+
Inpatient Services			
Inpatient Semi-Private Room	$100 copay reduction*	$1,500/day, days 1-3*	50% Co-insurance+
Physician Services	100% Coverage*		50% Co-insurance+
Outpatient Services			
Ambulatory Surgery Unit or Outpatient Surgery	$100 copay reduction*	$1,000 Co-pay*	50% Co-insurance+
Observation Stay	$100 copay reduction*	$1,500/day, days 1-3*	50% Co-insurance+
Physician Services	100% Coverage*		50% Co-insurance+
Lab Services	100% Coverage (some labs may be subject to deductible)		50% Co-insurance+
Major Diagnostic Testing	$200 Co-pay per test*	$300 Co-pay per test*	50% Co-insurance+
Other Hospital Outpatient Services	Up to $200 Co-pay per test*	Up to $300 Co-pay per test*	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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Emergency Services			
Emergency Room	$450 Co-pay per visit; waived if admitted within 24 hours*		
Ambulance	30% Co-insurance*		
Durable Medical Equipment			
Durable Medical Equipment	30% Co-insurance*		50% Co-insurance+
Extended Care Services			
Long-Term Acute Care Facility	$150 Co-pay per day*		50% Co-insurance+
Rehabilitation Facility	$150 Co-pay per day*		50% Co-insurance+
Skilled Nursing Facility	$150 Co-pay per day*		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	$40 Co-pay per visit*		50% Co-insurance+
Outpatient Rehabilitative Services	$40 Co-pay per visit*		50% Co-insurance+
Vision Services			
Vision Exam	$65 Co-pay per visit	$75 Co-pay per visit	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	$1,500/day, days 1-3*		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	$1,500/day, days 1-3*		50% Co-insurance+
Approved Transplant Services			
Approved Transplant Services	Applicable Inpatient or ASU/Outpatient Surgery Co-payment*		Not Covered

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*Benefit is subject to the In-Network Medical Deductible.

+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
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	$60 Co-payment
Tier IV Prescription Drugs	
All Pharmacies	$100 Co-payment
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 In-Network 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 *$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.