Medical Cost Share - Savings 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.

	In-Network	Out-of-Network
Individual Medical and Drug Deductible Combined	$7,000	$8,000
Family Medical and Drug Deductible Combined	$14,000	$16,000
Individual Out-of-Pocket Maximum[+]	$7,000	No Out-of-Pocket Maximum
Family Out-of-Pocket Maximum[+]	$14,000	No Out-of-Pocket Maximum
Co-insurance	100% Covered	50% Co-insurance
Office Visits and Services		
Primary Care Provider Office Visit	100% Covered*	50% Co-insurance[+]
Chiropractor	100% Covered*	50% Co-insurance[+]
OB/GYN	100% Covered*	50% Co-insurance[+]
Maternity Office Visit	100% Covered*	50% Co-insurance[+]
Specialty Care Provider Office Visit	100% Covered*	50% Co-insurance[+]
Office Labs	100% Covered*	50% Co-insurance[+]
Diagnostic Services	100% Covered*	50% Co-insurance[+]
Major Diagnostic Testing	100% Covered*	50% Co-insurance[+]
Wellness & Preventive Care	100% Covered	50% Co-insurance
After-Hours/Walk-In Clinics	100% Covered*	50% Co-insurance[+]
Urgent Care Centers	100% Covered*	50% Co-insurance[+]
Inpatient Services		
Inpatient Semi-Private Room	100% Covered*	50% Co-insurance[+]
Physician Services	100% Covered*	50% Co-insurance[+]
Outpatient Services		
Ambulatory Surgery Unit or Outpatient Surgery	100% Covered*	50% Co-insurance[+]
Observation Stay	100% Covered*	50% Co-insurance[+]
Physician Services	100% Covered*	50% Co-insurance[+]
Lab Services	100% Covered*	50% Co-insurance[+]
Major Diagnostic	100% Covered*	50% Co-insurance[+]
Other Hospital Outpatient Services	100% Covered*	50% Co-insurance[+]
Emergency Services		
Emergency Room	100% Covered*	
Ambulance	100% Covered*	

[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 and Drug 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	100% Covered*	50% Co-insurance+
Extended Care Services		
Long-Term Acute Care Facility	100% Covered*	50% Co-insurance+
Rehabilitation Facility	100% Covered*	50% Co-insurance+
Skilled Nursing Facility	100% Covered*	50% Co-insurance+
Other Covered Services		
Anti-cancer/Radiation Therapy	100% Covered*	50% Co-insurance*
Cardiac Rehabilitation	100% Covered*	50% Co-insurance*
Diabetes Management	100% Covered*	50% Co-insurance*
Dialysis	100% Covered*	50% Co-insurance*
Home Health Care	100% Covered*	Not Covered
Hospice	100% Covered*	Not Covered
Nutritional Counseling	100% Covered*	50% Co-insurance+
Outpatient Habilitative Services	100% Covered*	50% Co-insurance+
Outpatient Rehabilitative Services	100% Covered*	50% Co-insurance+
Vision Services		
Routine Vision Exam	100% Covered*	50% Co-insurance+
Glasses and Contacts for Children	100% Covered*	50% Co-insurance+
Mental Health Services		
Outpatient Mental Health Services (Physician)	100% Covered*	50% Co-insurance+
Inpatient Mental Health Services	100% Covered*	50% Co-insurance+
Alcohol and Chemical Dependency		
Outpatient Alcohol/Chemical Dependency (Physician)	100% Covered*	50% Co-insurance+
Inpatient Alcohol/Chemical Dependency	100% Covered*	50% Co-insurance+
Approved Transplant Services		
Approved Transplant Services	100% Covered*	Not Covered

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Prescription Drug Cost Share

IN-NETWORK PRESCRIPTION DRUG MEMBER COST SHARE	
Prescription Drug Deductible	Included in the In-Network Medical and Drug Deductible. Applies to all Prescription Drug Tiers.
Prescription Drug Out-of-Pocket Maximum	Included in the In-Network Out-of-Pocket Maximum
Retail or Mail Order 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.	
Tier I Prescription Drugs	
Affinity Health Network Pharmacies*	100% Coverage
All Other Pharmacies	100% Coverage
Tier II Prescription Drugs	
All Pharmacies	100% Coverage
Tier III Prescription Drugs	
All Pharmacies	100% Coverage
Tier IV Prescription Drugs	
All Pharmacies	100% Coverage
Tier V Prescription Drugs	
Participating Specialty Pharmacies	100% Coverage
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.

*This benefit may not be available for some out-of-state members. The mail order benefit is administered by Saint John Pharmacy and is only available for a 100-day supply. Not subject to In-Network Deductible.

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 services are not subject to any deductible on your plan.
  - *Comprehensive Dental services for children are subject to the applicable deductible. Comprehensive Dental services for adults are not subject to any deductible.
  - 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.