Medical Cost Share - Freedom Plan
Plan Year 2023

	AHN Providers	In-Network	Out-of-Network
Individual Medical Deductible	$3,000		$5,000
Family Medical Deductible	$9,000		$15,000
Individual Out-of-Pocket Maximum[1]	$7,250		No Out-of-Pocket Maximum
Family Out-of-Pocket Maximum[1]	$14,500		No Out-of-Pocket Maximum
Co-insurance	30% Co-insurance		50% Co-insurance
Office Visits and Services			
Primary Care Provider (Office Visit & Telehealth Services)	$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 & Telehealth Services)	$50 Co-pay per visit	$60 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	$20 Co-pay per visit	$30 Co-pay per visit	50% Co-insurance+
Urgent Care Centers	$50 Co-pay per visit	$60 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+
Emergency Services			
Emergency Room	$450 Co-pay per visit; waived if admitted within 24 hours*		
Ambulance	30% 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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Plan Year 2023

	AHN Providers	In-Network	Out-of-Network
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	$20 Co-pay per visit	$30 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	$20 Co-pay per visit	$30 Co-pay per visit	50% Co-insurance+
Outpatient Habilitative Services	$30 Co-pay per visit*		50% Co-insurance+
Outpatient Rehabilitative Services	$30 Co-pay per visit*		50% Co-insurance+
Vision Services			
Vision Exam	$50 Co-pay per visit	$60 Co-pay per visit	50% Co-insurance+
Glasses and Contacts for Children	50% Co-insurance		50% Co-insurance+
Glasses and Contacts for Adults	100% Coverage; $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	$1,500/day, days 1-3*		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	$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 Out-of-Network Medical Deductible.

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Prescription Drug Cost Share

IN-NETWORK PRESCRIPTION DRUG MEMBER COST SHARE	
Prescription Drug Deductible	$500 Individual; $1,500 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	
DeSiard Pharmacy 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	
DeSiard Pharmacy 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.

**The DeSiard Pharmacy Network Pharmacies 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 *$1,000 combined Basic and Major benefit maximum for adults.*	Adults and Children	**Children:** 50% Co-insurance **Adults:** 100% Coverage	**Children:** 50% Co-insurance **Adults:** 100% Coverage
Orthodontia	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.