



Medical Cost Share - Standard Plan Plan Year 2023

	AHN Providers	In-Network	Out-of-Network
Combined Individual Medical and Drug Deductible	\$0		\$5,000
Combined Family Medical and Drug Deductible	\$0		\$15,000
Individual Out-of-Pocket Maximum ¹	\$1,800		No Out-of-Pocket Maximum
Family Out-of-Pocket Maximum ¹	\$3,600		No Out-of-Pocket Maximum
Co-insurance	25% Co-insurance		50% Co-insurance
Office Visits and Services			
Primary Care Provider (Office Visit & Telehealth Services)	\$0 Co-pay per visit		50% Co-insurance ⁺
Chiropractor	\$0 Co-pay per visit		50% Co-insurance ⁺
OB/GYN	\$0 Co-pay per visit		50% Co-insurance ⁺
Maternity Office Visit (initial visit only)	\$0 Co-pay per visit		50% Co-insurance ⁺
Specialty Care Provider (Office Visit & Telehealth Services)	\$0 Co-pay per visit	\$10 Co-pay per visit	50% Co-insurance ⁺
Office Labs	25% Co-insurance		50% Co-insurance ⁺
Diagnostic Services	25% Co-insurance		50% Co-insurance ⁺
Major Diagnostic Testing	25% Co-insurance		50% Co-insurance ⁺
Wellness & Preventive Care	100% Coverage		50% Co-insurance
After-Hours/Walk-In Clinics	\$0 Co-pay per visit		50% Co-insurance ⁺
Urgent Care Centers	\$5 Co-pay per visit		50% Co-insurance ⁺
Inpatient Services			
Inpatient Semi-Private Room	25% Co-insurance		50% Co-insurance ⁺
Physician Services	25% Co-insurance		50% Co-insurance ⁺
Outpatient Services			
Ambulatory Surgery Unit or Outpatient Surgery	25% Co-insurance		50% Co-insurance ⁺
Observation Stay	25% Co-insurance		50% Co-insurance ⁺
Physician Services	25% Co-insurance		50% Co-insurance ⁺
Lab Services	25% Co-insurance		50% Co-insurance ⁺
Major Diagnostic Testing	25% Co-insurance		50% Co-insurance ⁺
Other Hospital Outpatient Services	25% Co-insurance		50% Co-insurance ⁺
Emergency Services			
Emergency Room	25% Co-insurance per visit; waived if admitted within 24 hours		
Ambulance	25% 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 Combined 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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	AHN Providers	In-Network	Out-of-Network
Durable Medical Equipment			
Durable Medical Equipment	25% Co-insurance		50% Co-insurance ⁺
Extended Care Services			
Long-Term Acute Care Facility	25% Co-insurance		50% Co-insurance ⁺
Rehabilitation Facility	25% Co-insurance		50% Co-insurance ⁺
Skilled Nursing Facility	25% Co-insurance		50% Co-insurance ⁺
Other Covered Services			
Anti-cancer/Radiation Therapy	25% Co-insurance		50% Co-insurance ⁺
Cardiac Rehabilitation	25% Co-insurance		50% Co-insurance ⁺
Diabetes Management	\$0 Co-pay per visit		50% Co-insurance ⁺
Dialysis	25% Co-insurance		50% Co-insurance ⁺
Home Health Care	25% Co-insurance		Not Covered
Hospice	25% Co-insurance		Not Covered
Nutritional Counseling	\$0 Co-pay per visit		50% Co-insurance ⁺
Outpatient Habilitative Services	\$0 Co-pay per visit		50% Co-insurance ⁺
Outpatient Rehabilitative Services	\$0 Co-pay per visit		50% Co-insurance ⁺
Vision Services			
Vision Exam	\$0 Co-pay per visit	\$10 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 maximum benefit		50% Co-insurance
Mental Health Services			
Outpatient Mental Health Services (Physician)	\$0 Co-pay per visit		50% Co-insurance ⁺
Inpatient Mental Health Services	25% Co-insurance		50% Co-insurance ⁺
Alcohol and Chemical Dependency			
Outpatient Alcohol/Chemical Dependency (Physician)	\$0 Co-pay per visit		50% Co-insurance ⁺
Inpatient Alcohol/Chemical Dependency	25% Co-insurance		50% Co-insurance ⁺
Approved Transplant Services			
Approved Transplant Services	25% 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

<u>IN-NETWORK PRESCRIPTION DRUG MEMBER COST SHARE</u>	
Prescription Drug Deductible	Included in the In-Network Deductible. No Prescription Drug Tiers apply to the In-Network Deductible.
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	\$0 Co-payment
Tier II Prescription Drugs	
All Pharmacies	\$0 Co-payment
Tier III Prescription Drugs	
All Pharmacies	\$5 Co-payment
Tier IV Prescription Drugs	
All Pharmacies	\$10 Co-payment
Tier V Prescription Drugs	
All Pharmacies	\$20 Co-payment
Tier VI Prescription Drugs	
All Pharmacies	100% Coverage

<u>DIABETIC SUPPLIES AND METERS</u>	
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 <i>\$1,000 combined Basic and Major benefit maximum for adults.</i>	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.

- **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.