



# COST SHARE SCHEDULE



**OGB MEDICAL HOME HMO PLAN  
EFFECTIVE JANUARY 1, 2023**

## MEDICAL MEMBER COST SHARE

<b>In-Network Medical Deductible</b>	<b>\$400 Individual</b> <b>\$800 Individual + 1 family member</b> <b>\$1,200 Family (Individual + 2 or more family members)</b>  <i>Retirees prior to 3/1/2015 (with or without Medicare):</i> <b>\$0 Individual</b> <b>\$0 Individual + 1 family member</b> <b>\$0 Family (Individual + 2 or more family members)</b>
<b>Out-of-Network Medical Deductible</b>	<b>\$2,000 Individual</b> <b>\$4,000 Individual + 1 family member</b> <b>\$6,000 Family (Individual + 2 or more family members)</b>
<b>Cost Share after Applicable Medical Deductible</b>	<b>In-Network Benefits: See Below</b> <b>Out-of-Network Benefits: 50% Co-insurance based on the Vantage Allowable, may be balance-billed</b>
<b>In-Network Medical Out-of-Pocket Maximum</b> <i>(includes In-Network Medical Deductible)</i>	<b>\$3,500 Individual</b> <b>\$6,000 Individual + 1 family member</b> <b>\$8,500 Family (Individual + 2 or more family members)</b>  <i>Retirees prior to 3/1/2015 (with or without Medicare):</i> <b>\$2,000 Individual</b> <b>\$3,000 Individual + 1 family member</b> <b>\$4,000 Family (Individual + 2 or more family members)</b>
<b>Out-of-Network Out-of-Pocket Maximum</b>	<b>Not applicable.</b>

## AFFINITY HEALTH NETWORK (AHN)

This Plan includes a preferred provider network, Affinity Health Network (AHN), which has lower copayments for certain Covered Services as indicated by "AHN" below.

## IN-NETWORK PROVIDERS

### **Physician Office Services**

Primary Care Provider (AHN PCP)	<b>\$20</b> AHN PCP office visit Co-payment
Primary Care Provider (PCP)	<b>\$40</b> PCP office visit Co-payment
Chiropractor	<b>\$40</b> Chiropractor office visit Co-payment
Specialty Care (AHN)	<b>\$45</b> AHN Specialty Care office visit Co-payment
Specialty Care	<b>\$65</b> Specialty Care office visit Co-payment
Office Diagnostic Services <i>(excludes Major Diagnostic testing and ultrasounds)</i>	100% coverage
Lab Services	100% coverage
Major Diagnostic Testing and Ultrasounds (AHN)	<b>\$25</b> AHN Co-payment per test
Major Diagnostic Testing and Ultrasounds	<b>\$50</b> Co-payment per test

**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, prior authorization requirements, exclusions, and limitations. Search for current providers at [www.VHP-StateGroup.com](http://www.VHP-StateGroup.com) or call Member Services at (318) 998-4435 or toll-free (844) 536-7104.**



# COST SHARE SCHEDULE



## OGB MEDICAL HOME HMO PLAN EFFECTIVE JANUARY 1, 2023

In-Network Covered Services:	In-Network Benefit:
<b>Maternity-Related Services</b>	
Office Visit	\$20 AHN or \$40 office visit Co-payment (initial visit only)
Office Diagnostic Services <i>(excludes Major Diagnostic testing and ultrasounds)</i>	100% coverage
Lab Services	100% coverage
Initial Ultrasounds	100% coverage for initial 4 ultrasounds
Major Diagnostic Testing/Additional Ultrasounds (AHN)	\$25 AHN Co-payment per test
Major Diagnostic Testing/Additional Ultrasounds	\$50 Co-payment per test
<b>Wellness &amp; Preventive Care</b>	
Annual Examination	100% coverage
Immunizations & Vaccines	100% coverage
Men's, Women's and Children's Health	100% coverage
<b>Inpatient Hospital Services</b>	
Inpatient Semi-Private Room (AHN)	\$100 AHN Co-payment per day for days 1-3, \$300 max per stay
Inpatient Semi-Private Room	\$250 Co-payment per day for days 1-3, \$750 max per stay
Physician Services	100% coverage*
<b>Outpatient Hospital Services</b>	
Observation Stay (AHN)	\$100 AHN Co-payment per day for days 1-3, \$300 max per stay
Observation Stay	\$250 Co-payment per day for days 1-3, \$750 max per stay
Physician Services	100% coverage*
Ambulatory Surgery (ASU)/Outpatient Surgery (AHN)	\$100 AHN Co-payment
Ambulatory Surgery (ASU)/Outpatient Surgery	\$250 Co-payment
Major Diagnostic Testing and Ultrasounds (AHN)	\$25 AHN Co-payment per test
Major Diagnostic Testing and Ultrasounds	\$50 Co-payment per test
Lab Services	100% coverage
Other Hospital Outpatient Services	100% coverage*
<b>Emergency Medical Services</b>	
Emergency Room	\$200 Co-payment per visit (waived if admitted)
Physician Services	100% coverage*
Ambulance	\$50 Co-payment for ground ambulance per trip; \$250 Co-payment for air ambulance per trip
<b>Durable Medical Equipment and Supplies</b>	
	20% Co-insurance* up to \$5,000 of the Vantage Allowable; 100% covered after first \$5,000 of the Vantage Allowable
<b>After-Hours/Walk-In Clinics (AHN)</b>	
<b>After-Hours/Walk-In Clinics</b> <i>(Diagnostic services may be subject to Deductible.)</i>	\$20 AHN PCP office visit Co-payment
<b>Urgent Care Services</b>	\$40 PCP office visit Co-payment
	\$65 Co-payment per visit
<b>Extended Care Facilities</b>	
Long-Term Acute Care Facility	\$250 Co-payment per day for days 1-3, \$750 max per stay
Rehabilitation Facility	
Skilled Nursing Facility	
Extended Care Facilities Physician Services	100% coverage*

Covered services that are subject to the In-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, prior authorization requirements, exclusions, and limitations. Search for current providers at [www.VHP-StateGroup.com](http://www.VHP-StateGroup.com) or call Member Services at (318) 998-4435 or toll-free (844) 536-7104.

In-Network Covered Services:	In-Network Benefit:
<b>Other Covered Services</b>	
Allergenic Testing	20% Co-insurance*
Autism Spectrum Disorders	\$20 AHN or \$40 office visit Co-payment
Cardiac Rehabilitation	\$45 AHN or \$65 Co-payment
Chemotherapy/Radiation Therapy (Office)	\$65 Co-payment
Chemotherapy/Radiation Therapy (Outpatient)	100% coverage*
Diabetes Management	\$20 AHN or \$40 office visit Co-payment
Dialysis	100% coverage*
Home Health Care	100% coverage*
Hospice	100% coverage*
Nutritional Counseling	\$20 AHN or \$40 office visit Co-payment
Occupational and Speech Therapy	\$20 AHN or \$40 office visit Co-payment
Physical Therapy	\$20 AHN or \$40 office visit Co-payment
<b>Mental Health and Alcohol &amp; Chemical Dependency Services</b>	
Outpatient Mental Health Services	\$20 AHN or \$ 40 PCP office visit Co-payment
Inpatient Mental Health Services	\$250 Co-payment per day for days 1-3, \$750 max per stay
Outpatient Alcohol & Chemical Dependency	\$40 PCP office visit Co-payment
Inpatient Alcohol & Chemical Dependency	\$250 Co-payment per day for days 1-3, \$750 max per stay
Inpatient Physician Services	100% coverage*
<b>Vision Services</b>	
Routine Vision Exam	\$45 AHN or \$65 Specialty Care office visit Co-payment
Glasses and Contacts	50% Co-insurance; \$100 max benefit
<b>Dental Services</b>	
Preventive Dental Exam and Cleaning	100% coverage of the Vantage Allowable
Comprehensive Dental Services	50% Co-insurance; \$500 maximum benefit

\*Covered services that are subject to the In-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, prior authorization requirements, exclusions, and limitations. Search for current providers at [www.VHP-StateGroup.com](http://www.VHP-StateGroup.com) or call Member Services at (318) 998-4435 or toll-free (844) 536-7104.

### PRESCRIPTION DRUG MEMBER COST SHARE

#### Prescription Drug Deductible

#### No Prescription Drug Deductible.

#### In-Network Retail Prescription Drugs (30-day supply)

##### Tier I Prescription Drugs:

- Preferred Pharmacies **100%** coverage
- All other Pharmacies **\$15** Co-payment per prescription up to 30-day supply

##### Tier II Prescription Drugs:

**\$40** Co-payment per prescription up to 30-day supply

##### Tier III Prescription Drugs

**\$75** Co-payment per prescription up to 30-day supply

##### Tier IV Prescription Drugs:

**\$100** Co-payment per prescription up to 30-day supply

##### Tier V Prescription Drugs:

**\$150** Co-payment per prescription up to 30-day supply

##### Tier VI Preventive Prescription Drugs:

**100%** coverage

#### Mail Order Prescription Drugs:

##### Tier I Prescription Drugs:

- Preferred Pharmacies 100-day supply for **\$0** AHN Co-payment
- Other Pharmacies Prescription Drug Co-payments apply.  
30-day supply for 1 Co-payment  
60-day supply for 2 Co-payments  
100-day supply for 3 Co-payments

##### Tiers II, III and IV:

*All Pharmacies*

30-day supply for 1 Co-payment  
60-day supply for 2 Co-payments  
100-day supply for 3 Co-payments

##### Tier V:

30-day supply for 1 Co-payment  
60-day and 100-day supplies are not available.

##### Tier VI:

**100%** coverage

#### Diabetic Supplies and Meters:

Preferred Pharmacies

**\$0** Co-payment

All Other Pharmacies

Prescription Drug Co-payments apply.

**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, prior authorization requirements, exclusions, and limitations. Search for current providers at [www.VHP-StateGroup.com](http://www.VHP-StateGroup.com) or call Member Services at (318) 998-4435 or toll-free (844) 536-7104.**