COST SHARE SCHEDULE
ESSENTIAL 3000
SHORT-TERM PLAN
PLAN YEAR 2019

MEMBER COST SHARE	
Medical Deductible	**In-Network Benefits: $3,000** **Out-of-Network Benefits: $15,000**
In-Network Providers	**Co-payment for primary care office visits.** **30% Co-insurance of the Vantage Allowable after the In-Network Deductible on all other benefits.**
Out-of-Network Providers *(excluding Emergency Medical Services)*	**50% Co-insurance of the Vantage Allowable after the Out-of-Network Deductible.**
Out-of-Pocket Maximum	**In-Network Benefits: $7,000** **Out-of-Network Benefits: No Out-of-Pocket Maximum**
Combined Benefit Maximum (Maximum coverage by Vantage during the Benefit Period for total In-Network and Out-of-Network Covered Services)	**$1,000,000**
Out-of-Network Benefit Maximum (included in the Combined Benefit Maximum)	**$100,000**

IN-NETWORK PROVIDERS	
In-Network Covered Services:	**In-Network Cost Share:**
Physician Office Services	
Medical Home Primary Care Provider (MH-PCP) and After Hours/Walk-In Clinics:	
Office Visit	**$50** Co-payment (Not subject to Deductible)
Office Diagnostic Services – Lab, X-ray, Other	**30%** Co-insurance up to the Out-of-Pocket Maximum
Specialty Care Provider	**30%** Co-insurance up to the Out-of-Pocket Maximum
Inpatient Hospital Services Inpatient Semi-Private Room, Physician Services	**30%** Co-insurance up to the Out-of-Pocket Maximum
Ambulatory Surgery Unit or Outpatient Surgery	**30%** Co-insurance up to the Out-of-Pocket Maximum
Outpatient Services Hospital Observation Stay, Physician Services Major Diagnostic Testing Lab and Other Outpatient Services	**30%**Co-insurance up to the Out-of-Pocket Maximum
Emergency Medical Services Emergency Room Ground Ambulance	**30%** Co-insurance up to the Out-of-Pocket Maximum
Urgent Care Centers	**30%** Co-insurance up to the Out-of-Pocket Maximum
Other Covered Services Chemotherapy/Radiation Therapy Diabetes Management Dialysis Nutritional Counseling Physical, Occupational and Speech Therapy	**30%** Co-insurance up to the Out-of-Pocket Maximum

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. Search for current providers at www.VantageHealthPlan.com or call Member Services at (855) 934-6847.

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Non-Covered Services:

- Air Ambulance
- Cardiac Rehabilitation
- Drugs, both Prescription and non-Prescription
- Durable and Disposable Medical Equipment
- Exclusions as listed in the Certificate of Coverage
- Extended Care Facilities (Skilled Nursing, LTAC, Rehabilitation)
- Home Health
- Hospice
- Interpreter Services (Deaf/Hard of Hearing)
- Low Protein Foods
- Maternity-related Services
- Mental Health and Substance Abuse Services
- Pain Management
- Planned or Elective Procedures for conditions that existed at the time of enrollment, regardless of whether diagnosed or reported prior to enrollment
- Reconstructive or cosmetic surgery other than mastectomy as covered under this plan
- Self-Inflicted, Leaving against Medical Advice, Drug/Alcohol Injuries
- Vision and Dental Services

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