



**COST SHARE SCHEDULE  
HIGH DEDUCTIBLE 2000  
SHORT-TERM PLAN  
PLAN YEAR 2019**

<b>MEMBER COST SHARE</b>	
<b>Medical Deductible</b>	<b>In-Network Benefits: \$2,000 Out-of-Network Benefits: \$5,000</b>
<b>In-Network Providers</b>	<b>20% Co-insurance of the Vantage Allowable after the In-Network Deductible on all other benefits.</b>
<b>Out-of-Network Providers</b> <i>(excluding Emergency Medical Services)</i>	<b>50% Co-insurance of the Vantage Allowable after the Out-of-Network Deductible.</b>
<b>Out-of-Pocket Maximum</b>	<b>In-Network Benefits: \$5,000 Out-of-Network Benefits: No Out-of-Pocket Maximum</b>
<b>Combined Benefit Maximum</b> <i>(Maximum coverage by Vantage during the Benefit Period for total In-Network and Out-of-Network Covered Services)</i>	<b>\$1,000,000</b>
<b>Out-of-Network Benefit Maximum</b> <i>(included in the Combined Benefit Maximum)</i>	<b>\$100,000</b>

<b>IN-NETWORK PROVIDERS</b>	
<b>In-Network Covered Services:</b>	<b>In-Network Cost Share:</b>
<b>Physician Office Services</b>	
Medical Home Primary Care Provider (MH-PCP) and After Hours/Walk-In Clinics:	
Office Visit	<b>20% Co-insurance up to the Out-of-Pocket Maximum</b>
Office Diagnostic Services – Lab, X-ray, Other	<b>20% Co-insurance up to the Out-of-Pocket Maximum</b>
Specialty Care Provider	<b>20% Co-insurance up to the Out-of-Pocket Maximum</b>
<b>Inpatient Hospital Services</b>	<b>20% Co-insurance up to the Out-of-Pocket Maximum</b>
Inpatient Semi-Private Room, Physician Services	
<b>Ambulatory Surgery Unit or Outpatient Surgery</b>	<b>20% Co-insurance up to the Out-of-Pocket Maximum</b>
<b>Outpatient Services</b>	<b>20% Co-insurance up to the Out-of-Pocket Maximum</b>
Hospital Observation Stay, Physician Services	
Major Diagnostic Testing	
Lab and Other Outpatient Services	
<b>Emergency Medical Services</b>	<b>20% Co-insurance up to the Out-of-Pocket Maximum</b>
Emergency Room	
Ground Ambulance	
<b>Urgent Care Centers</b>	<b>20% Co-insurance up to the Out-of-Pocket Maximum</b>
<b>Other Covered Services</b>	<b>20% Co-insurance up to the Out-of-Pocket Maximum</b>
Chemotherapy/Radiation Therapy	
Diabetes Management	
Dialysis	
Nutritional Counseling	
Physical, Occupational and Speech Therapy	



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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