COST SHARE SCHEDULE

OGB MEDICAL HOME HMO PLAN
EFFECTIVE JANUARY 1, 2017

MEDICAL MEMBER COST SHARE	
In-Network Medical Deductible	**$400 Individual** **$800 Individual + 1 family member** **$1,200 Family (Individual + 2 or more family members)** ***Retirees prior to 3/1/2015 (with or without Medicare):*** **$0 Individual** **$0 Individual + 1 family member** **$0 Family (Individual + 2 or more family members)**
Out-of-Network Medical Deductible	**$1,500 Individual** **$3,000 Individual + 1 family member** **$4,500 Family (Individual + 2 or more family members)**
Cost Share after Applicable Medical Deductible	**In-Network Benefits: See Below** **Out-of-Network Benefits: 50% Co-insurance based on the Vantage Allowable, may be balance-billed**
In-Network Medical Out-of-Pocket Maximum *(includes In-Network Medical Deductible)*	**$2,500 Individual** **$5,000 Individual + 1 family member** **$7,500 Family (Individual + 2 or more family members)** ***Retirees prior to 3/1/2015 (with or without Medicare):*** **$1,000 Individual** **$2,000 Individual + 1 family member** **$3,000 Family (Individual + 2 or more family members)**
Out-of-Network Out-of-Pocket Maximum	**Not applicable.**

AFFINITY HEALTH NETWORK (AHN)

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

IN-NETWORK PROVIDERS

Physician Office Services	
Medical Home Primary Care Provider (AHN MH-PCP)	**$10** AHN MH-PCP office visit Co-payment
Medical Home Primary Care Provider (MH-PCP)	**$20** MH-PCP office visit Co-payment
Chiropractor	**$20** Chiropractor office visit Co-payment
Specialty Care (AHN)	**$35** AHN Specialty Care office visit Co-payment
Specialty Care	**$45** Specialty Care office visit Co-payment
Office Diagnostic Services *(excludes Major Diagnostic testing and ultrasounds)*	100% coverage
Lab Services	100% coverage
Major Diagnostic Testing and Ultrasounds (AHN)	**$0** AHN Co-payment per test
Major Diagnostic Testing and Ultrasounds	**$50** Co-payment per test

***In-Network covered services that *are* subject to the applicable Medical Deductible.**

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EFFECTIVE JANUARY 1, 2017

In-Network Covered Services:	In-Network Benefit:
Maternity-Related Services	
Office Visit (AHN)	**$10** AHN MH-PCP office visit Co-payment *(initial visit only)*
Office Visit	**$20** MH-PCP office visit Co-payment *(initial visit only)*
Office Diagnostic Services *(excludes Major Diagnostic testing and ultrasounds)*	100% coverage
Lab Services	100% coverage
Major Diagnostic Testing (AHN)	**$0** AHN Co-payment per test
Major Diagnostic Testing	**$50** Co-payment per test
Ultrasounds	100% coverage for initial 2 ultrasounds
Wellness & Preventive Care	
Annual Examination	100% coverage
Immunizations & Vaccines	100% coverage
Men's, Women's and Children's Health	100% coverage
Inpatient Hospital Services	
Inpatient Semi-Private Room (AHN)	**$50** AHN Co-payment per day for days 1-3, **$150** max per stay
Inpatient Semi-Private Room	**$100** Co-payment per day for days 1-3, **$300** max per stay
Physician Services	100% coverage*
Outpatient Hospital Services	
Observation Stay (AHN)	**$50** AHN Co-payment per day for days 1-3, **$150** max per stay
Observation Stay	**$100** Co-payment per day for days 1-3, **$300** max per stay
Physician Services	100% coverage*
Ambulatory Surgery (ASU)/Outpatient Surgery (AHN)	**$50** AHN Co-payment
Ambulatory Surgery (ASU)/Outpatient Surgery	**$100** Co-payment
Major Diagnostic Testing and Ultrasounds (AHN)	**$0** 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
Emergency Medical Services	
Emergency Room	**$150** Co-payment per visit (waived if admitted)
Physician Services	100% coverage*
Ambulance	**$50** Co-payment for ground ambulance; **$250** Co-payment for air ambulance
Durable Medical Equipment and Supplies	**20%** Co-insurance* up to $5,000 of the Allowable; 100% covered* after first $5,000
After-Hours/Walk-In Clinics (AHN)	**$10** AHN MH-PCP office visit Co-payment
After-Hours/Walk-In Clinics (Diagnostic services may be subject to Deductible.)	**$20** MH-PCP office visit Co-payment
Urgent Care Services	**$50** Co-payment per visit
Extended Care Facilities	**$100** Co-payment per day for days 1-3, **$300** max per stay
Long-Term Acute Care Facility	
Rehabilitation Facility	
Skilled Nursing Facility	
Extended Care Facilities Physician Services	100% coverage*

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EFFECTIVE JANUARY 1, 2017

In-Network Covered Services:	In-Network Benefit:
Other Covered Services	
Accidental Dental	**20%** Co-insurance*
Allergenic Testing	**20%** Co-insurance*
Autism Spectrum Disorders	**$10** AHN or **$20** office visit Co-payment
Cardiac Rehabilitation (Office)	**$20** MH-PCP or **$45** Specialty Co-payment
Cardiac Rehabilitation (Outpatient)	**$50** Co-payment
Chemotherapy/Radiation Therapy (Office)	**$20** Co-payment
Chemotherapy/Radiation Therapy (Outpatient)	100% coverage*
Diabetes Management	**$10** AHN or **$20** office visit Co-payment
Dialysis	100% coverage*
Home Health Care	100% coverage*
Hospice	100% coverage*
Nutritional Counseling	**$10** AHN or **$20** office visit Co-payment
Occupational and Speech Therapy	**$10** AHN or **$20** office visit Co-payment
Physical Therapy	**$10** AHN or **$20** office visit Co-payment
Supplementary Benefits (Alcohol- and Drug-related Injuries; Breast Reduction; Cochlear Implant; Leaving Against Medical Advice; Pain Management; Self-inflicted Injuries)	**40%** Co-insurance*
Mental Health and Alcohol & Chemical Dependency Services	
Outpatient Mental Health Services	**$10** AHN or **$20** MH-PCP office visit Co-payment
Inpatient Mental Health Services	**$100** Co-payment per day for days 1-3, **$300** max per stay
Outpatient Alcohol & Chemical Dependency	**$10** AHN or **$20** MH-PCP office visit Co-payment
Inpatient Alcohol & Chemical Dependency	**$100** Co-payment per day for days 1-3, **$300** max per stay
Inpatient Physician Services	100% coverage*
Vision Services	
Routine Vision Exam for Children	**$35** AHN or **$45** Specialty Care office visit Co-payment
Routine Vision Exam for Adults	**$35** AHN or **$45** Specialty Care office visit Co-payment
Glasses and Contacts	**50%** Co-insurance; **$100** max benefit for adults
Dental Services	
Routine Dental Exam and Cleaning	100% coverage of the Vantage Allowable
Additional Dental Services	**50%** Co-insurance; **$500** maximum benefit for adults
Approved Transplant Services	Applicable Inpatient or ASU/Outpatient Surgery Co-payment
Approved Transplant Physician Services	100% coverage*

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PRESCRIPTION DRUG MEMBER COST SHARE

Prescription Drug Deductible	**No Prescription Drug Deductible.**
In-Network Retail Prescription Drugs	
Tier I: Preferred Generic Prescription Drugs	**$5** Co-payment per prescription up to 30-day supply
Tier II: Non-Preferred Generic Prescription Drugs	**$20** Co-payment per prescription up to 30-day supply
Tier III: Preferred Brand Prescription Drugs	**$50** Co-payment per prescription up to 30-day supply
Tier IV: Non-Preferred Brand Prescription Drugs	**$80** Co-payment per prescription up to 30-day supply
Tier V: Specialty Prescription Drugs	**$150** Co-payment per prescription up to 30-day supply
Tier VI: Preventive Prescription Drugs	**100%** coverage
Mail Order Prescription Drugs: *(Not available for Tier V Specialty Prescription Drugs)*	
Tier I (Preferred Generic):	
Affinity Health Network – Saint John Pharmacy	90-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 90-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 90-day supply for 3 Co-payments
Diabetic Supplies and Meters:	
Affinity Health Network – Saint John Pharmacy	**$0** Co-payment
All Other Pharmacies	Prescription Drug Co-payments apply.

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