



OGB MEDICAL HOME HMO PLAN EFFECTIVE JANUARY 1, 2020

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	\$2,000 Individual \$4,000 Individual + 1 family member \$6,000 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)	\$3,500 Individual \$6,000 Individual + 1 family member \$8,500 Family (Individual + 2 or more family members)	
	Retirees prior to 3/1/2015 (with or without Medicare): \$2,000 Individual \$3,000 Individual + 1 family member \$4,000 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 copayments for certain Covered Services as indicated by "AHN" below.

IN-NETWORK PROVIDERS

Physician Office Services

Medical Home Primary Care Provider (AHN MH-PCP)
Medical Home Primary Care Provider (MH-PCP)
Chiropractor
Specialty Care (AHN)

\$10 AHN MH-PCP office visit Co-payment
\$25 MH-PCP office visit Co-payment
\$25 Chiropractor office visit Co-payment

Specialty Care (AHN) \$35 AHN Specialty Care office visit Co-payment \$50 Specialty Care office visit Co-payment

Specialty Care \$50 Specialty Care office visit Co-payment

Office Diagnostic Services 100% coverage (excludes Major Diagnostic testing and ultrasounds)

ab Services 100% coverage

Major Diagnostic Testing and Ultrasounds (AHN)

Major Diagnostic Testing and Ultrasounds

\$25 AHN Co-payment per test
\$50 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 or call Member Services at (318) 998-4435 or toll-free (844) 536-7104.





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After-Hours/Walk-In Clinics (Diagnostic services may be subject to Deductible.) Urgent Care Services Extended Care Facilities Long-Term Acute Care Facility Rehabilitation Facility Skilled Nursing Facility \$25 MH-PCP office visit Co-payment \$50 Co-payment per visit \$100 Co-payment per day for days 1-3, \$300 max per stay	After-Hours/Walk-In Clinics (AHN)	\$10 AHN 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 \$100 Co-payment per day for days 1-3, \$300 max per stay Long-Term Acute Care Facility Rehabilitation Facility Skilled Nursing Facility		A=0
Long-Term Acute Care Facility Rehabilitation Facility Skilled Nursing Facility		. , .
Rehabilitation Facility Skilled Nursing Facility		\$100 Co-payment per day for days 1-3, \$300 max per stay
Skilled Nursing Facility		
Extended Care Facilities Physician Services 100% coverage*		4000/
	Extended Care Facilities Physician Services	100% coverage*

^{*}Covered services that <u>are</u> 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 or call Member Services at (318) 998-4435 or toll-free (844) 536-7104.





OGB MEDICAL HOME HMO PLAN EFFECTIVE JANUARY 1, 2020

In-Network Covered Services:	In-Network Benefit:	
Other Covered Services		
Allergenic Testing	20% Co-insurance*	
Autism Spectrum Disorders	\$10 AHN or \$25 office visit Co-payment	
Cardiac Rehabilitation (AHN)	\$35 AHN Co-payment	
Cardiac Rehabilitation	\$50 Co-payment	
Chemotherapy/Radiation Therapy (Office)	\$25 Co-payment	
Chemotherapy/Radiation Therapy (Outpatient)	100% coverage*	
Diabetes Management	\$10 AHN or \$25 office visit Co-payment	
Dialysis	100% coverage*	
Home Health Care	100% coverage*	
Hospice	100% coverage*	
Nutritional Counseling	\$10 AHN or \$25 office visit Co-payment	
Occupational and Speech Therapy	\$10 AHN or \$25 office visit Co-payment	
Physical Therapy	\$10 AHN or \$25 office visit Co-payment	
Mental Health and Alcohol & Chemical Dependency Services		
Outpatient Mental Health Services	\$10 AHN or \$25 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	\$25 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 \$50 Specialty Care office visit Co-payment	
Routine Vision Exam for Adults	\$35 AHN or \$50 Specialty Care office visit Co-payment	
Glasses and Contacts	50% Co-insurance; \$100 max benefit (all members)	
Dental Services		
Preventive Dental Exam and Cleaning	100% coverage of the Vantage Allowable	
Additional Dental Services	50% Co-insurance; \$500 maximum benefit (all members)	
Approved Transplant Services	Applicable Inpatient or ASU/Outpatient Surgery Co-payment	
Approved Transplant Physician Services	100% coverage*	

^{*}Covered services that <u>are</u> subject to the In-Network Medical Deductible.

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PRESCRIPTION DRUG MEMBER COST SHARE

Prescription Drug Deductible No Prescription Drug Deductible.

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

Tier I Prescription Drugs:

100% coverage Affinity Health Network Pharmacies

\$10 Co-payment per prescription up to 30-day supply · All other Pharmacies

\$30 Co-payment per prescription up to 30-day supply Tier II Prescription Drugs: **\$55** Co-payment per prescription up to 30-day supply

Tier III Prescription Drugs **\$80** Co-payment per prescription up to 30-day supply

Tier IV Prescription Drugs:

\$150 Co-payment per prescription up to 30-day supply Tier V Prescription Drugs:

100% coverage Tier VI Preventive Prescription Drugs:

Mail Order Prescription Drugs:

Tier I Prescription Drugs:

 Affinity Health Network – Saint John Pharmacy 90-day supply for **\$0** AHN Co-payment

Prescription Drug Co-payments apply. Other Pharmacies

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: 30-day supply for 1 Co-payment

All Pharmacies 60-day supply for 2 Co-payments 90-day supply for 3 Co-payments

30-day supply for 1 Co-payment Tier V:

60-day and 90-day supplies are not available.

Tier VI: 100% coverage

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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