COST SHARE SCHEDULE

OGB MEDICAL HOME HMO PLAN
EFFECTIVE JANUARY 1, 2016

MEDICAL MEMBER COST SHARE	
Tier I 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)**
Tier II and 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	**Tier I Benefits: See Below** **Tier II Benefits: 20% Co-insurance plus Tier I Cost Share** **Out-of-Network Benefits: 50% Co-insurance based on the Vantage Allowable, may be balance-billed**
Tier I Medical Out-of-Pocket Maximum *(includes Tier I 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)**
Tier II and 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.

AHN and STANDARD NETWORK (TIER I) PROVIDERS

Physician Office Services	
Medical Home Primary Care Physician (AHN MH-PCP)	**$10** AHN MH-PCP office visit Co-payment
Medical Home Primary Care Physician (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.**

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.VHP-StateGroup.com or call Member Services at (318) 998-4434 or (844) 536-7104.

COST SHARE SCHEDULE*

OGB MEDICAL HOME HMO PLAN
EFFECTIVE JANUARY 1, 2016

Tier I Covered Services:	Tier I 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*

***In-Network covered services that *are* subject to the applicable 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, exclusions and limitations. Search for current providers at www.VHP-StateGroup.com or call Member Services at (318) 998-4434 or (844) 536-7104.

COST SHARE SCHEDULE*

OGB MEDICAL HOME HMO PLAN
EFFECTIVE JANUARY 1, 2016

Tier I Covered Services (continued):	Tier I 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 Co-payment; **$45** Specialty Co-payment
Cardiac Rehabilitation (Outpatient)	**$50** Co-payment
Chemotherapy/Radiation Therapy (Office)	**$20** MH-PCP 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 or **$35** AHN or **$45** Specialty Care 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 or **$35** AHN or **$45** Specialty Care 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
Routine Bitewing X-rays	100% coverage; **$50** maximum benefit for adults
Additional Dental Services	**50%** Co-insurance; **$500** maximum benefit for adults*
Approved Transplant Services	Applicable Inpatient or ASU/Outpatient Surgery Co-payment*

TIER II PROVIDERS	
Tier II Covered Services	**20%** Co-insurance in addition to the Tier I Cost Share* after applicable Medical Deductible

***In-Network covered services that *are* subject to the applicable 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, exclusions and limitations. Search for current providers at www.VHP-StateGroup.com or call Member Services at (318) 998-4434 or (844) 536-7104.

COST SHARE SCHEDULE*

OGB MEDICAL HOME HMO PLAN
EFFECTIVE JANUARY 1, 2016

PRESCRIPTION DRUG MEMBER COST SHARING

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 Prescription Drugs	**$50** Co-payment per prescription up to 30-day supply
Tier IV: Non-Preferred 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
Mail Order Prescription Drugs: *(Not available for Tier V Specialty Prescription Drugs)*	
Tier I:	
Affinity Health Network – Saint John Pharmacy	90-day supply for **$0** AHN Co-payment
Other Pharmacies	Prescription Drug Co-payments apply.
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.

***In-Network covered services that *are* subject to the applicable 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, exclusions and limitations. Search for current providers at www.VHP-StateGroup.com or call Member Services at (318) 998-4434 or (844) 536-7104.