



COST SHARE SCHEDULE

ESSENTIAL SILVER 3000-73
Plan Year 2019

MEMBER COST SHARE

Medical Deductibles	In-Network Benefits: \$3,000 Individual; \$9,000 Family** Out-of-Network Benefits: \$5,000 Individual; \$10,000 Family**
In-Network Providers	Co-payments vary and are listed below. 30% Co-insurance on other benefits (unless otherwise noted below)
Out-of-Network Providers (excluding Emergency Medical Services and Dental Services)	50% Co-insurance of the Vantage Allowable after the Deductible, unless otherwise noted. (No Out-of-Network coverage for Prescription Drugs, Private Duty Nursing, Transplants, Home Health and Hospice)
Out-of-Pocket Maximums (Medical and Prescription Drugs are combined.)	In-Network Benefits: \$5,200 Individual; \$10,400 Family** Out-of-Network Benefits: No Out-of-Pocket Maximum

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

In-Network Covered Services:	In-Network Cost Share:
Physician Office Services	
Medical Home Primary Care Provider (AHN)	\$30 AHN MH-PCP office visit Co-payment*
Medical Home Primary Care Provider	\$40 MH-PCP office visit Co-payment*
Chiropractor	\$40 chiropractor office visit Co-payment*
OB/GYN	\$40 office visit Co-payment*
Specialty Care (AHN)	30% Co-insurance up to the Out-of-Pocket Maximum
Specialty Care	30% Co-insurance up to the Out-of-Pocket Maximum
Office Diagnostic Services – Lab (May be subject to Deductible)	100% Coverage
Office Diagnostic Services – X-rays, other services	30% Co-insurance up to the Out-of-Pocket Maximum
Major Diagnostic Testing	30% Co-insurance up to the Out-of-Pocket Maximum
Maternity-Related Services	
Office Visit (AHN)	\$30 AHN Co-payment (<i>initial visit only</i>)*
Office Visit	\$40 Co-payment (<i>initial visit only</i>)*
Office Diagnostic Services – Lab (May be subject to Deductible)	100% Coverage
Office Diagnostic Services X-rays, other services	30% Co-insurance up to the Out-of-Pocket Maximum
Major Diagnostic Testing	30% Co-insurance up to the Out-of-Pocket Maximum
Ultrasounds	30% Co-insurance up to the Out-of-Pocket Maximum

***Not subject to Deductible.**

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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 (844) 833-7505.



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In-Network Covered Services (continued):	In-Network Cost Share:
Wellness & Preventive Care Annual Examination Immunizations & Vaccines Men's Health Women's Health Children's Health	100% Coverage* 100% Coverage* 100% Coverage* 100% Coverage* 100% Coverage*
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 Hospital Services Observation Stay Physician Services Major Diagnostic Testing Lab Services (May be subject to Deductible) Other Hospital Outpatient Services	30% Co-insurance up to the Out-of-Pocket Maximum
Emergency Medical Services Emergency Room Ambulance	30% Co-insurance up to the Out-of-Pocket Maximum
Durable Medical Equipment and Supplies (DME)	30% Co-insurance up to the Out-of-Pocket Maximum
After-Hours/Walk-In Clinics (AHN) After-Hours/Walk-In Clinics (Diagnostic services may be subject to Deductible.) Urgent Care Centers	\$30 AHN MH-PCP office visit Co-payment* \$40 MH-PCP office visit Co-payment* 30% Co-insurance up to the Out-of-Pocket Maximum
Extended Care Facilities Long-Term Acute Care Facility Rehabilitation Facility Skilled Nursing Facility	30% Co-insurance up to the Out-of-Pocket Maximum 30% Co-insurance up to the Out-of-Pocket Maximum 30% Co-insurance up to the Out-of-Pocket Maximum

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In-Network Covered Services (continued):	In-Network Cost Share:
Other Covered Services	
Allergenic Testing	30% Co-insurance up to the Out-of-Pocket Maximum
Cardiac Rehabilitation	30% Co-insurance up to the Out-of-Pocket Maximum
Chemotherapy/Radiation Therapy	30% Co-insurance up to the Out-of-Pocket Maximum
Diabetes Management (AHN)	\$30 AHN Co-payment per visit*
Diabetes Management	\$40 Co-payment per visit*
Dialysis	30% Co-insurance up to the Out-of-Pocket Maximum
Home Health Care	30% Co-insurance up to the Out-of-Pocket Maximum
Hospice	30% Co-insurance up to the Out-of-Pocket Maximum
Nutritional Counseling (AHN)	\$30 AHN Co-payment per visit*
Nutritional Counseling	\$40 Co-payment per visit*
Outpatient Habilitative Services	30% Co-insurance up to the Out-of-Pocket Maximum
Outpatient Rehabilitation Services	30% Co-insurance up to the Out-of-Pocket Maximum
Vision Services	
Vision Exam	30% Co-insurance up to the Out-of-Pocket Maximum
Glasses and Contacts	50% Co-insurance; \$100 maximum benefit for adults*
Dental Services	
Preventive Dental Exam, Cleaning and X-Rays	100% coverage of the Vantage Allowable*
Additional Dental Services	50% Co-insurance; \$500 maximum benefit for adults*
Mental Health Services	
Outpatient Mental Health Services (AHN)	\$30 AHN MH-PCP office visit Co-payment*
Outpatient Mental Health Services	\$40 MH-PCP office visit Co-payment*
Inpatient Mental Health Services	30% Co-insurance up to the Out-of-Pocket Maximum
Alcohol and Chemical Dependency	
Outpatient Alcohol/Chemical Dependency (AHN)	\$30 AHN MH-PCP office visit Co-payment*
Outpatient Alcohol/Chemical Dependency	\$40 MH-PCP office visit Co-payment*
Inpatient Alcohol/Chemical Dependency	30% Co-insurance up to the Out-of-Pocket Maximum
Approved Transplant Services	30% Co-insurance up to the Out-of-Pocket Maximum

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PRESCRIPTION DRUG MEMBER COST SHARE	
Prescription Drug Deductible	\$500 Individual; \$1,500 Family** (Applies to Tier III, Tier IV and Tier V)
Prescription Drug Out-of-Pocket Maximum	Included in the In-Network Out-of-Pocket Maximum
In-Network Retail Prescription Drugs: <i>(Cost Shares listed below are per Prescription up to a 30-day supply)</i>	
Tier I Prescription Drugs:	
• Affinity Health Network Pharmacies	100% Coverage. Not subject to Prescription Drug Deductible.
• All other Pharmacies	\$10 Co-payment per prescription. Not subject to Prescription Drug Deductible.
Tier II Prescription Drugs:	
	\$30 Co-payment per prescription. Not subject to Prescription Drug Deductible.
Tier III Prescription Drugs:	
	50% Co-insurance up to the Out-of-Pocket Maximum. Subject to Prescription Drug Deductible.
Tier IV Prescription Drugs:	
	50% Co-insurance up to the Out-of-Pocket Maximum. Subject to Prescription Drug Deductible.
Tier V Prescription Drugs:	
	50% Co-insurance up to the Out-of-Pocket Maximum. Subject to Prescription Drug Deductible.
Tier VI Preventive Prescription Drugs:	
	100% Coverage. Not subject to Prescription Drug Deductible.
Mail Order Prescription Drugs: <i>(Not available for Tier V Prescription Drugs)</i>	
Tier I:	
Affinity Health Network – Saint John Pharmacy	100% Coverage for 90-day supply.
All Other Pharmacies	In-Network Retail Prescription Drug Co-payments apply and are listed above.
Tier II:	
All Pharmacies	In-Network Retail Prescription Drug Co-payments apply and are listed above.
Tier III and IV:	
All Pharmacies	50% Co-insurance up to the Out-of-Pocket Maximum.
Tier VI:	
All Pharmacies	100% Coverage for 90-day supply.
Diabetic Supplies and Meters:	
Affinity Health Network Pharmacies	100% Coverage. Not subject to Prescription Drug Deductible.
All Other Pharmacies	In-Network Retail Prescription Drug Cost Share applies and is listed above.

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