COST SHARE SCHEDULE

ESSENTIAL SILVER 1000-87
Plan Year 2019

MEMBER COST SHARE	
Medical Deductibles	**In-Network Benefits: $1,000 Individual; $3,000 Family**** **Out-of-Network Benefits: $5,000 Individual; $10,000 Family****
In-Network Providers	**Co-payments vary and are listed below.** **20% 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: $2,000 Individual; $4,000 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)	**$0 AHN** MH-PCP office visit Co-payment*
Medical Home Primary Care Provider	**$10** MH-PCP office visit Co-payment*
Chiropractor	**$10** chiropractor office visit Co-payment*
OB/GYN	**$10** office visit Co-payment*
Specialty Care (AHN)	**20%** Co-insurance up to the Out-of-Pocket Maximum
Specialty Care	**20%** 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	**20%** Co-insurance up to the Out-of-Pocket Maximum
Major Diagnostic Testing	**20%** Co-insurance up to the Out-of-Pocket Maximum
Maternity-Related Services	
Office Visit (AHN)	**$0 AHN** Co-payment *(initial visit only)**
Office Visit	**$10** Co-payment *(initial visit only)**
Office Diagnostic Services – Lab (May be subject to Deductible)	100% Coverage
Office Diagnostic Services X-rays, other services	**20%** Co-insurance up to the Out-of-Pocket Maximum
Major Diagnostic Testing	**20%** Co-insurance up to the Out-of-Pocket Maximum
Ultrasounds	**20%** Co-insurance up to the Out-of-Pocket Maximum

***Not subject to Deductible.**
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COST SHARE SCHEDULE

ESSENTIAL SILVER 1000-87
Plan Year 2019

In-Network Covered Services (continued):	In-Network Cost Share:
Wellness & Preventive Care	
Annual Examination	100% Coverage*
Immunizations & Vaccines	100% Coverage*
Men's Health	100% Coverage*
Women's Health	100% Coverage*
Children's Health	100% Coverage*
Inpatient Hospital Services Inpatient Semi-Private Room Physician Services	**20%** Co-insurance up to the Out-of-Pocket Maximum
Ambulatory Surgery Unit or Outpatient Surgery	**20%** 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	**20%** Co-insurance up to the Out-of-Pocket Maximum
Emergency Medical Services Emergency Room Ambulance	**20%** Co-insurance up to the Out-of-Pocket Maximum
Durable Medical Equipment and Supplies (DME)	**20%** Co-insurance up to the Out-of-Pocket Maximum
After-Hours/Walk-In Clinics (AHN)	**$0 AHN** MH-PCP office visit Co-payment*
After-Hours/Walk-In Clinics (Diagnostic services may be subject to Deductible.)	**$10** MH-PCP office visit Co-payment*
Urgent Care Centers	**20%** Co-insurance up to the Out-of-Pocket Maximum
Extended Care Facilities	
Long-Term Acute Care Facility	**20%** Co-insurance up to the Out-of-Pocket Maximum
Rehabilitation Facility	**20%** Co-insurance up to the Out-of-Pocket Maximum
Skilled Nursing Facility	**20%** Co-insurance up to the Out-of-Pocket Maximum

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COST SHARE SCHEDULE

ESSENTIAL SILVER 1000-87
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In-Network Covered Services (continued):	In-Network Cost Share:
Other Covered Services	
Allergenic Testing	**20%** Co-insurance up to the Out-of-Pocket Maximum
Cardiac Rehabilitation	**20%** Co-insurance up to the Out-of-Pocket Maximum
Chemotherapy/Radiation Therapy	**20%** Co-insurance up to the Out-of-Pocket Maximum
Diabetes Management (AHN)	**$0 AHN** Co-payment per visit*
Diabetes Management	**$10** Co-payment per visit*
Dialysis	**20%** Co-insurance up to the Out-of-Pocket Maximum
Home Health Care	**20%** Co-insurance up to the Out-of-Pocket Maximum
Hospice	**20%** Co-insurance up to the Out-of-Pocket Maximum
Nutritional Counseling (AHN)	**$0 AHN** Co-payment per visit*
Nutritional Counseling	**$10** Co-payment per visit*
Outpatient Habilitative Services	**20%** Co-insurance up to the Out-of-Pocket Maximum
Outpatient Rehabilitation Services	**20%** Co-insurance up to the Out-of-Pocket Maximum
Vision Services	
Vision Exam	**20%** 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)	**$0 AHN** MH-PCP office visit Co-payment*
Outpatient Mental Health Services	**$10** MH-PCP office visit Co-payment*
Inpatient Mental Health Services	**20%** Co-insurance up to the Out-of-Pocket Maximum
Alcohol and Chemical Dependency	
Outpatient Alcohol/Chemical Dependency (AHN)	**$0 AHN** MH-PCP office visit Co-payment*
Outpatient Alcohol/Chemical Dependency	**$10** MH-PCP office visit Co-payment*
Inpatient Alcohol/Chemical Dependency	**20%** Co-insurance up to the Out-of-Pocket Maximum
Approved Transplant Services	**20%** Co-insurance up to the Out-of-Pocket Maximum

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PRESCRIPTION DRUG MEMBER COST SHARE	
Prescription Drug Deductible	**$150 Individual; $450 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: *(Cost Shares listed below are per Prescription up to a 30-day supply)*	
Tier I Prescription Drugs: • Affinity Health Network Pharmacies	100% Coverage. Not subject to Prescription Drug Deductible.
• All other Pharmacies	**$5** Co-payment per prescription. Not subject to Prescription Drug Deductible.
Tier II Prescription Drugs:	**$15** Co-payment per prescription. Not subject to Prescription Drug Deductible.
Tier III Prescription Drugs:	**20%** Co-insurance up to the Out-of-Pocket Maximum. Subject to Prescription Drug Deductible.
Tier IV Prescription Drugs:	**20%** 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: *(Not available for Tier V Prescription Drugs)*	
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.

***Not subject to Deductible.**
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