



# COST SHARE SCHEDULE

ESSENTIAL SILVER 100-94  
Plan Year 2019

## MEMBER COST SHARE

<b>Medical Deductibles</b>	<b>In-Network Benefits: \$100 Individual; \$300 Family**</b> <b>Out-of-Network Benefits: \$5,000 Individual; \$10,000 Family**</b>
<b>In-Network Providers</b>	<b>Co-payments vary and are listed below.</b> <b>10% Co-insurance on other benefits</b> (unless otherwise noted below)
<b>Out-of-Network Providers</b> <i>(excluding Emergency Medical Services and Dental Services)</i>	<b>50% Co-insurance</b> 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)
<b>Out-of-Pocket Maximums</b> <i>(Medical and Prescription Drugs are combined.)</i>	<b>In-Network Benefits: \$1,600 Individual; \$3,200 Family**</b> <b>Out-of-Network Benefits: No Out-of-Pocket Maximum</b>

## 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

<b>In-Network Covered Services:</b>	<b>In-Network Cost Share:</b>
<b>Physician Office Services</b>	
Medical Home Primary Care Provider (AHN)	<b>\$0 AHN MH-PCP office visit Co-payment*</b>
Medical Home Primary Care Provider	<b>\$5 MH-PCP office visit Co-payment*</b>
Chiropractor	<b>\$5 chiropractor office visit Co-payment*</b>
OB/GYN	<b>\$5 office visit Co-payment*</b>
Specialty Care (AHN)	<b>10% Co-insurance up to the Out-of-Pocket Maximum</b>
Specialty Care	<b>10% Co-insurance up to the Out-of-Pocket Maximum</b>
Office Diagnostic Services – Lab <i>(May be subject to Deductible)</i>	<b>100% Coverage</b>
Office Diagnostic Services – X-rays, other services	<b>10% Co-insurance up to the Out-of-Pocket Maximum</b>
Major Diagnostic Testing	<b>10% Co-insurance up to the Out-of-Pocket Maximum</b>
<b>Maternity-Related Services</b>	
Office Visit (AHN)	<b>\$0 AHN Co-payment (initial visit only)*</b>
Office Visit	<b>\$5 Co-payment (initial visit only)*</b>
Office Diagnostic Services – Lab <i>(May be subject to Deductible)</i>	<b>100% Coverage</b>
Office Diagnostic Services X-rays, other services	<b>10% Co-insurance up to the Out-of-Pocket Maximum</b>
Major Diagnostic Testing	<b>10% Co-insurance up to the Out-of-Pocket Maximum</b>
Ultrasounds	<b>10% Co-insurance up to the Out-of-Pocket Maximum</b>

**\*Not subject to Deductible.**

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In-Network Covered Services (continued):	In-Network Cost Share:
<b>Wellness &amp; Preventive Care</b> Annual Examination Immunizations & Vaccines Men's Health Women's Health Children's Health	100% Coverage* 100% Coverage* 100% Coverage* 100% Coverage* 100% Coverage*
<b>Inpatient Hospital Services</b> Inpatient Semi-Private Room Physician Services	<b>10%</b> Co-insurance up to the Out-of-Pocket Maximum
<b>Ambulatory Surgery Unit or Outpatient Surgery</b>	<b>10%</b> Co-insurance up to the Out-of-Pocket Maximum
<b>Outpatient Hospital Services</b> Observation Stay Physician Services Major Diagnostic Testing Lab Services (May be subject to Deductible) Other Hospital Outpatient Services	<b>10%</b> Co-insurance up to the Out-of-Pocket Maximum
<b>Emergency Medical Services</b> Emergency Room Ambulance	<b>10%</b> Co-insurance up to the Out-of-Pocket Maximum
<b>Durable Medical Equipment and Supplies (DME)</b>	<b>10%</b> Co-insurance up to the Out-of-Pocket Maximum
<b>After-Hours/Walk-In Clinics (AHN)</b> <b>After-Hours/Walk-In Clinics</b> (Diagnostic services may be subject to Deductible.) <b>Urgent Care Centers</b>	<b>\$0</b> AHN MH-PCP office visit Co-payment* <b>\$5</b> MH-PCP office visit Co-payment* <b>10%</b> Co-insurance up to the Out-of-Pocket Maximum
<b>Extended Care Facilities</b> Long-Term Acute Care Facility Rehabilitation Facility Skilled Nursing Facility	<b>10%</b> Co-insurance up to the Out-of-Pocket Maximum <b>10%</b> Co-insurance up to the Out-of-Pocket Maximum <b>10%</b> Co-insurance up to the Out-of-Pocket Maximum

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In-Network Covered Services (continued):	In-Network Cost Share:
<b>Other Covered Services</b>	
Allergenic Testing	<b>10%</b> Co-insurance up to the Out-of-Pocket Maximum
Cardiac Rehabilitation	<b>10%</b> Co-insurance up to the Out-of-Pocket Maximum
Chemotherapy/Radiation Therapy	<b>10%</b> Co-insurance up to the Out-of-Pocket Maximum
Diabetes Management (AHN)	<b>\$0 AHN</b> Co-payment per visit*
Diabetes Management	<b>\$5</b> Co-payment per visit*
Dialysis	<b>10%</b> Co-insurance up to the Out-of-Pocket Maximum
Home Health Care	<b>10%</b> Co-insurance up to the Out-of-Pocket Maximum
Hospice	<b>10%</b> Co-insurance up to the Out-of-Pocket Maximum
Nutritional Counseling (AHN)	<b>\$0 AHN</b> Co-payment per visit*
Nutritional Counseling	<b>\$5</b> Co-payment per visit*
Outpatient Habilitative Services	<b>10%</b> Co-insurance up to the Out-of-Pocket Maximum
Outpatient Rehabilitation Services	<b>10%</b> Co-insurance up to the Out-of-Pocket Maximum
<b>Vision Services</b>	
Vision Exam	<b>10%</b> Co-insurance up to the Out-of-Pocket Maximum
Glasses and Contacts	<b>50%</b> Co-insurance; <b>\$100</b> maximum benefit for adults*
<b>Dental Services</b>	
Preventive Dental Exam, Cleaning and X-Rays	100% coverage of the Vantage Allowable*
Additional Dental Services	<b>50%</b> Co-insurance; <b>\$500</b> maximum benefit for adults*
<b>Mental Health Services</b>	
Outpatient Mental Health Services (AHN)	<b>\$0 AHN</b> MH-PCP office visit Co-payment*
Outpatient Mental Health Services	<b>\$5</b> MH-PCP office visit Co-payment*
Inpatient Mental Health Services	<b>10%</b> Co-insurance up to the Out-of-Pocket Maximum
<b>Alcohol and Chemical Dependency</b>	
Outpatient Alcohol/Chemical Dependency (AHN)	<b>\$0 AHN</b> MH-PCP office visit Co-payment*
Outpatient Alcohol/Chemical Dependency	<b>\$5</b> MH-PCP office visit Co-payment*
Inpatient Alcohol/Chemical Dependency	<b>10%</b> Co-insurance up to the Out-of-Pocket Maximum
<b>Approved Transplant Services</b>	<b>10%</b> Co-insurance up to the Out-of-Pocket Maximum

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## PRESCRIPTION DRUG MEMBER COST SHARE

<b>Prescription Drug Deductible</b>	<b>\$100 Individual; \$300 Family** (Applies to Tier III, Tier IV and Tier V)</b>
<b>Prescription Drug Out-of-Pocket Maximum</b>	<b>Included in the In-Network Out-of-Pocket Maximum</b>
<b>In-Network Retail Prescription Drugs:</b> <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	<b>\$5</b> Co-payment per prescription. Not subject to Prescription Drug Deductible.
Tier II Prescription Drugs:	<b>\$7</b> Co-payment per prescription. Not subject to Prescription Drug Deductible.
Tier III Prescription Drugs:	<b>10%</b> Co-insurance up to the Out-of-Pocket Maximum. Subject to Prescription Drug Deductible.
Tier IV Prescription Drugs:	<b>10%</b> Co-insurance up to the Out-of-Pocket Maximum. Subject to Prescription Drug Deductible.
Tier V Prescription Drugs:	<b>50%</b> 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.
<b>Mail Order Prescription Drugs:</b> <i>(Not available for Tier V Prescription Drugs)</i>	
<b>Tier I:</b>	
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.
<b>Tier II:</b>	
All Pharmacies	In-Network Retail Prescription Drug Co-payments apply and are listed above.
<b>Tier III and IV:</b>	
All Pharmacies	<b>50%</b> Co-insurance up to the Out-of-Pocket Maximum.
<b>Tier VI:</b>	
All Pharmacies	100% Coverage for 90-day supply.
<b>Diabetic Supplies and Meters:</b>	
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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