COST SHARE SCHEDULE

FREEDOM SILVER 100-94
Plan Year 2019

MEDICAL MEMBER COST SHARING	
Medical Deductibles	**In-Network Benefits: $100 Individual; $300 Family**** **Out-of-Network Benefits: $5,000 Individual; $10,000 Family****
Out-of-Pocket Maximums (Medical and Prescription Drugs are combined.)	**In-Network Benefits: $1,000 Individual; $2,000 Family**** **Out-of-Network Benefits: No Out-of-Pocket Maximum**
In-Network Providers	**Co-payments vary and are listed below.** **10% 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; may be balance billed (No Out-of-Network coverage for Prescription Drugs, Transplants, Private Duty Nursing, Home Health and Hospice)

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 (MH-PCP)	**$5** MH-PCP office visit Co-payment*
Chiropractor	**$5** chiropractor office visit Co-payment*
OB/GYN	**$5** office visit Co-payment*
Specialty Care (AHN)	**$5 AHN** Specialty Care office visit Co-payment*
Specialty Care	**$15** Specialty Care office visit Co-payment*
Office Diagnostic Services – Lab (May be subject to Deductible)	100% coverage
Office Diagnostic Services - X-rays, other services *(excludes Major Diagnostic tests)*	100% coverage
Major Diagnostic Testing (AHN)	**$0 AHN** Co-payment per test
Major Diagnostic Testing	**$100** Co-payment per test
Maternity-Related Services	
Office Visit (AHN)	**$0 AHN** Co-payment *(initial visit only)**
Office Visit	**$5** Co-payment *(initial visit only)**
Office Diagnostic Services – Lab (May be subject to Deductible)	100% coverage
Office Diagnostic Services - X-rays, other services *(excludes Major Diagnostic tests)*	100% coverage
Major Diagnostic Testing (AHN)	**$0 AHN** Co-payment per test
Major Diagnostic Testing	**$100** Co-payment per test
Initial Ultrasounds	100% coverage*
Additional Ultrasounds	100% Co-insurance up to **$100** daily maximum cost share

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

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In-Network Covered Services (continued):	In-Network Cost Share:
Wellness & Preventive Care	
Annual Examination	100% coverage*
Immunizations & Vaccines	100% coverage*
Children's Health	100% coverage*
Men's Health	100% coverage*
Women's Health	100% coverage*
Inpatient Hospital Services	
Inpatient Semi-Private Room (AHN)	**$100** off Inpatient Semi-Private Room Standard Co-payment
Inpatient Semi-Private Room	**$100** Co-payment per day for days 1-3
Physician Services	100% coverage
Ambulatory Surgery Unit or Outpatient Surgery (AHN)	**$0 AHN** Co-payment
Ambulatory Surgery Unit or Outpatient Surgery	**$100** Co-payment
Outpatient Hospital Services	
Observation Stay (AHN)	**$100** off Observation Stay Standard Co-payment
Observation Stay	**$100** Co-payment per day for days 1-3
Physician Services	100% coverage
Major Diagnostic Testing (AHN)	**$0 AHN** Co-payment per test
Major Diagnostic Testing	**$100** Co-payment per test
Lab Services (May be subject to Deductible)	100% coverage
Other Hospital Outpatient Services (AHN)	100% Co-insurance up to **$0** daily maximum cost share
Other Hospital Outpatient Services	100% Co-insurance up to **$100** daily maximum cost share
Emergency Medical Services	
Emergency Room	**$150** Co-payment per visit, waived if admitted
Ambulance	**10%** Co-insurance
Durable Medical Equipment and Supplies (DME)	**10%** Co-insurance
After-Hours/Walk-In Clinics (AHN)	**$0 AHN** MH-PCP office visit Co-payment*
After-Hours/Walk-In Clinics	**$5** MH-PCP office visit Co-payment*
Urgent Care Centers	**$15** Co-payment per visit*
Extended Care Facilities	
Long-Term Acute Care Facility	**$50** Co-payment per day
Rehabilitation Facility	**$50** Co-payment per day
Skilled Nursing Facility	**$50** Co-payment per day

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In-Network Covered Services (continued):	In-Network Cost Share:
Other Covered Services	
Allergenic Testing	**10%** Co-insurance
Cardiac Rehabilitation	**10%** Co-insurance
Chemotherapy/Radiation Therapy	**10%** Co-insurance
Diabetes Management (AHN)	**$0 AHN** Co-payment per visit*
Diabetes Management	**$5** Co-payment per visit*
Dialysis	**10%** Co-insurance
Home Health Care	**10%** Co-insurance
Hospice	**10%** Co-insurance
Nutritional Counseling (AHN)	**$0 AHN** Co-payment per visit*
Nutritional Counseling	**$5** Co-payment per visit*
Outpatient Habilitative Services	**$20** Co-payment per visit
Outpatient Rehabilitation Services	**$20** Co-payment per visit
Vision Services	
Vision Exam (AHN)	**$5 AHN** Specialty Care office visit Co-payment*
Vision Exam	**$15** Specialty Care office visit Co-payment*
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	**$5** MH-PCP office visit Co-payment*
Inpatient Mental Health Services	**$100** Co-payment per day for days 1-3
Alcohol and Chemical Dependency	
Outpatient Alcohol/Chemical Dependency (AHN)	**$0 AHN** MH-PCP office visit Co-payment*
Outpatient Alcohol/Chemical Dependency	**$5** MH-PCP office visit Co-payment*
Inpatient Alcohol and Chemical Dependency	**$100** Co-payment per day for days 1-3
Approved Transplant Services	Applicable Inpatient or ASU/Outpatient Surgery Co-payment

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PRESCRIPTION DRUG MEMBER COST SHARE	
Prescription Drug Deductible	**$100 Individual; $300 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:	**$7** Co-payment per prescription. Not subject to Prescription Drug Deductible
Tier III Prescription Drugs:	**$15** Co-payment per prescription. Subject to Prescription Drug Deductible
Tier IV Prescription Drugs:	**$40** Co-payment per prescription. Subject to Prescription Drug Deductible
Tier V Prescription Drugs:	**50%** Co-insurance per prescription. 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.
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.
Tiers III and IV:	
All Pharmacies	In-Network Retail Prescription Drug Co-payments apply and are listed above.
Tier VI:	
All Pharmacies	100% Coverage for 90-day supply.
Diabetic Supplies and Meters at a Pharmacy:	
Affinity Health Network Pharmacies	100% Coverage. Not subject to Prescription Drug Deductible.
All Other Pharmacies	In-Network Retail Prescription Drug Cost Share applies.

***Not subject to Medical Deductible.**
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