COST SHARE SCHEDULE

SAVINGS BRONZE 6750 LIMITED
EFFECTIVE Plan Year 2019

Members of Federally Recognized Tribes who receive services from Participating Indian Health Service Providers will not have to pay In-Network Deductible, Co-payments or Co-insurance. Such services will be provided at zero cost sharing for these Members. The following Member Cost Sharing will apply to Covered Services received from Providers who are not Participating Indian Health Service Providers.

MEMBER COST SHARE	
Deductibles	**In-Network Benefits: $6,750 Individual; $13,500 Family**** *(applies to both In-Network medical and prescription drug benefits)* **Out-of-Network Benefits: $8,000 Individual; $16,000 Family****
In-Network Providers	**0% Co-insurance** (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, Transplants, Private Duty Nursing, Home Health and Hospice)
Out-of-Pocket Maximums (Medical and Prescription Drugs are combined.)	**In-Network Benefits: $6,750 Individual; $13,500 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	**0%** Co-insurance up to the Out-of-Pocket Maximum
Maternity-Related Services	**0%** Co-insurance up to the Out-of-Pocket Maximum
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	**0%** Co-insurance up to the Out-of-Pocket Maximum
Ambulatory Surgery Unit or Outpatient Surgery	**0%** Co-insurance up to the Out-of-Pocket Maximum
Outpatient Hospital Services	**0%** Co-insurance up to the Out-of-Pocket Maximum
Emergency Medical Services	**0%** Co-insurance up to the Out-of-Pocket Maximum

***Not subject to Deductible.**

****A single family member has met his or her deductible or in-network maximum amount(s) by reaching the individual deductible or in-network maximum amount(s). Other family members' payments for in-network covered services combine to meet the remainder of the family deductible or in-network maximum amount(s).**

This plan is HSA qualified.

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.

COST SHARE SCHEDULE

SAVINGS BRONZE 6750 LIMITED
EFFECTIVE Plan Year 2019

In-Network Covered Services (continued):	In-Network Cost Share:
Durable Medical Equipment and Supplies (DME)	**0%** Co-insurance up to the Out-of-Pocket Maximum
After-Hours/Walk-In Clinics (Diagnostic services may be subject to Deductible.)	**0%** Co-insurance up to the Out-of-Pocket Maximum
Urgent Care Centers	**0%** Co-insurance up to the Out-of-Pocket Maximum
Extended Care Facilities	**0%** Co-insurance up to the Out-of-Pocket Maximum
Other Covered Services	**0%** Co-insurance up to the Out-of-Pocket Maximum
Vision Services	
Vision Exam for Children and Adults	**0%** Co-insurance up to the Out-of-Pocket Maximum
Glasses and Contacts for Children	**0%** Co-insurance
Dental Services	
Preventive Dental Exam, Cleaning and X-Rays	100% coverage of the Vantage Allowable*
Additional Dental Services for Children	**0%** Co-insurance
Mental Health Services	**0%** Co-insurance up to the Out-of-Pocket Maximum
Alcohol and Chemical Dependency	**0%** Co-insurance up to the Out-of-Pocket Maximum
Approved Transplant Services	**0%** Co-insurance up to the Out-of-Pocket Maximum

***Not subject to Deductible.**

****A single family member has met his or her deductible or in-network maximum amount(s) by reaching the individual deductible or in-network maximum amount(s). Other family members' payments for in-network covered services combine to meet the remainder of the family deductible or in-network maximum amount(s).**

This plan is HSA qualified.

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.

COST SHARE SCHEDULE

SAVINGS BRONZE 6750 LIMITED
EFFECTIVE Plan Year 2019

PRESCRIPTION DRUG MEMBER COST SHARE	
Prescription Drug Deductible	**Included in the In-Network Deductible**
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 In-Network Deductible.
• All other Pharmacies	**0%** Co-insurance up to the Out-of-Pocket Maximum. Subject to In-Network Deductible.
Tier II Prescription Drugs:	**0%** Co-insurance up to the Out-of-Pocket Maximum. Subject to In-Network Deductible.
Tier III Prescription Drugs:	**0%** Co-insurance up to the Out-of-Pocket Maximum. Subject to In-Network Deductible.
Tier IV Prescription Drugs:	**0%** Co-insurance up to the Out-of-Pocket Maximum. Subject to In-Network Deductible.
Tier V Prescription Drugs:	**0%** Co-insurance up to the Out-of-Pocket Maximum. Subject to In-Network Deductible.
Tier VI Preventive Prescription Drugs:	100% Coverage. Not subject to In-Network 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. Not subject to In-Network Deductible.
All Other Pharmacies	In-Network Retail Prescription Drug Co-insurance applies and is listed above.
Tier II, III and IV: All Pharmacies	In-Network Retail Prescription Drug Co-insurance applies and is listed above.
Tier VI: All Pharmacies	100% Coverage for 90-day supply. Not subject to In-Network Deductible.
Diabetic Supplies and Meters: Affinity Health Network Pharmacies	100% Coverage. Not subject to In-Network Deductible.
All Other Pharmacies	In-Network Retail Prescription Drug Co-insurance applies and is listed above.

***Not subject to Deductible.**

****A single family member has met his or her deductible or in-network maximum amount(s) by reaching the individual deductible or in-network maximum amount(s). Other family members' payments for in-network covered services combine to meet the remainder of the family deductible or in-network maximum amount(s).**

This plan is HSA qualified.

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.