



COST SHARE SCHEDULE

SAVINGS GOLD 3000
Plan Year 2019

MEMBER COST SHARE

Deductibles	In-Network Benefits: \$3,000 Individual; \$6,000 Family** <i>(applies to both In-Network medical and prescription drug benefits)</i>
	Out-of-Network Benefits: \$5,000 Individual; \$10,000 Family**
In-Network Providers	0% Co-insurance (unless otherwise noted below)
Out-of-Network Providers <i>(excluding Emergency Medical Services and Dental Services)</i>	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 <i>(Medical and Prescription Drugs are combined.)</i>	In-Network Benefits: \$3,000 Individual; \$6,000 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	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.



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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 Glasses and Contacts for Children	0% Co-insurance up to the Out-of-Pocket Maximum 0% Co-insurance
Dental Services Preventive Dental Exam, Cleaning and X-Rays Additional Dental Services for Children	100% coverage of the Vantage Allowable* 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

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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: <i>(Cost Shares listed below are per Prescription up to a 30-day supply)</i>	
Tier I Prescription Drugs:	
<ul style="list-style-type: none"> Affinity Health Network Pharmacies All other Pharmacies 	<p>100% Coverage. Not subject to In-Network Deductible.</p> <p>0% Co-insurance up to the Out-of-Pocket Maximum. Subject to In-Network Deductible.</p>
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: <i>(Not available for Tier V Prescription Drugs)</i>	
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.

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