COST SHARE SCHEDULE

SAVINGS SILVER 5000
Plan Year 2019

MEMBER COST SHARE	
Deductibles	**In-Network Benefits: $5,000 Individual; $10,000 Family**** *(applies to both In-Network medical and prescription drug benefits)* **Out-of-Network Benefits: $5,000 Individual; $10,000 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: $5,000 Individual; $10,000 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.

COST SHARE SCHEDULE

SAVINGS SILVER 5000
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	**0%** Co-insurance up to the Out-of-Pocket Maximum
(Diagnostic services may be subject to Deductible.)	
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.**

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COST SHARE SCHEDULE

SAVINGS SILVER 5000
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.**

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