



# COST SHARE SCHEDULE

SAVINGS SILVER 5000 LIMITED  
Plan Year 2019

Members of Federally Recognized Tribes who enroll in this Zero Cost Sharing Plan can receive services from In-Network Providers at no cost.

## MEMBER COST SHARE

<b>Deductibles</b>	<b>In-Network Benefits: \$5,000 Individual; \$10,000 Family**</b> <i>(applies to both In-Network medical and prescription drug benefits)</i>
	<b>Out-of-Network Benefits: \$5,000 Individual; \$10,000 Family**</b>
<b>In-Network Providers</b>	<b>0% Co-insurance</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, Transplants, Private Duty Nursing, Home Health and Hospice)
<b>Out-of-Pocket Maximums</b> <i>(Medical and Prescription Drugs are combined.)</i>	<b>In-Network Benefits: \$5,000 Individual; \$10,000 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

In-Network Covered Services:	In-Network Cost Share:
<b>Physician Office Services</b>	0% Co-insurance up to the Out-of-Pocket Maximum
<b>Maternity-Related Services</b>	0% Co-insurance up to the Out-of-Pocket Maximum
<b>Wellness &amp; Preventive Care</b>	
Annual Examination	100% Coverage*
Immunizations & Vaccines	100% Coverage*
Men's Health	100% Coverage*
Women's Health	100% Coverage*
Children's Health	100% Coverage*
<b>Inpatient Hospital Services</b>	0% Co-insurance up to the Out-of-Pocket Maximum
<b>Ambulatory Surgery Unit or Outpatient Surgery</b>	0% Co-insurance up to the Out-of-Pocket Maximum
<b>Outpatient Hospital Services</b>	0% Co-insurance up to the Out-of-Pocket Maximum
<b>Emergency Medical Services</b>	0% Co-insurance up to the Out-of-Pocket Maximum

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\*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](http://www.VantageHealthPlan.com) or call Member Services at (844) 833-7505.



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In-Network Covered Services (continued):	In-Network Cost Share:
<b>Durable Medical Equipment and Supplies (DME)</b>	0% Co-insurance up to the Out-of-Pocket Maximum
<b>After-Hours/Walk-In Clinics</b> (Diagnostic services may be subject to Deductible.)	0% Co-insurance up to the Out-of-Pocket Maximum
<b>Urgent Care Centers</b>	0% Co-insurance up to the Out-of-Pocket Maximum
<b>Extended Care Facilities</b>	0% Co-insurance up to the Out-of-Pocket Maximum
<b>Other Covered Services</b>	0% Co-insurance up to the Out-of-Pocket Maximum
<b>Vision Services</b> Vision Exam for Children and Adults Glasses and Contacts for Children	0% Co-insurance up to the Out-of-Pocket Maximum 0% Co-insurance
<b>Dental Services</b> Preventive Dental Exam, Cleaning and X-Rays Additional Dental Services for Children	100% coverage of the Vantage Allowable* 0% Co-insurance
<b>Mental Health Services</b>	0% Co-insurance up to the Out-of-Pocket Maximum
<b>Alcohol and Chemical Dependency</b>	0% Co-insurance up to the Out-of-Pocket Maximum
<b>Approved Transplant Services</b>	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
<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:	
<ul style="list-style-type: none"> <li>Affinity Health Network Pharmacies</li> <li>All other Pharmacies</li> </ul>	<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.
<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. Not subject to In-Network Deductible.
All Other Pharmacies	In-Network Retail Prescription Drug Co-insurance applies and is listed above.
<b>Tier II, III and IV:</b>	
All Pharmacies	In-Network Retail Prescription Drug Co-insurance applies and is listed above.
<b>Tier VI:</b>	
All Pharmacies	100% Coverage for 90-day supply. Not subject to In-Network Deductible.
<b>Diabetic Supplies and Meters:</b>	
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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