

FREEDOM PLANS Benefit Comparison

The following comparison is not a complete comparison. All of these plans offer out-of-network coverage. Members may be balance billed by out-of-network providers. Visit www.VantageHealthPlan.com/Marketplace for a complete set of Vantage Marketplace plan documents.

BENEFITS	FREEDOM PLATINUM	FREEDOM GOLD 1000	FREEDOM GOLD 1500	FREEDOM SILVER 4500
In-Network Medical Deductible	\$0 Individual; \$0 Family	\$1,000 Individual; \$3,000 Family	\$1,500 Individual; \$4,500 Family	\$4,500 Individual; \$13,500 Family
In-Network Out-of-Pocket Maximum	\$2,800 Individual; \$5,600 Family	\$7,200 Individual; \$14,400 Family	\$7,200 Individual; \$14,400 Family	\$8,000 Individual; \$16,000 Family
Medical Home - Primary Care Provider (MH-PCP)*	\$15 AHN/ \$25 copay per visit	\$20 AHN/ \$30 copay per visit	\$20 AHN/ \$30 copay per visit	\$30 AHN/ \$40 copay per visit
Specialist Office Visit*	\$30 AHN/ \$40 copay per visit	\$40 AHN/ \$50 copay per visit	\$40 AHN/ \$50 copay per visit	\$65 AHN/ \$75 copay per visit
Inpatient Hospital (\$100 savings at AHN)	\$500 copay/ day; \$1,500 max	\$750 copay/ day; \$2,250 max	\$750 copay/ day; \$2,250 max	\$1,500 copay/ day; \$4,500 max
Outpatient Surgery Services	\$200 AHN/ \$300 copay	\$300 AHN/ \$400 copay	\$650 AHN/ \$750 copay	\$900 AHN/ \$1,000 copay
Emergency Room	\$300 ER copay per visit	\$350 ER copay per visit	\$400 ER copay per visit	\$400 ER copay per visit
Major Diagnostic Test (MRI, CT scan, stress test, etc)	\$50 AHN/ \$150 copay per test	\$100 AHN/ \$200 copay per test	\$100 AHN/ \$200 copay per test	\$200 AHN/ \$300 copay per test
Outpatient Lab	100% covered	100% covered	100% covered	100% covered
X-Rays and Other Outpatient Hospital Services	100% coinsurance up to: AHN: \$50/day Standard: \$150/day	100% coinsurance up to: AHN: \$100/day Standard: \$200/day	100% coinsurance up to: AHN: \$100/day Standard: \$200/day	100% coinsurance up to: AHN: \$200/day Standard: \$300/day
Radiation and Chemotherapy	20% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance
Physical/Occupational/Speech Therapy	\$25 copay per day	\$30 copay per day	\$30 copay per day	\$40 copay per day
Vision Exam*	\$30 AHN/ \$40 copay per visit	\$40 AHN/ \$50 copay per visit	\$40 AHN/ \$50 copay per visit	\$65 AHN/ \$75 copay per visit
Glasses/ Contacts*	50% coinsurance; Max benefit for adults: \$100	50% coinsurance; Max benefit for adults: \$100	50% coinsurance; Max benefit for adults: \$100	50% coinsurance; Max benefit for adults: \$100
Preventive Dental*	100% covered	100% covered	100% covered	100% covered
Comprehensive Dental - Child*	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance
Comprehensive Dental - Adult*	50% coinsurance; Max benefit: \$500	50% coinsurance; Max benefit: \$500	50% coinsurance; Max benefit: \$500	50% coinsurance; Max benefit: \$500
Prescription Drug Deductible (Applies to tiers 3,4,5)	\$0 Individual; \$0 Family	\$250 Individual; \$750 Family	\$0 Individual; \$0 Family	\$1,000 Individual; \$3,000 Family
Prescription Drugs	Tier 1.....\$10 copay Tier 2.....\$30 copay Tier 3.....\$60 copay Tier 4.....\$100 copay Tier 5.....50% coinsurance	Tier 1.....\$10 copay** Tier 2.....\$30 copay** Tier 3.....\$60 copay Tier 4.....\$100 copay Tier 5.....50% coinsurance	Tier 1.....\$10 copay Tier 2.....\$30 copay Tier 3.....\$60 copay Tier 4.....\$100 copay Tier 5.....50% coinsurance	Tier 1.....\$10 copay** Tier 2.....\$30 copay** Tier 3.....\$60 copay Tier 4.....\$100 copay Tier 5.....50% coinsurance
Out-of-Network Medical Deductible	\$5,000 Individual; \$15,000 Family	\$5,000 Individual; \$15,000 Family	\$5,000 Individual; \$15,000 Family	\$5,000 Individual; \$15,000 Family
Out-of-Network Coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance

*Not subject to in-network medical deductible. **Not subject to prescription drug deductible.

ESSENTIAL PLANS Benefit Comparison

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BENEFITS	ESSENTIAL GOLD 2000	ESSENTIAL SILVER 4000	ESSENTIAL SILVER 5000	ESSENTIAL BRONZE 6500
In-Network Medical Deductible	\$2,000 Individual; \$6,000 Family	\$4,000 Individual; \$12,000 Family	\$5,000 Individual; \$15,000 Family	\$6,500 Individual; \$13,000 Family
In-Network Out-of-Pocket Maximum	\$6,500 Individual; \$13,000 Family	\$8,000 Individual; \$16,000 Family	\$8,000 Individual; \$16,000 Family	\$8,000 Individual; \$16,000 Family
Medical Home - Primary Care Provider (MH-PCP)*	\$20 AHN/ \$30 copay per visit	\$30 AHN/ \$40 copay per visit	\$30 AHN/ \$40 copay per visit	\$40 AHN/ \$50 copay per visit
Specialist Office Visit	20% coinsurance	30% coinsurance	40% coinsurance	50% coinsurance
Inpatient Hospital	20% coinsurance	30% coinsurance	40% coinsurance	50% coinsurance
Outpatient Surgery Services	20% coinsurance	30% coinsurance	40% coinsurance	50% coinsurance
Emergency Room	20% coinsurance	30% coinsurance	40% coinsurance	50% coinsurance
Major Diagnostic Test (MRI, CT scan, stress test, etc)	20% coinsurance	30% coinsurance	40% coinsurance	50% coinsurance
Outpatient Lab	20% coinsurance	30% coinsurance	40% coinsurance	50% coinsurance
X-Rays and Other Outpatient Hospital Services	20% coinsurance	30% coinsurance	40% coinsurance	50% coinsurance
Radiation and Chemotherapy	20% coinsurance	30% coinsurance	40% coinsurance	50% coinsurance
Physical/Occupational/Speech Therapy	20% coinsurance	30% coinsurance	40% coinsurance	50% coinsurance
Vision Exam	20% coinsurance	30% coinsurance	40% coinsurance	50% coinsurance
Glasses/ Contacts*	50% coinsurance; Max benefit for adults: \$100	50% coinsurance; Max benefit for adults: \$100	50% coinsurance; Max benefit for adults: \$100	50% coinsurance; Max benefit for adults: \$100
Preventive Dental*	100% covered	100% covered	100% covered	100% covered
Comprehensive Dental - Child*	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance
Comprehensive Dental - Adult*	50% coinsurance; Max benefit: \$500	50% coinsurance; Max benefit: \$500	50% coinsurance; Max benefit: \$500	50% coinsurance; Max benefit: \$500
Prescription Drug Deductible (applies to Tiers 3, 4, 5)	\$300 Individual; \$900 Family	\$800 Individual; \$2,400 Family	\$800 Individual; \$2,400 Family	\$1,000 Individual; \$2,000 Family
Prescription Drugs	Tier 1..... \$10 copay** Tier 2..... \$30 copay** Tier 3..... 20% coinsurance Tier 4..... 20% coinsurance Tier 5..... 50% coinsurance	Tier 1..... \$10 copay** Tier 2..... \$30 copay** Tier 3..... 50% coinsurance Tier 4..... 50% coinsurance Tier 5..... 50% coinsurance	Tier 1..... \$10 copay** Tier 2..... \$30 copay** Tier 3..... 50% coinsurance Tier 4..... 50% coinsurance Tier 5..... 50% coinsurance	Tier 1..... \$10 copay** Tier 2..... \$30 copay** Tier 3..... 50% coinsurance Tier 4..... 50% coinsurance Tier 5..... 50% coinsurance
Out-of-Network Medical Deductible	\$5,000 Individual; \$15,000 Family	\$5,000 Individual; \$15,000 Family	\$5,000 Individual; \$15,000 Family	\$8,000 Individual \$16,000 Family
Out-of-Network Coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance

*Not subject to in-network medical deductible. **Not subject to prescription drug deductible.

SAVINGS PLANS Benefit Comparison

The following comparison is not a complete comparison. All of these plans offer out-of-network coverage. Members may be balance billed by out-of-network providers. Visit www.VantageHealthPlan.com/Marketplace for a complete set of Vantage Marketplace plan documents.

BENEFITS	SAVINGS GOLD 3200	SAVINGS SILVER 4500	SAVINGS BRONZE 5500
In-Network Combined Medical/Prescription Drug Deductible	\$3,200 Individual; \$6,400 Family	\$4,500 Individual; \$9,000 Family	\$5,500 Individual; \$11,000 Family
In-Network Out-of-Pocket Maximum	\$3,200 Individual; \$6,400 Family	\$6,000 Individual; \$12,000 Family	\$6,900 Individual; \$13,800 Family
Medical Home - Primary Care Provider (MH-PCP)	100% covered	50% coinsurance	50% coinsurance
Specialist Office Visit	100% covered	50% coinsurance	50% coinsurance
Inpatient Hospital	100% covered	50% coinsurance	50% coinsurance
Outpatient Surgery Services	100% covered	50% coinsurance	50% coinsurance
Emergency Room	100% covered	50% coinsurance	50% coinsurance
Major Diagnostic Test (MRI, CT scan, stress test, etc)	100% covered	50% coinsurance	50% coinsurance
Outpatient Lab	100% covered	50% coinsurance	50% coinsurance
X-Rays and Other Outpatient Hospital Services	100% covered	50% coinsurance	50% coinsurance
Radiation and Chemotherapy	100% covered	50% coinsurance	50% coinsurance
Physical/Occupational/Speech Therapy	100% covered	50% coinsurance	50% coinsurance
Vision Exam	100% covered	50% coinsurance	50% coinsurance
Glasses/ Contacts	100% covered; no adult coverage	50% coinsurance no adult coverage	50% coinsurance; no adult coverage
Preventive Dental*	100% covered	100% covered	100% covered
Comprehensive Dental- Child	50% coinsurance	50% coinsurance	50% coinsurance
Comprehensive Dental- Adult*	50% coinsurance; Max benefit: \$500	50% coinsurance; Max benefit: \$500	50% coinsurance; Max benefit: \$500
Prescription Drug Deductible	See Combined Medical/Prescription Drug Deductible Above	See Combined Medical/Prescription Drug Deductible Above	See Combined Medical/Prescription Drug Deductible Above
Prescription Drugs	Tier 1..... 100% covered Tier 2..... 100% covered Tier 3..... 100% covered Tier 4..... 100% covered Tier 5..... 100% covered	Tier 1..... 50% coinsurance Tier 2..... 50% coinsurance Tier 3..... 50% coinsurance Tier 4..... 50% coinsurance Tier 5..... 50% coinsurance	Tier 1..... 50% coinsurance Tier 2..... 50% coinsurance Tier 3..... 50% coinsurance Tier 4..... 50% coinsurance Tier 5..... 50% coinsurance
Out-of-Network Medical Deductible	\$5,000 Individual; \$15,000 Family	\$5,000 Individual; \$15,000 Family	\$8,000 Individual; \$16,000 Family
Out-of-Network Coinsurance	50% coinsurance	50% Coinsurance	50% Coinsurance
HSA Qualified	YES	YES	YES

*Not subject to in-network deductible.