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 3000*	**FREEDOM** *SILVER 4500*
In-Network Medical Deductible	**$0** Individual; **$0** Family	**$1,000** Individual; **$3,000** Family	**$1,500** Individual; **$4,500** Family	**$3,000** Individual; **$9,000** Family	**$4,500** Individual; **$13,500** Family
In-Network Out-of-Pocket Maximum	**$2,700** Individual; **$5,400** Family	**$7,800** Individual; **$15,600** Family	**$7,800** Individual; **$15,600** Family	**$8,000** Individual; **$16,000** Family	**$8,550** Individual; **$17,100** Family
Primary Care Provider (PCP)*	**$15** AHN/ **$25** copay per visit	**$20** AHN/ **$30** copay per visit	**$20** AHN/ **$30** copay per visit	**$25** AHN/ **$35** 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	**$50** AHN/ **$60** 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	**$1,000** copay/ day; **$3,000** 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	**$900** AHN/ **$1,000** copay
Emergency Room	**$300** ER copay per visit	**$350** ER copay per visit	**$450** ER copay per visit	**$450** ER copay per visit	**$450** 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	**$150** AHN/ **$250** copay per test	**$200** AHN/ **$300** copay per test
Outpatient Lab	**100%** covered	**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: **$150**/day Standard: **$250**/day	**100%** coinsurance up to: AHN: **$200**/day Standard: **$300**/day
Radiation and Chemotherapy	**20%** coinsurance	**20%** coinsurance	**20%** coinsurance	**30%** coinsurance	**30%** coinsurance
Physical/Occupational/Speech Therapy	**$25** copay per day	**$30** copay per day	**$30** copay per day	**$35** 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	**$50** AHN/ **$60** 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**	**50%** coinsurance; Max benefit for adults: **$100**
Preventive Dental*	**100%** covered	**100%** covered	**100%** covered	**100%** covered	**100%** covered
Comprehensive Dental - Child*	**50%** coinsurance	**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**	**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	**$500** Individual; **$1,500** Family	**$1,000** Individual; **$3,000** Family
Prescription Drugs (30-day supply)	Tier 1....**$0** or $10** copay Tier 2....**$30** copay Tier 3....**$60** copay Tier 4....**$100** copay Tier 5....**50%** coinsurance	Tier 1....**$0** or $10** copay Tier 2....**$30** copay Tier 3....**$60** copay Tier 4....**$100** copay Tier 5....**50%** coinsurance	Tier 1....**$0** or $10** copay Tier 2....**$30** copay Tier 3....**$60** copay Tier 4....**$100** copay Tier 5....**50%** coinsurance	Tier 1....**$0** or $10** copay Tier 2....**$30** copay Tier 3....**$60** copay Tier 4....**$100** copay Tier 5....**50%** coinsurance	Tier 1....**$0** or $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	**$5,000** Individual; **$15,000** Family
Out-of-Network Coinsurance	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance

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

***The preferred mail order copay of $0 for Tier 1 preferred generic drugs is only available from the preferred mail order pharmacy, Saint John Pharmacy, for a 100-day supply.*

ESSENTIAL 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	**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	**$7,500** Individual; **$15,000** Family	**$8,200** Individual; **$16,400** Family	**$8,400** Individual; **$16,800** Family	**$8,550** Individual; **$17,100** Family
Primary Care Provider (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 (30-day supply)	Tier 1.....**$0** or $10** copay Tier 2.....**$30** copay Tier 3.....**20%** coinsurance Tier 4.....**20%** coinsurance Tier 5.....**50%** coinsurance	Tier 1.....**$0** or $10** copay Tier 2.....**$30** copay Tier 3.....**50%** coinsurance Tier 4.....**50%** coinsurance Tier 5.....**50%** coinsurance	Tier 1.....**$0** or $10** copay Tier 2.....**$30** copay Tier 3.....**50%** coinsurance Tier 4.....**50%** coinsurance Tier 5.....**50%** coinsurance	Tier 1.....**$0** or $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.*

***The preferred mail order copay of $0 for Tier 1 preferred generic drugs is only available from the preferred mail order pharmacy, Saint John Pharmacy, for a 100-day supply.*

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 3500*	**SAVINGS** *SILVER 4500*	**SAVINGS** *BRONZE 5500*
In-Network Combined Medical/Prescription Drug Deductible	**$3,500** Individual; **$7,000** Family	**$4,500** Individual; **$9,000** Family	**$5,500** Individual; **$11,000** Family
In-Network Out-of-Pocket Maximum	**$3,500** Individual; **$7,000** Family	**$7,000** Individual; **$14,000** Family	**$7,200** Individual; **$14,400** Family
Primary Care Provider (PCP)	**100%** covered	**100%** covered	**50%** coinsurance
Specialist Office Visit	**100%** covered	**100%** covered	**50%** coinsurance
Inpatient Hospital	**100%** covered	**100%** covered	**50%** coinsurance
Outpatient Surgery Services	**100%** covered	**100%** covered	**50%** coinsurance
Emergency Room	**100%** covered	**100%** covered	**50%** coinsurance
Major Diagnostic Test (MRI, CT scan, stress test, etc)	**100%** covered	**100%** covered	**50%** coinsurance
Outpatient Lab	**100%** covered	**100%** covered	**50%** coinsurance
X-Rays and Other Outpatient Hospital Services	**100%** covered	**100%** covered	**50%** coinsurance
Radiation and Chemotherapy	**100%** covered	**100%** covered	**50%** coinsurance
Physical/Occupational/Speech Therapy	**100%** covered	**100%** covered	**50%** coinsurance
Vision Exam	**100%** covered	**100%** covered	**50%** coinsurance
Glasses/Contacts	**100%** covered; No adult coverage	**100%** covered No adult coverage	**50%** covered; 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	**100%** covered**	**50%** coinsurance**	**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

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

***A preferred mail order copay of $0 for Tier 1 preferred generic drugs with no deductible is only available from the preferred mail order pharmacy, Saint John Pharmacy, for a 100-day supply.*

VALUE 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	**VALUE** *GOLD 2000*	**VALUE** *SILVER 3000*
In-Network Medical Deductible	**$2,000** Individual; **$6,000** Family	**$3,000** Individual; **$9,000** Family
In-Network Out-of-Pocket Maximum	**$6,000** Individual; **$12,000** Family	**$8,550** Individual; **$17,100** Family
Primary Care Provider (PCP)*	**$20** AHN/ **$30** copay per visit	**$30** AHN/ **$40** copay per visit
Specialist Office Visit*	**$50** AHN/ **$60** copay per visit	**$65** AHN/ **$75** copay per visit
Inpatient Hospital	**20%** coinsurance	**40%** coinsurance
Outpatient Surgery Services	**20%** coinsurance	**40%** coinsurance
Emergency Room	**$350** ER copay per visit	**$450** ER copay per visit
Major Diagnostic Test (MRI, CT scan, stress test, etc)	**20%** coinsurance	**40%** coinsurance
Outpatient Lab	**20%** coinsurance	**40%** coinsurance
X-Rays and Other Outpatient Hospital Services	**20%** coinsurance	**40%** coinsurance
Radiation and Chemotherapy	**20%** coinsurance	**40%** coinsurance
Physical/Occupational/Speech Therapy	**20%** coinsurance	**40%** coinsurance
Vision Exam*	**$50** AHN/ **$60** 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**
Preventive Dental*	**100%** covered	**100%** covered
Comprehensive Dental - Child*	**50%** coinsurance	**50%** coinsurance
Comprehensive Dental - Adult*	**50%** coinsurance; Max benefit: **$500**	**50%** coinsurance; Max benefit: **$500**
Prescription Drug Deductible (applies to Tiers 4 and 5)	**$500** Individual; **$1,500** Family	**$800** Individual; **$2,400** Family
Prescription Drugs (30-day supply)	**Tier 1**.....**$0** or $10** copay **Tier 2**.....**$30** copay **Tier 3**.....**$60** copay **Tier 4**.....20% coinsurance **Tier 5**.....20% coinsurance	**Tier 1**.....**$0** or $20** copay **Tier 2**.....**$40** copay **Tier 3**.....**$75** copay **Tier 4**.....40% coinsurance **Tier 5**.....40% coinsurance
Out-of-Network Medical Deductible	**$5,000** Individual; **$15,000** Family	**$5,000** Individual; **$15,000** Family
Out-of-Network Coinsurance	**50%** coinsurance	**50%** Coinsurance

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

***The preferred mail order copay of $0 for Tier 1 preferred generic drugs is only available from the preferred mail order pharmacy, Saint John Pharmacy, for a 100-day supply.*