GROUP 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	*PLATINUM/PLATINUM PLUS* **FREEDOM** *ON AND OFF EXCHANGE*	*GOLD/GOLD PLUS* **FREEDOM 750** *ON AND OFF EXCHANGE*	*SILVER/SILVER PLUS* **FREEDOM 2400** *ON AND OFF EXCHANGE*
In-Network Medical Deductible	No medical deductible.	**$750** Individual; **$1,500** Family	**$2,400** Individual; **$4,800** Family
In-Network Out-of-Pocket Maximum	**$1,700** Individual; **$3,400** Family	**$5,000** Individual; **$10,000** Family	**$7,350** Individual; **$14,700** Family
Medical Home - Primary Care Provider (MH-PCP) Office Visit	AHN: **$0** copay per visit Standard: **$10** copay per visit	AHN: **$5** copay per visit* Standard: **$15** copay per visit*	AHN: **$10** copay per visit* Standard: **$25** copay per visit*
Specialist Office Visit	AHN: **$25** copay per visit Standard: **$35** copay per visit	AHN: **$30** copay per visit* Standard: **$50** copay per visit*	AHN: **$55** copay per visit* Standard: **$75** copay per visit*
Office Lab & Flu Shots	100% covered	100% covered*	100% covered*
Inpatient Hospital	AHN: Standard cost share less **$300** Standard: **$400** copay per day, maximum **$1,200** copay	AHN: Standard cost share less **$300** Standard: **$750** copay per day, maximum **$2,250** copay	AHN: Standard cost share less **$300** Standard: **$1,500** copay per day, maximum **$4,500** copay
Outpatient Surgery Services	AHN: **$100** copay per visit Standard: **$200** copay per visit	AHN: **$300** copay per visit Standard: **$400** copay per visit	AHN: **$900** copay per visit Standard: **$1,000** copay per visit
Hospital Physicians	100% covered	100% covered	100% covered
Emergency Room	**$150** ER copay per visit	**$250** ER copay per visit	**$300** ER copay per visit
Major Diagnostic Test (MRI, CT scan, stress test, etc)	AHN: **$50** copay per test Standard: **$150** copay per test	AHN: **$100** copay per test Standard: **$200** copay per test	AHN: **$200** copay per test Standard: **$300** copay per test
Outpatient Lab	100% covered	100% covered	100% covered
X-Rays and Other Outpatient Hospital Services	AHN: **100%** coinsurance up to **$50** per day Standard: **100%** coinsurance up to **$150** per day	AHN: **100%** coinsurance up to **$100** per day Standard: **100%** coinsurance up to **$200** per day	AHN: **100%** coinsurance up to **$200** per day Standard: **100%** coinsurance up to **$300** per day
Radiation and Chemotherapy	**30%** coinsurance	**30%** coinsurance	**30%** coinsurance
Physical Therapy/Occupational Therapy/Speech Therapy	**$40** copay per day	**$40** copay per day	**$40** copay per day
Vision Exam	AHN: **$25** copay per visit Standard: **$35** copay per visit	AHN: **$30** copay per visit* Standard: **$50** copay per visit*	AHN: **$55** copay per visit* Standard: **$75** copay per visit*
Glasses/Contacts	**50%** coinsurance; adults - **$100** maximum benefit	**50%** coinsurance*; adults - **$100** maximum benefit	**50%** coinsurance*; adults - **$100** maximum benefit
Preventive Dental	100% covered	100% covered*	100% covered*
Comprehensive Dental - Child	**50%** coinsurance	**50%** coinsurance*	**50%** coinsurance*
Comprehensive Dental - Adult	**50%** coinsurance; **$500** maximum benefit	**50%** coinsurance*; **$500** maximum benefit	**50%** coinsurance*; **$500** maximum benefit
Prescription Drugs	Tier 1..... **$3** copay Tier 2..... **$15** copay Tier 3..... **$45** copay Tier 4..... **$95** copay Tier 5..... **33%** coinsurance *No Rx Deductible*	Tier 1..... **$3** copay Tier 2..... **$15** copay Tier 3..... **$45** copay Tier 4..... **$95** copay Tier 5..... **33%** coinsurance *No Rx Deductible*	Tier 1..... **$3** copay** Tier 2..... **$15** copay** Tier 3..... **$45** copay Tier 4..... **$95** copay Tier 5..... **33%** coinsurance *Rx Deductible: $100 Individual; $200 Family (applies to Tiers 3, 4, 5)*
Out-of-Network Deductible and Coinsurance	**$5,000** Individual; **$10,000** Family **50%** coinsurance	**$5,000** Individual; **$10,000** Family **50%** coinsurance	**$5,000** Individual; **$10,000** Family **50%** coinsurance

**Not subject to in-network medical deductible* ***Not subject to prescription drug (Rx) deductible*

GROUP ESSENTIAL PLANS Benefit Comparison

VANTAGE HEALTH PLAN

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	*PLATINUM/PLATINUM PLUS* **ESSENTIAL 500** *OFF EXCHANGE ONLY*	*GOLD/GOLD PLUS* **ESSENTIAL 1200** *OFF EXCHANGE ONLY*	*GOLD/GOLD PLUS* **ESSENTIAL 1500** *OFF EXCHANGE ONLY*	*GOLD/GOLD PLUS* **ESSENTIAL 2000** *OFF EXCHANGE ONLY*
In-Network Medical Deductible	**$500** Individual; **$1,500** Family	**$1,200** Individual; **$3,600** Family	**$1,500** Individual; **$4,500** Family	**$2,000** Individual; **$6,000** Family
In-Network Out-of-Pocket Maximum	**$3,000** Individual; **$6,000** Family	**$3,500** Individual; **$7,000** Family	**$4,000** Individual; **$8,000** Family	**$4,000** Individual; **$8,000** Family
Medical Home - Primary Care Provider (MH-PCP) Office Visit	AHN: **$0** copay per visit* Standard: **$10** copay per visit*	AHN: **$5** copay per visit* Standard: **$15** copay per visit*	AHN: **$5** copay per visit* Standard: **$15** copay per visit*	AHN: **$5** copay per visit* Standard: **$15** copay per visit*
Specialist Office Visit	AHN: **$25** copay per visit* Standard: **$35** copay per visit*	AHN: **$30** copay per visit* Standard: **$50** copay per visit*	AHN: **$30** copay per visit* Standard: **$50** copay per visit*	AHN: **$30** copay per visit* Standard: **$50** copay per visit*
Office Lab & Flu Shots	100% covered*	100% covered*	100% covered*	100% covered*
Inpatient Hospital	**20%** coinsurance	**20%** coinsurance	**20%** coinsurance	**20%** coinsurance
Outpatient Surgery Services	**20%** coinsurance	**20%** coinsurance	**20%** coinsurance	**20%** coinsurance
Hospital Physicians	**20%** coinsurance	**20%** coinsurance	**20%** coinsurance	**20%** coinsurance
Emergency Room	**20%** coinsurance	**20%** coinsurance	**20%** coinsurance	**20%** coinsurance
Major Diagnostic Test (MRI, CT scan, stress test, etc)	**20%** coinsurance	**20%** coinsurance	**20%** coinsurance	**20%** coinsurance
Outpatient Lab	**20%** coinsurance	**20%** coinsurance	**20%** coinsurance	**20%** coinsurance
X-Rays and Other Outpatient Hospital Services	**20%** coinsurance	**20%** coinsurance	**20%** coinsurance	**20%** coinsurance
Radiation and Chemotherapy	**20%** coinsurance	**20%** coinsurance	**20%** coinsurance	**20%** coinsurance
Physical Therapy/Occupational Therapy/Speech Therapy	**20%** coinsurance	**20%** coinsurance	**20%** coinsurance	**20%** coinsurance
Vision Exam	AHN: **$25** copay per visit* Standard: **$35** copay per visit*	AHN: **$30** copay per visit* Standard: **$50** copay per visit*	AHN: **$30** copay per visit* Standard: **$50** copay per visit*	AHN: **$30** copay per visit* Standard: **$50** copay per visit*
Glasses/Contacts	**50%** coinsurance*; adults - **$100** benefit max	**50%** coinsurance*; adults - **$100** benefit max	**50%** coinsurance*; adults - **$100** benefit max	**50%** coinsurance*; adults - **$100** benefit max
Preventive Dental	100% covered*	100% covered*	100% covered*	100% covered*
Comprehensive Dental - Child	**50%** coinsurance*	**50%** coinsurance*	**50%** coinsurance*	**50%** coinsurance*
Comprehensive Dental - Adult	**Optional: 50%** coinsurance*; **$500** benefit max	**Optional: 50%** coinsurance*; **$500** benefit max	**Optional: 50%** coinsurance*; **$500** benefit max	**Optional: 50%** coinsurance*; **$500** benefit max
Prescription Drugs	Tier 1........................**$3** copay Tier 2........................**$20** copay Tier 3........................**20%** coinsurance Tier 4........................**20%** coinsurance Tier 5........................**33%** coinsurance *No Rx Deductible*	Tier 1........................**$3** copay** Tier 2........................**$20** copay** Tier 3........................**20%** coinsurance Tier 4........................**20%** coinsurance Tier 5........................**33%** coinsurance *Rx Deductible: $300 Individual; $900 Family (applies to Tiers 3, 4, 5)*	Tier 1........................**$3** copay** Tier 2........................**$20** copay** Tier 3........................**20%** coinsurance Tier 4........................**20%** coinsurance Tier 5........................**33%** coinsurance *Rx Deductible: $300 Individual; $900 Family (applies to Tiers 3, 4, 5)*	Tier 1........................**$3** copay** Tier 2........................**$20** copay** Tier 3........................**20%** coinsurance Tier 4........................**20%** coinsurance Tier 5........................**33%** coinsurance *Rx Deductible: $300 Individual; $900 Family (applies to Tiers 3, 4, 5)*
Out-of-Network Deductible and Coinsurance	**$5,000** Individual; **$10,000** Family **50%** coinsurance	**$5,000** Individual; **$10,000** Family **50%** coinsurance	**$5,000** Individual; **$10,000** Family **50%** coinsurance	**$5,000** Individual; **$10,000** Family **50%** coinsurance

**Not subject to in-network medical deductible   **Not subject to prescription drug (Rx) deductible*

GROUP ESSENTIAL PLANS Benefit Comparison (continued)

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	*SILVER/SILVER PLUS* **ESSENTIAL 2500** *OFF EXCHANGE ONLY*	*SILVER/SILVER PLUS* **ESSENTIAL 3000** *OFF EXCHANGE ONLY*	*SILVER/SILVER PLUS* **ESSENTIAL 4500** *OFF EXCHANGE ONLY*	*BRONZE/BRONZE PLUS* **ESSENTIAL 6500** *ON AND OFF EXCHANGE*
In-Network Medical Deductible	**$2,500** Individual; **$7,500** Family	**$3,000** Individual; **$9,000** Family	**$4,500** Individual; **$13,500** Family	**$6,500** Individual; **$13,000** Family
In-Network Out-of-Pocket Maximum	**$6,000** Individual; **$12,000** Family	**$6,500** Individual; **$13,000** Family	**$7,350** Individual; **$14,700** Family	**$7,350** Individual; **$14,700** Family
Medical Home - Primary Care Provider (MH-PCP) Office Visit	AHN: **$10** copay per visit* Standard: **$25** copay per visit*	AHN: **$10** copay per visit* Standard: **$25** copay per visit*	AHN: **$10** copay per visit* Standard: **$25** copay per visit*	AHN: **$25** copay per visit* Standard: **$45** copay per visit*
Specialist Office Visit	AHN: **$55** copay per visit* Standard: **$75** copay per visit*	AHN: **$55** copay per visit* Standard: **$75** copay per visit*	AHN: **$55** copay per visit* Standard: **$75** copay per visit*	AHN: **$60** copay per visit* Standard: **$90** copay per visit*
Office Lab & Flu Shots	100% covered*	100% covered*	100% covered*	100% covered*
Inpatient Hospital	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance
Outpatient Surgery Services	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance
Hospital Physicians	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance
Emergency Room	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance
Major Diagnostic Test (MRI, CT scan, stress test, etc)	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance
Outpatient Lab	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance
X-Rays and Other Outpatient Hospital Services	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance
Radiation and Chemotherapy	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance
Physical Therapy/Occupational Therapy/Speech Therapy	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance
Vision Exam	AHN: **$55** copay per visit* Standard: **$75** copay per visit*	AHN: **$55** copay per visit* Standard: **$75** copay per visit*	AHN: **$55** copay per visit* Standard: **$75** copay per visit*	AHN: **$60** copay per visit* Standard: **$90** copay per visit*
Glasses/Contacts	**50%** coinsurance*; adults - **$100** benefit max	**50%** coinsurance*; adults - **$100** benefit max	**50%** coinsurance*; adults - **$100** benefit max	**50%** coinsurance*; adults - **$100** benefit max
Preventive Dental	100% covered*	100% covered*	100% covered*	100% covered*
Comprehensive Dental - Child	**50%** coinsurance*	**50%** coinsurance*	**50%** coinsurance*	**50%** coinsurance*
Comprehensive Dental - Adult	**Optional: 50%** coinsurance*; **$500** benefit max	**Optional: 50%** coinsurance*; **$500** benefit max	**Optional: 50%** coinsurance*; **$500** benefit max	**Optional Off-Exchange: 50%** coinsurance*; **$500** benefit max (1)
Prescription Drugs	Tier 1........ **$3** copay** Tier 2........ **$20** copay** Tier 3........ **50%** coinsurance Tier 4........ **50%** coinsurance Tier 5........ **50%** coinsurance *Rx Deductible: $500 Individual; $1,500 Family (applies to Tiers 3, 4, 5)*	Tier 1........ **$3** copay** Tier 2........ **$20** copay** Tier 3........ **50%** coinsurance Tier 4........ **50%** coinsurance Tier 5........ **50%** coinsurance *Rx Deductible: $500 Individual; $1,500 Family (applies to Tiers 3, 4, 5)*	Tier 1........ **$3** copay** Tier 2........ **$20** copay** Tier 3........ **50%** coinsurance Tier 4........ **50%** coinsurance Tier 5........ **50%** coinsurance *Rx Deductible: $500 Individual; $1,500 Family (applies to Tiers 3, 4, 5)*	Tier 1........ **$3** copay** Tier 2........ **$20** copay** Tier 3........ **50%** coinsurance Tier 4........ **50%** coinsurance Tier 5........ **50%** coinsurance *Rx Deductible: $850 Individual; $1,700 Family (applies to Tiers 3, 4, 5)*
Out-of-Network Deductible and Coinsurance	**$5,000** Individual; **$10,000** Family **50%** coinsurance	**$5,000** Individual; **$10,000** Family **50%** coinsurance	**$5,000** Individual; **$10,000** Family **50%** coinsurance	**$8,000** Individual; **$16,000** Family **50%** coinsurance

**Not subject to in-network medical deductible* ***Not subject to prescription drug (Rx) deductible* *(1) - Included in On-Exchange plans*

GROUP 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	*GOLD/GOLD PLUS* **SAVINGS 1500** *OFF EXCHANGE ONLY*	*SILVER/SILVER PLUS* **SAVINGS 3000** *OFF EXCHANGE ONLY*	*BRONZE/BRONZE PLUS* **SAVINGS 6000** *ON AND OFF EXCHANGE*
In-Network Combined Medical/Prescription Drug Deductible	**$1,500** Individual; **$3,000** Family	**$3,000** Individual; **$6,000** Family	**$6,000** Individual; **$12,000** Family
In-Network Out-of-Pocket Maximum	**$3,000** Individual; **$6,000** Family	**$5,500** Individual; **$11,000** Family	**$6,500** Individual; **$13,000** Family
Medical Home – Primary Care Provider (MH-PCP) Office Visit	**20%** coinsurance	**50%** coinsurance	**50%** coinsurance
Specialist Office Visit	**20%** coinsurance	**50%** coinsurance	**50%** coinsurance
Office Lab	**20%** coinsurance	**50%** coinsurance	**50%** coinsurance
Inpatient Hospital	**20%** coinsurance	**50%** coinsurance	**50%** coinsurance
Outpatient Surgery Services	**20%** coinsurance	**50%** coinsurance	**50%** coinsurance
Hospital Physicians	**20%** coinsurance	**50%** coinsurance	**50%** coinsurance
Emergency Room	**20%** coinsurance	**50%** coinsurance	**50%** coinsurance
Major Diagnostic Test (MRI, CT scan, stress test, etc)	**20%** coinsurance	**50%** coinsurance	**50%** coinsurance
Outpatient Lab	**20%** coinsurance	**50%** coinsurance	**50%** coinsurance
X-Rays and Other Outpatient Hospital Services	**20%** coinsurance	**50%** coinsurance	**50%** coinsurance
Radiation and Chemotherapy	**20%** coinsurance	**50%** coinsurance	**50%** coinsurance
Physical Therapy/Occupational Therapy/Speech Therapy	**20%** coinsurance	**50%** coinsurance	**50%** coinsurance
Vision Exam	**20%** coinsurance	**50%** coinsurance	**50%** coinsurance
Glasses/Contacts (child only)	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance
Preventive Dental	100% covered*	100% covered*	100% covered*
Comprehensive Dental (child)	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance
Comprehensive Dental (adult)	Not covered	Not covered	Not covered
Prescription Drugs	Tier 1 ..... **20%** coinsurance Tier 2 ..... **20%** coinsurance Tier 3 ..... **50%** coinsurance Tier 4 ..... **50%** coinsurance Tier 5 ..... **50%** coinsurance *See Combined Medical/Prescription Drug Deductible above*	ALL TIERS **50%** coinsurance *See Combined Medical/Prescription Drug Deductible above*	ALL TIERS **50%** coinsurance *See Combined Medical/Prescription Drug Deductible above*
Out-of-Network Deductible and Coinsurance	**$5,000** Individual; **$10,000** Family **50%** coinsurance	**$5,000** Individual; **$10,000** Family **50%** coinsurance	**$8,000** Individual; **$16,000** Family **50%** coinsurance

**Not subject to Combined Medical/Prescription Drug Deductible*