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.

PLEASE NOTE: Refer to the Healthcare Savings Chart on page 4 to find out if you may qualify for these Vantage Marketplace Silver Cost Share Reduction Plans.

BENEFITS	**SILVER 73** *SILVER 2200-73*	**SILVER 87** *SILVER 700-87*	**SILVER 94** *SILVER 100-94*
In-Network Medical Deductible	**$2,200** Individual; **$6,600** Family	**$700** individual; **$2,100** Family	**$100** Individual; **$300** Family
In-Network Out-of-Pocket Maximum	**$6,000** Individual; **$12,000** Family	**$2,200** Individual; **$4,400** Family	**$1,000** Individual; **$2,000** Family
Medical Home - Primary Care Provider (MH-PCP)*	**$20** AHN/ **$30** copay per visit	**$0** AHN/ **$10** copay per visit	**$0** AHN/ **$5** copay per visit
Specialist Office Visit*	**$65** AHN/ **$75** copay per visit	**$20** AHN/ **$30** copay per visit	**$5** AHN/ **$15** copay per visit
Inpatient Hospital ($100 savings at AHN)	**$1,500** copay/ day; **$4,500** max	**$500** copay/ day; **$1,500** max	**$100** copay/ day; **$300** max
Outpatient Surgery Services	**$900** AHN/ **$1,000** copay	**$400** AHN/ **$500** copay	**$0** AHN/ **$100** copay
Emergency Room	**$400** ER copay per visit	**$250** ER copay per visit	**$150** ER copay per visit
Major Diagnostic Test (MRI, CT scan, stress test, etc)	**$200** AHN/ **$300** copay per test	**$150** AHN/ **$250** copay per test	**$0** AHN/ **$100** copay per test
Outpatient Lab	**100%** covered	**100%** covered	**100%** covered
Outpatient X-Rays and Other Hospital Services	**100%** coinsurance up to AHN: **$200**/day Standard: **$300**/day	**100%** coinsurance up to **AHN: $150**/day Standard: **$250**/day	**100%** coinsurance up to AHN: **$50**/day Standard: **$100**/day
Radiation and Chemotherapy	**30%** coinsurance	**20%** coinsurance	**10%** coinsurance
Physical/Occupational/Speech Therapy	**$40** copay per day	**$30** copay per day	**$20** copay per day
Vision Exam*	**$65** AHN/ **$75** copay per visit	**$20** AHN/ **$30** copay per visit	**$5** AHN/ **$15** copay per visit
Glasses and Contacts*	**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
Comprehensive Dental - Child*	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance
Comprehensive Dental - Adults*	**50%** coinsurance; Max benefit: **$500**	**50%** coinsurance; Max benefit: **$500**	**50%** coinsurance; Max benefit: **$500**
Drug Deductible (applies to Tiers 3, 4, 5)	**$500** Individual; **$1,500** Family	**$100** Individual; **$300** Family	**$100** Individual; **$300** 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.....**$5** copay** Tier 2.....**$15** copay** Tier 3.....**$40** copay Tier 4.....**$70** copay Tier 5.....**50%** coinsurance	Tier 1.....**$5** copay** Tier 2.....**$7** copay** Tier 3.....**$15** copay Tier 4.....**$40** copay Tier 5.....**50%** coinsurance
Out-of-Network Deductible	**$5,000** Individual **$10,000** Family	**$5,000** Individual **$10,000** Family	**$5,000** Individual **$10,000** Family
Out-of-Network Coinsurance	**50%** Coinsurance	**50%** Coinsurance	**50%** Coinsurance

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

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.

PLEASE NOTE: Refer to the Healthcare Savings Chart on page 4 to find out if you may qualify for these Vantage Marketplace Silver Cost Share Reduction Plans.

BENEFITS	**SILVER 73** *SILVER 3000-73*	**SILVER 87** *SILVER1000-87*	**SILVER 94** *SILVER 100-94*
In-Network Medical Deductible	**$3,000** Individual; **$9,000** Family	**$1,000** Individual; **$3,000** Family	**$100** Individual; **$300** Family
In-Network Out-of-Pocket Maximum	**$5,200** Individual; **$10,400** Family	**$2,000** Individual; **$4,000** Family	**$1,600** Individual; **$3,200** Family
Medical Home - Primary Care Provider (MH-PCP)*	**$30** AHN/ **$40** copay per visit	**$0** AHN/ **$10** copay per visit	**$0** AHN/ **$5** copay per visit
Specialist Office Visit	**30%** coinsurance	**20%** coinsurance	**10%** coinsurance
Inpatient Hospital	**30%** coinsurance	**20%** coinsurance	**10%** coinsurance
Outpatient Surgery Services	**30%** coinsurance	**20%** coinsurance	**10%** coinsurance
Emergency Room	**30%** coinsurance	**20%** coinsurance	**10%** coinsurance
Major Diagnostic Test (MRI, CT scan, stress test, etc)	**30%** coinsurance	**20%** coinsurance	**10%** coinsurance
Outpatient Lab	**30%** coinsurance	**20%** coinsurance	**10%** coinsurance
Outpatient X-Rays and Other Hospital Services	**30%** coinsurance	**20%** coinsurance	**10%** coinsurance
Radiation and Chemotherapy	**30%** coinsurance	**20%** coinsurance	**10%** coinsurance
Physical/Occupational/Speech Therapy	**30%** coinsurance	**20%** coinsurance	**10%** coinsurance
Vision Exam	**30%** coinsurance	**20%** coinsurance	**10%** coinsurance
Glasses and Contacts*	**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
Comprehensive Dental - Child*	**50%** coinsurance	**50%** coinsurance	**50%** coinsurance
Comprehensive Dental - Adults*	**50%** coinsurance; Max benefit: **$500**	**50%** coinsurance; Max benefit: **$500**	**50%** coinsurance; Max benefit: **$500**
Drug Deductible (applies to Tiers 3, 4, 5)	**$500** Individual; **$1,500** Family	**$150** Individual; **$450** Family	**$100** Individual; **$300** Family
Prescription Drugs	Tier 1.....**$10** copay** Tier 2.....**$30** copay** Tier 3.....**50%** coinsurance Tier 4.....**50%** coinsurance Tier 5.....**50%** coinsurance	Tier 1.....**$5** copay** Tier 2.....**$15** copay** Tier 3.....**20%** coinsurance Tier 4.....**20%** coinsurance Tier 5.....**50%** coinsurance	Tier 1.....**$5** copay** Tier 2.....**$7** copay** Tier 3.....**10%** coinsurance Tier 4.....**10%** coinsurance Tier 5.....**50%** coinsurance
Out-of-Network Co-insurance	**$5,000** Individual **$10,000** Family	**$5,000** Individual **$10,000** Family	**$5,000** Individual **$10,000** Family
Out-of-Network Co-insurance	**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.

PLEASE NOTE: Refer to the Healthcare Savings Chart on page 4 to find out if you may qualify for these Vantage Marketplace Silver Cost Share Reduction Plans.

BENEFITS	**SILVER 73** *SILVER 3500-73*	**SILVER 87** *SILVER 1350-87*	**SILVER 94** *SILVER 600-94*
In-Network Combined Medical/Prescription Drug Deductible	**$3,500** Individual; **$7,000** Family	**$1,350** Individual; **$2,700** Family	**$600** Individual; **$1,200** Family
In-Network Out-of-Pocket Maximum	**$3,500** Individual; **$7,000** Family	**$1,350** Individual; **$2,700** Family	**$600** Individual; **$1,200** Family
Medical Home - Primary Care Provider (MH-PCP)	**100%** covered	**100%** covered	**100%** covered
Specialist Office Visit	**100%** covered	**100%** covered	**100%** covered
Inpatient Hospital	**100%** covered	**100%** covered	**100%** covered
Outpatient Surgery Services	**100%** covered	**100%** covered	**100%** covered
Emergency Room	**100%** covered	**100%** covered	**100%** covered
Major Diagnostic Test (MRI, CT scan, stress test, etc)	**100%** covered	**100%** covered	**100%** covered
Outpatient Lab	**100%** covered	**100%** covered	**100%** covered
Outpatient X-Rays and Other Hospital Services	**100%** covered	**100%** covered	**100%** covered
Radiation and Chemotherapy	**100%** covered	**100%** covered	**100%** covered
Physical/Occupational/Speech Therapy	**100%** covered	**100%** covered	**100%** covered
Vision Exam	**100%** covered	**100%** covered	**100%** covered
Glasses/ Contacts	**100%** covered; no adult coverage	**100%** covered; no adult coverage	**100%** covered; no adult coverage
Preventive Dental*	**100%** covered	**100%** covered	**100%** covered
Comprehensive Dental- Child	**100%** covered	**100%** covered	**100%** covered
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.....**100%** covered Tier 2.....**100%** covered Tier 3.....**100%** covered Tier 4.....**100%** covered Tier 5.....**100%** covered	Tier 1.....**100%** covered Tier 2.....**100%** covered Tier 3.....**100%** covered Tier 4.....**100%** covered Tier 5.....**100%** covered
Out-of-Network Deductible	**$5,000** Individual **$10,000** Family	**$5,000** Individual **$10,000** Family	**$5,000** Individual **$10,000** Family
Out-of-Network Coinsurance	**50%** Coinsurance	**50%** Coinsurance	**50%** Coinsurance
HSA Qualified	YES	NO	NO

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