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 ON AND OFF EXCHANGE	GOLD 1000 ON AND OFF EXCHANGE	SILVER 2500 OFF EXCHANGE ONLY	SILVER 3000 ON AND OFF EXCHANGE	SILVER 4000 OFF EXCHANGE ONLY
In-Network Medical Deductible	**$0** Individual; **$0** Family	**$1,000** Individual; **$3,000** Family	**$2,500** Individual; **$7,500** Family	**$3,000** Individual; **$9,000** Family	**$4,000** Individual; **$12,000** Family
In-Network Out-of-Pocket Maximum	**$2,000** Individual; **$4,000** Family	**$5,500** Indiviudal; **$11,000** Family	**$7,500** Individual; **$15,000** Family	**$7,850** Individual; **$15,700** Family	**$7,850** Individual; **$15,700** Family
Medical Home - Primary Care Provider (MH-PCP)*	**$5** AHN/ **$15** copay per visit	**$15** AHN/ **$25** copay per visit	**$30** AHN/ **$40** copay per visit	**$30** AHN/ **$40** copay per visit	**$40** AHN/ **$50** copay per visit
Specialist Office Visit*	**$30** AHN/ **$40** copay per visit	**$40** AHN/ **$50** copay per visit	**$65** AHN/ **$75** copay per visit	**$65** AHN/ **$75** 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	**$1,500** copay/ day; **$4,500** max	**$1,500** copay/ day; **$4,500** max	**$1,500** copay/ day; **$4,500** max
Outpatient Surgery Services	**$100** AHN/ **$200** copay	**$300** AHN/ **$400** copay	**$900** AHN/ **$1,000** copay	**$900** AHN/ **$1,000** copay	**$900** AHN/ $**1,000** copay
Emergency Room	**$200** ER copay per visit	**$300** ER copay per visit	**$400** 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	**$200** AHN/ **$300** copay per test	**$200** AHN/ **$300** copay per test	**$200** AHN/ **$300** copay per test
Outpatient Lab	**100%** covered	**100%** covered	**100%** covered	**100%** covered	**100%** covered
Outpatient X-Rays and Other 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: **$200**/day Standard: **$300**/day	**100%** coinsurance up to: AHN: **$200**/day Standard: **$300**/day	**100%** coinsurance up to AHN: **$200**/day Standard: **$300**/day
Radiation and Chemotherapy	**20%** coinsurance	**20%** coinsurance	**30%** coinsurance	**30%** coinsurance	**30%** coinsurance
Physical/Occupational/Speech Therapy	**$40** copay per day	**$40** copay per day	**$40** copay per day	**$40** copay per day	**$40** copay per day
Vision Exam*	**$30** AHN/ **$40** copay per visit	**$40** AHN/ **$50** copay per visit	**$65** AHN/ **$75** copay per visit	**$65** AHN/ **$75** 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- Adults*	**50%** coinsurance; Max benefit: **$500**	**50%** coinsurance; Max benefit: **$500**	**50%** coinsurance; Max benefit: **$500** **(If coverage is selected)**	**50%** coinsurance; Max benefit: **$500**	**50%** coinsurance; Max benefit: **$500** **(If coverage is selected)**
Drug Deductible (applies to Tiers 3, 4, 5)	**$250** Individual; **$750** Family	**$500** Individual; **$1,500** Family	**$750** Individual; **$2,250** Family	**$750** Individual; **$2,250** Family	**$750** Individual; **$2,250** Family
Prescription Drugs	Tier 1.....**$10** copay** Tier2 .....**$30** copay** Tier 3.....**$60** copay Tier 4.....**$100** copay Tier 5.....**50%** coinsurance	Tier 1.....**$10** copay** Tier2 .....**$30** copay** Tier 3.....**$60** copay Tier 4.....**$100** copay Tier 5.....**50%** coinsurance	Tier 1.....**$10** copay** Tier2 .....**$30** copay** Tier 3.....**50%** coinsurance Tier 4.....**50%** coinsurance Tier 5.....**50%** coinsurance	Tier 1.....**$10** copay** Tier2 .....**$30** copay** Tier 3.....**$60** copay Tier 4.....**$100** copay Tier 5.....**50%** coinsurance	Tier 1.....**$10** copay** Tier2 .....**$30** copay** Tier 3.....**50%** coinsurance Tier 4.....**50%** coinsurance 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	**$5,000** Individual **$10,000** Family	**$5,000** Individual **$10,000** Family
Out-of-Network Coinsurance	**50%** 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

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 1500** *ON AND OFF EXCHANGE*	**SILVER 3500** *ON AND OFF EXCHANGE*	**BRONZE 6500** *ON AND OFF EXCHANGE*
In-Network Medical Deductible	**$1,500** Individual; **$4,500** Family	**$3,500** Individual; **$10,500** Family	**$6,500** Individual; **$13,000** Family
In-Network Out-of-Pocket Maximum	**$4,000** Individual; **$8,000** Family	**$7,700** Individual; **$15,400** Family	**$7,850** Individual; **$15,700** Family
Medical Home - Primary Care Provider (MH-PCP)*	**$20** AHN/ **$30** copay per visit	**$30** AHN/ **$40** copay per visit	**$40** AHN/ **$50** copay per visit
Specialist Office Visit	**20%** coinsurance	**30%** coinsurance	**50%** coinsurance
Inpatient Hospital	**20%** coinsurance	**30%** coinsurance	**50%** coinsurance
Outpatient Surgery Services	**20%** coinsurance	**30%** coinsurance	**50%** coinsurance
Emergency Room	**20%** coinsurance	**30%** coinsurance	**50%** coinsurance
Major Diagnostic Test (MRI, CT scan, stress test, etc)	**20%** coinsurance	**30%** coinsurance	**50%** coinsurance
Outpatient Lab	**20%** coinsurance	**30%** coinsurance	**50%** coinsurance
Outpatient X-Rays and Other Hospital Services	**20%** coinsurance	**30%** coinsurance	**50%** coinsurance
Radiation and Chemotherapy	**20%** coinsurance	**30%** coinsurance	**50%** coinsurance
Physical/Occupational/Speech Therapy	**20%** coinsurance	**30%** coinsurance	**50%** coinsurance
Vision Exam	**20%** coinsurance	**30%** 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**
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**
Drug Deductible (applies to Tiers 3, 4, 5)	**$500** Individual; **$1,500** Family	**$750** Individual; **$2,250** 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
Out-of-Network Deductible	**$5,000** Individual **$10,000** Family	**$5,000** Individual **$10,000** Family	**$8,000** Individual **$16,000** Family
Out-of-Network Coinsurance	**50%** Coinsurance	**50%** Coinsurance	**50%** Coinsurance

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

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 3000** *ON AND OFF EXCHANGE*	**SILVER 3800** *OFF EXCHANGE ONLY*	**SILVER 5000** *ON AND OFF EXCHANGE*	**BRONZE 5500** *ON AND OFF EXCHANGE*	**BRONZE 6750** *ON AND OFF EXCHANGE*
In-Network Combined Medical/Prescription Drug Deductible	**$3,000** Individual; **$6,000** Family	**$3,800** Individual; **$7,600** Family	**$5,000** Individual; **$10,000** Family	**$5,500** Individual; **$11,000** Family	**$6,750** Individual; **$13,500** Family
In-Network Out-of-Pocket Maximum	**$3,000** Individual; **$6,000** Family	**$6,000** Individual; **$12,000** Family	**$5,000** Individual; **$10,000** Family	**$6,750** Individual; **$13,500** Family	**$6,750** Individual; **$13,500** Family
Medical Home – Primary Care Provider (MH-PCP)	**100%** covered	**30%** coinsurance	**100%** covered	**50%** coinsurance	**100%** covered
Specialist Office Visit	**100%** covered	**30%** coinsurance	**100%** covered	**50%** coinsurance	**100%** covered
Inpatient Hospital	**100%** covered	**30%** coinsurance	**100%** covered	**50%** coinsurance	**100%** covered
Outpatient Surgery Services	**100%** covered	**30%** coinsurance	**100%** covered	**50%** coinsurance	**100%** covered
Emergency Room	**100%** covered	**30%** coinsurance	**100%** covered	**50%** coinsurance	**100%** covered
Major Diagnostic Test (MRI, CT scan, stress test, etc)	**100%** covered	**30%** coinsurance	**100%** covered	**50%** coinsurance	**100%** covered
Outpatient Lab	**100%** covered	**30%** coinsurance	**100%** covered	**50%** coinsurance	**100%** covered
Outpatient X-Rays and Other Hospital Services	**100%** covered	**30%** coinsurance	**100%** covered	**50%** coinsurance	**100%** covered
Radiation and Chemotherapy	**100%** covered	**30%** coinsurance	**100%** covered	**50%** coinsurance	**100%** covered
Physical/Occupational/Speech Therapy	**100%** covered	**30%** coinsurance	**100%** covered	**50%** coinsurance	**100%** covered
Vision Exam	**100%** covered	**30%** coinsurance	**100%** covered	**50%** coinsurance	**100%** covered
Glasses/ Contacts	**100%** covered; no adult coverage	**50%** coinsurance; no adult coverage	**100%** covered; no adult coverage	**50%** coinsurance; no adult coverage	**100%** covered; no adult coverage
Preventive Dental*	**100%** Covered	**100%** Covered	**100%** Covered	**100%** Covered	**100%** Covered
Comprehensive Dental- Child	**100%** covered	**50%** coinsurance	**100%** covered	**50%** coinsurance	**100%** covered
Comprehensive Dental – Adults*	No option available	**50%** coinsurance; Max benefit: **$500** **(If coverage is selected)**	No option available	No option available	No option available
Drug Deductible	See Combined Medical/Prescription Drug Deductible Above	See Combined Medical/Prescription Drug Deductible Above	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.....**30%** coinsurance Tier 2.....**30%** coinsurance Tier 3.....**50%** coinsurance Tier 4.....**50%** coinsurance Tier 5.....**50%** coinsurance	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.....**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	**$8,000** Individual **$16,000** Family	**$8,000** Individual **$16,000** Family
Out-of-Network Coinsurance	**50%** Coinsurance	**50%** Coinsurance	**50%** Coinsurance	**50%** Coinsurance	**50%** Coinsurance
HSA Qualified	YES	YES	YES	YES	YES

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