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	SILVER 73	SILVER 87	SILVER 94
In-Network Medical Deductible	**$3,000** Individual; **$9,000** Family	**$500** Individual; **$1,500** Family	**$0** Individual; **$0** Family
In-Network Out-of-Pocket Maximum	**$6,800** Individual; **$13,600** Family	**$2,500** Individual; **$5,000** Family	**$1,000** Individual; **$2,000** Family
Primary Care Provider (PCP)*	**$20** AHN/ **$30** copay per visit	**$5** AHN/ **$15** copay per visit	**$0** AHN/ **$5** copay per visit
Specialist Office Visit*	**$50** AHN/ **$60** copay per visit	**$25** AHN/ **$35** copay per visit	**$5** AHN/ **$15** copay per visit
Inpatient Hospital ($100 savings at AHN)	**$1,500** copay/ day; **$4,500** max	**$750** copay/ day; **$2,250** max	**$200** copay/ day; **$600** max
Outpatient Surgery Services	**$900** AHN/ **$1,000** copay	**$400** AHN/ **$500** copay	**$150** AHN/ **$250** copay
Emergency Room	**$400** ER copay per visit	**$350** ER copay per visit	**$250** 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/ **$50** copay per test
Outpatient Lab	**100%** covered	**100%** covered	**100%** covered
X-Rays and Other Outpatient 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: **$0**/day Standard: **$50**/day
Radiation and Chemotherapy	**30%** coinsurance	**20%** coinsurance	**10%** coinsurance
Physical/Occupational/Speech Therapy	**$30** copay per day	**$15** copay per day	**$5** copay per day
Vision Exam*	**$50** AHN/ **$60** copay per visit	**$25** AHN/ **$35** 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**
Prescription Drug Deductible (applies to Tiers 3, 4, 5)	**$500** Individual; **$1,500** Family	**$500** Individual; **$1,500** Family	**$500** Individual; **$1,500** 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**.....**$20** copay **Tier 3**.....**$60** copay **Tier 4**.....**$75** copay **Tier 5**.....**50%** coinsurance	Tier 1.....**$0** or $5** copay Tier 2.....**$10** copay Tier 3.....**$30** copay Tier 4.....**$75** 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
Out-of-Network 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.*