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 3500** *OFF EXCHANGE ONLY*	**SILVER 4500** *ON AND OFF EXCHANGE*
In-Network Medical Deductible	**$3,500** Individual; **$10,500** Family	**$4,500** Individual; **$13,500** Family
In-Network Out-of-Pocket Maximum	**$8,550** Individual; **$17,100** Family	**$8,550** Individual; **$17,100** Family
Primary Care Provider (PCP)*	**$30** AHN/ **$40** copay per visit	**$30** AHN/ **$40** copay per visit
Specialist Office Visit*	**$65** AHN/ **$75** copay per visit	**$65** AHN/ **$75** copay per visit
Inpatient Hospital ($100 savings at AHN)	**$1,500** copay/ day; **$4,500** max	**$1,500** copay/ day; **$4,500** max
Outpatient Surgery Services	**$900** AHN/ **$1,000** copay	**$900** AHN/ **$1,000** copay
Emergency Room	**$400** ER copay per visit	**$450** ER copay per visit
Major Diagnostic Test (MRI, CT scan, stress test, etc)	**$200** AHN/ **$300** copay per test	**$200** AHN/ **$300** copay per test
Outpatient Lab	**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: **$200**/day Standard: **$300**/day
Radiation and Chemotherapy	**30%** coinsurance	**30%** coinsurance
Physical/Occupational/Speech Therapy	**$40** copay per day	**$40** copay per day
Vision Exam*	**$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**
Preventive Dental*	**100%** covered	**100%** covered
Comprehensive Dental- Child*	**50%** coinsurance	**50%** coinsurance
Comprehensive Dental- Adults*	**50%** coinsurance; Max benefit: **$500**	**50%** coinsurance; Max benefit: **$500**
Prescription Drug Deductible (applies to Tiers 3, 4, 5)	**$1,000** Individual; **$3,000** 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
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.*

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 1600** *ON AND OFF EXCHANGE*	**BRONZE 6500** *ON AND OFF EXCHANGE*
In-Network Medical Deductible	**$1,600** Individual; **$4,800** Family	**$6,500** Individual; **$13,000** Family
In-Network Out-of-Pocket Maximum	**$7,500** Individual; **$15,000** Family	**$8,550** Individual; **$17,100** Family
Primary Care Provider (PCP)*	**$20** AHN/ **$30** copay per visit	**$40** AHN/ **$50** copay per visit
Specialist Office Visit	**20%** coinsurance	**50%** coinsurance
Inpatient Hospital	**20%** coinsurance	**50%** coinsurance
Outpatient Surgery Services	**20%** coinsurance	**50%** coinsurance
Emergency Room	**20%** coinsurance	**50%** coinsurance
Major Diagnostic Test (MRI, CT scan, stress test, etc)	**20%** coinsurance	**50%** coinsurance
Outpatient Lab	**20%** coinsurance	**50%** coinsurance
Outpatient X-Rays and Other Hospital Services	**20%** coinsurance	**50%** coinsurance
Radiation and Chemotherapy	**20%** coinsurance	**50%** coinsurance
Physical/Occupational/Speech Therapy	**20%** coinsurance	**50%** coinsurance
Vision Exam	**20%** coinsurance	**50%** coinsurance
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 3, 4, 5)	**$600** Individual; **$1,800** 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
Out-of-Network Medical Deductible	**$5,000** Individual **$15,000** Family	**$8,000** Individual **$16,000** 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.*

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	**BRONZE 5500** *ON AND OFF EXCHANGE*	**BRONZE 7000** *ON AND OFF EXCHANGE*
In-Network Combined Medical/ Prescription Drug Deductible	**$5,500** Individual; **$11,000** Family	**$7,000** Individual; **$14,000** Family
In-Network Out-of-Pocket Maximum	**$7,000** Individual; **$14,000** Family	**$7,000** Individual; **$14,000** Family
Primary Care Provider (PCP)	**50%** coinsurance	**100%** covered
Specialist Office Visit	**50%** coinsurance	**100%** covered
Inpatient Hospital	**50%** coinsurance	**100%** covered
Outpatient Surgery Services	**50%** coinsurance	**100%** covered
Emergency Room	**50%** coinsurance	**100%** covered
Major Diagnostic Test (MRI, CT scan, stress test, etc)	**50%** coinsurance	**100%** covered
Outpatient Lab	**50%** coinsurance	**100%** covered
Outpatient X-Rays and Other Hospital Services	**50%** coinsurance	**100%** covered
Radiation and Chemotherapy	**50%** coinsurance	**100%** covered
Physical/Occupational/Speech Therapy	**50%** coinsurance	**100%** covered
Vision Exam	**50%** coinsurance	**100%** covered
Glasses/ Contacts	**50%** coinsurance; no adult coverage	**100%** covered; no adult coverage
Preventive Dental*	**100%** covered	**100%** covered
Comprehensive Dental- Child	**50%** coinsurance	**50%** coinsurance
Comprehensive Dental - Adults*	**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
Prescription Drugs	**50%** coinsurance**	**100%** covered**
Out-of-Network Medical Deductible	**$8,000** Individual **$16,000** Family	**$8,000** Individual **$16,000** Family
Out-of-Network Coinsurance	**50%** coinsurance	**50%** coinsurance
HSA Qualified	Yes	Yes

**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.*