

**Medicare Advantage Plans  
Benefits Comparison  
Benefits effective January 1, 2017 - December 31, 2017**

	Vantage Premium HMO-POS	Vantage HMO-POS	Vantage Zero-Premium HMO-POS	Peoples Health HMO-POS
	Network	Network	Network	Network
	<b>You Pay</b>	<b>You Pay</b>	<b>You Pay</b>	<b>You Pay</b>
<b>Deductible</b>				
You	\$0	\$0	\$0	\$0
You + 1 (Spouse or child)	\$0	\$0	\$0	\$0
You + Children	\$0	\$0	\$0	\$0
You + Family	\$0	\$0	\$0	\$0
<b>Out-of-Pocket Maximum</b>				
You	\$2,000 per member	\$3,000 per member	\$6,700 per member	\$2,500 per member
You + 1 (Spouse or child)				
You + Children				
You + Family				
<b>State Funding</b>	<b>The Plan Pays</b>		<b>The Plan Pays</b>	
You	Not Available	Not Available	Not Available	Not Available
You + 1 (Spouse or child)				
You + Children				
You + Family				
<b>Physicians' Services</b>	<b>The Plan Pays</b>		<b>The Plan Pays</b>	
<b>Primary Care Physician or Specialist Office</b> - Treatment of illness or injury	100% coverage after a \$5 or \$0 AHN PCP copayment and \$20 or \$10 AHN SPC copayment per visit	100% coverage after a \$10 or \$0 AHN PCP copayment and \$40 or \$30 AHN SPC copayment per visit	100% coverage after a \$15 or \$5 AHN PCP copayment and \$50 or \$40 AHN SPC copayment per visit	100% coverage after a \$5 PCP or \$10 SPC copayment per visit.
<b>Preventative Care Primary Care Physician or Specialist Office or Clinic</b> For a complete list of benefits, refer to the Preventive and Wellness/ Routine Care in the Benefit Plan	100% coverage	100% coverage	100% coverage	100% coverage
<b>Physician Services for Emergency Room Care</b>	100% coverage	100% coverage	100% coverage	100% coverage
<b>Allergy Shots and Serum</b>	80% coverage	80% coverage	80% coverage	95% coverage
<b>Outpatient Surgery/Services</b> when billed as office visits	100% coverage	100% coverage	100% coverage	100% coverage
<b>Inpatient Services</b> Inpatient care, delivery and inpatient short-term acute rehabilitation services	100% coverage after \$50 copayment per day (days 1-10)	100% coverage after \$300 or \$150 AHN copayment per day (days 1-5)	100% coverage after \$345 or \$200 AHN copayment per day (days 1-5)	100% coverage after \$50 copayment per day (days 1-10)
<b>Outpatient Surgery/Services</b> Hospital/Facility	100% coverage	100% coverage after \$300 or \$150 AHN copayment per visit	100% coverage \$450 or \$200 AHN copayment per visit	100% coverage
<b>Emergency Room Care - Hospital</b> Treatment of an emergency medical condition or injury	100% coverage after \$50 copayment per visit; waived if admitted	100% coverage after \$75 copayment per visit; waived if admitted	100% coverage after \$75 copayment per visit; waived if admitted	100% coverage after \$50 copayment per visit; waived if admitted

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	Vantage Premium HMO-POS	Vantage HMO-POS	Vantage Zero-Premium HMO-POS	Peoples Health HMO-POS
	Network	Network	Network	Network
<b>Behavioral Health</b>	<b>The Plan Pays</b>	<b>The Plan Pays</b>	<b>The Plan Pays</b>	<b>The Plan Pays</b>
<b>Mental Health and Substance Abuse</b> Inpatient Facility	100% coverage after \$25 copay per day (days 1-5)	100% coverage after \$390 copay per day (days 1-4)	100% coverage after \$390 copay per day (days 1-4)	100% coverage after \$25 copay per day (days 1-5)
<b>Mental Health and Substance Abuse</b> Outpatient Visits - Professional	100% coverage after \$5 AHN copay or \$10 copay per mental health visit; \$10 AHN copay or \$20 copay per substance abuse visit	100% coverage after \$30 AHN copay or \$40 copay per visit	100% coverage after \$30 AHN copay or \$40 copay per visit	100% coverage
<b>Other Coverage</b>	<b>The Plan Pays</b>	<b>The Plan Pays</b>	<b>The Plan Pays</b>	<b>The Plan Pays</b>
<b>Outpatient Acute Short-Term Rehabilitation Services</b> Physical Therapy, Speech Therapy, Occupational Therapy, Other short term rehabilitative services	100% coverage, subject to Medicare maximum	100% coverage after \$25AHN/ \$40 copay per visit subject to Medicare maximum	100% coverage after \$25AHN/ \$40 copay per visit subject to Medicare maximum	100% coverage; subject to Medicare maximum
<b>Chiropractic Care</b>	100% coverage after a \$20 copay per visit	100% coverage after a \$20 copay per visit	100% coverage after a \$20 copay per visit.	100% coverage after a \$10 copay per visit.
<b>Vision Exam (routine)</b>	100% coverage; 1 exam per year	100% coverage; 1 exam per year	100% coverage; 1 exam per year	100% coverage after \$15 copay; 1 exam per year
<b>Urgent Care Center</b>	100% coverage after \$10 copay per visit	100% coverage after \$65 copay per visit	100% coverage after \$65 copay per visit	100% coverage after \$10 copay per visit
<b>Home Health Care Services</b>	100% coverage	100% coverage	100% coverage	100% coverage
<b>Skilled Nursing Facility Services</b>	100% coverage after \$0 copay (days 1-20); \$25 copay per day (days 21-100)	100% coverage after \$0 copay (days 1-20); \$160 copay per day (days 21-100)	100% coverage after \$0 copay (days 1-20); \$160 copay per day (days 21-100)	\$0 Ubpay (days 1-20); \$25 copay per day (days 21+)
<b>Hospice Care</b>	Covered by Medicare	Covered by Medicare	Covered by Medicare	Covered by Medicare
<b>Durable Medical Equipment (DME) –Rental or Purchase</b>	95% coverage	80% coverage	80% coverage	95% coverage
<b>Transplant Services</b>	100% coverage after \$50 copay per day (days 1-10)	100% coverage after \$300 or \$150 AHN copay per day (days 1-5)	100% coverage after \$345 or \$200 AHN copay per day (days 1-5)	100% coverage after \$50 copay per day (days 1-10)
<b>Pharmacy</b>	<b>You Pay</b>	<b>You Pay</b>	<b>You Pay</b>	<b>You Pay</b>
<b>Tier 1 - Preferred Generic</b>	\$5 copay	\$4 copay	\$4 copay	\$0 copay
<b>Tier 2 - Non-Preferred Generic</b>	\$10 copay	\$10 copay	\$10 copay	\$0 copay
<b>Tier 3 - Preferred Brand</b>	\$25 copay	\$47 copay	\$47 copay	\$20 copay
<b>Tier 4 - Non-Preferred Brand</b>	\$50 copay	\$100 copay	\$100 copay; after \$125 deductible	\$40 copay
<b>Tier 5 - Specialty</b>	20% coinsurance	33% coinsurance	25% coinsurance; after \$125 deductible	20% coinsurance

This comparison chart is a summary of plan features and is presented for general information only. It is not a guarantee of coverage.

The benefits outlined in this document were provided by Peoples Health and Vantage Health Plan. OGB is not responsible for the accuracy of this information.

**NOTE:** Prior authorizations, visit limits and age and/or time restrictions may apply to some benefits - refer to your official plan document for details. All services are subject to deductibles/copays/coinsurance, if Medicare Deductibles have not been met