VANTAGE HEALTH PLAN

Vantage **Medicare Advantage**

2016

Vantage Health Plan

www.VantageMedicare.com

Summary of Benefits

130 DeSiard Street,
Suite 300
Monroe, LA 71201

AAA1 Vantage VALUE (HMO-POS)

CONTACT MEMBER SERVICES

Local
(318) 361-0900

Toll-Free
(888) 823-1910

TTY Local
(318) 361-2131

TTY Toll-Free
(866) 524-5144

Available to Louisiana residents of: Acadia, Allen, Avoyelles, Beauregard, Bienville, Bossier, Caddo, Calcasieu, Caldwell, Cameron, Catahoula, Claiborne, Concordia, Evangeline, Franklin, Grant, Iberia, Jackson, Jefferson Davis, La Salle, Lafourche, Lincoln, Madison, Morehouse, Natchitoches, Rapides, Red River, Richland, Sabine, Tensas, Terrebonne, Union, Vermilion, Webster, and Winn

Vantage Health Plan is a plan with a Medicare contract. Enrollment in Vantage Health Plan, Inc. depends on contract renewal.

MedicareRx
Prescription Drug Coverage

H5576_1065_18_CY2016_CMS Accepted

Summary of Benefits
January 1, 2016 - December 31, 2016

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

You have choices about how to get your Medicare benefits

One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.

Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **AAA1 Vantage VALUE (HMO-POS)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **AAA1 Vantage VALUE (HMO-POS)** covers and what you pay.

If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.

If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

This document is available in other formats such as Braille and large print.
This document may be available in a non-English language. For additional information, call us at (866) 704-0109.

Things to Know About AAA1 Vantage VALUE (HMO-POS)

Hours of Operation

From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Central time.

From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Central time.

AAA1 Vantage VALUE (HMO-POS) Phone Numbers and Website

If you are a member of this plan, call toll-free *(866) 704-0109.*

If you are not a member of this plan, call toll-free *(866) 704-0109.*

Our website: *http://www.VantageMedicare.com*

Who can join?

To join **AAA1 Vantage VALUE (HMO-POS)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in Louisiana: Acadia, Allen, Avoyelles, Beauregard, Bienville, Bossier, Caddo, Calcasieu, Caldwell, Cameron, Catahoula, Claiborne, Concordia, Evangeline, Franklin, Grant, Iberia, Jackson, Jefferson Davis, La Salle, Lafourche, Lincoln, Madison, Morehouse, Natchitoches, Rapides, Red River, Richland, Sabine, Tensas, Terrebonne, Union, Vermilion, Webster, and Winn.

Which doctors, hospitals, and pharmacies can I use?

AAA1 Vantage VALUE (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers. For some services you can use providers that are not in our network.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

You can see our plan's provider and pharmacy directory at our website (*www.VantageMedicare.com*). Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and *more*.

Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.

Our plan members also get *more than what is* covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, *http://www.VantageMedicare.com*. Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

How much is the monthly premium?

$119 per month. In addition, you must keep paying your Medicare Part B premium.

How much is the deductible?

This plan has deductibles for some hospital and medical services.

$250 per year for out-of-network services.

This plan does not have a deductible for Part D prescription drugs.

Is there any limit on how much I will pay for my covered services?

Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.

Your yearly limit(s) in this plan:

$5,000 for services you receive from in-network providers.

If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.

Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

Is there a limit on how much the plan will pay?

Our plan has a coverage limit every year for certain benefits from any provider. Contact us for services that apply.

Covered Medical and Hospital Benefits

Note: Services with a [1] may require prior authorization.

Outpatient Care and Services

Acupuncture	Not covered
Ambulance[1]	**In-network**: $250 copay **Out-of-network**: $250 copay The ambulance copay is per one way trip.
Chiropractic Care[1]	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): **In-network**: $20 copay **Out-of-network**: 40% of the cost
Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)[1]: **In-network**: 20% of the cost **Out-of-network**: 40% of the cost Preventive dental services: Cleaning: **In-network**: $0 copay. You are covered for up to 1 every six months. **Out-of-network**: $0 copay. There may be a limit to how often these services are covered. Dental x-ray(s): **In-network**: $0 copay. You are covered for up to 1 every six months. **Out-of-network**: $0 copay. There may be a limit to how often these services are covered.

Oral exam:

In-network: $0 copay. You are covered for up to 1 every six months.

Out-of-network: $0 copay. There may be a limit to how often these services are covered.

Our plan pays up to $150 every six months for preventive dental services from an in-network provider. There is a limit to how much our plan will pay from an out-of-network provider.

There is a $300 maximum benefit every year for dentures and dental plates.

Diabetes Supplies and Services

Diabetes monitoring supplies:

In-network: 0-20% of the cost, depending on the supply

Out-of-network: 40% of the cost

Diabetes self-management training[1]:

In-network: 20% of the cost

Out-of-network: 40% of the cost

Therapeutic shoes or inserts[1]:

In-network: 20% of the cost

Out-of-network: 40% of the cost

Diabetes monitoring supplies are limited to TRUEtest 50 ct or 100 ct strips, TRUEplus lancets and TRUEresult meters manufactured by Nipro Diagnostics and can be purchased through preferred mail order (AHN) for 0% coinsurance. 20% coinsurance applies to all other purchases.

If an office visit is billed on the same date of service as diabetes self-management training, applicable office visit copay is charged.

Diagnostic Tests, Lab and Radiology Services, and X-Rays *(Costs for these services may vary based on place of service)*	Diagnostic radiology services (such as MRIs, CT scans)[1]: **In-network**: $175 copay **Out-of-network**: 40% of the cost Diagnostic tests and procedures[1]: **In-network**: $175 copay **Out-of-network**: 40% of the cost Lab services: **In-network**: You pay nothing **Out-of-network**: 40% of the cost Outpatient x-rays: **In-network**: $175 copay **Out-of-network**: 40% of the cost Therapeutic radiology services (such as radiation treatment for cancer)[1]: **In-network**: 20% of the cost **Out-of-network**: 40% of the cost The copay is per day and applies to the following combination of services: Diagnostic Radiology Services, Diagnostic Tests and Procedures, and Outpatient X-ray services. Once the copay is met, such additional outpatient services rendered on that day are paid by the plan at 100%. The following services are NOT included in this daily copay: Lab services ($0 cost share) and Medicare-covered therapeutic radiology services (20% coinsurance applies). If an office visit is billed on same date of service as the procedure/test, the applicable office visit copay applies ($15 MH-PCP or $45 Specialist).

Doctor's Office Visits	Medical home - primary care physician (MH-PCP) visit: **In-network**: $15 copay or 0-20% of the cost, depending on the service **Out-of-network**: 40% of the cost Specialist visit[1]: **In-network**: $45 copay or 0-20% of the cost, depending on the service **Out-of-network**: 40% of the cost The copay only applies to office visits. The coinsurance applies if the physician renders a service that has coinsurance (e.g., pain management and allergy services). 20% coinsurance for pain management and allergy services. Member shall not pay copay and coinsurance for office visit. PAs and NPs, depending on the specialty, could require a copay: MH-PCP office visits: $15 copay Specialist office visits: $45 copay
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*[1]	**In-network**: 20% of the cost **Out-of-network**: 40% of the cost
Emergency Care	$75 copay If you are admitted to the hospital within 72 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.
Foot Care *(podiatry services)*[1]	Foot exams and treatment if you have diabetes-related nerve damage and/ or meet certain conditions: **In-network**: $45 copay **Out-of-network**: 40% of the cost

Hearing Services	Exam to diagnose and treat hearing and balance issues[1]: **In-network**: 20% of the cost **Out-of-network**: 40% of the cost Routine hearing exam: **In-network**: $0 copay. You are covered for up to 1 every year. **Out-of-network**: $0 copay. There may be a limit to how often these services are covered. Our plan pays up to $40 every year for routine hearing exams from an in-network provider. There is a limit to how much our plan will pay from an out-of-network provider.
Home Health Care[1]	**In-network**: You pay nothing **Out-of-network**: 40% of the cost
Mental Health Care[1]	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.

In-network:
$390 copay per day for days 1 through 4
You pay nothing per day for days 5 through 90

Out-of-network:
40% of the cost per stay

Outpatient group therapy visit:

In-network: $40 copay

Out-of-network: 40% of the cost

Outpatient individual therapy visit:

In-network: $40 copay

Out-of-network: 40% of the cost

Outpatient Rehabilitation[1]

Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks):

In-network: 20% of the cost

Out-of-network: 40% of the cost

Occupational therapy visit:

In-network: $40 copay

Out-of-network: 40% of the cost

Physical therapy and speech and language therapy visit:

In-network: $40 copay

Out-of-network: 40% of the cost

Copay applies to facility and professional claims.

Outpatient Substance Abuse[1]	Group therapy visit: **In-network**: $50 copay **Out-of-network**: 40% of the cost Individual therapy visit: **In-network**: $50 copay **Out-of-network**: 40% of the cost Copay for Medicare-covered individual or group visits applies to both facility and professional services.
Outpatient Surgery[1]	Ambulatory surgical center: **In-network**: $300 copay **Out-of-network**: 40% of the cost Outpatient hospital: **In-network**: $300 copay **Out-of-network**: 40% of the cost
Over-the-Counter Items	Not Covered
Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	Prosthetic devices: **In-network**: 20% of the cost **Out-of-network**: 40% of the cost Related medical supplies: **In-network**: 20% of the cost **Out-of-network**: 40% of the cost

Renal Dialysis[1]	**In-network**: 20% of the cost **Out-of-network**: 20% of the cost If professional and facility bill for same date of service, 20% coinsurance applies to both claims.
Transportation	Not covered
Urgently Needed Services	$65 copay
Vision Services	<u>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)</u>: **In-network**: $0-$45 copay, depending on the service **Out-of-network**: 40% of the cost <u>Routine eye exam</u>: **In-network**: $0 copay. You are covered for up to 1 visit(s) every year. **Out-of-network**: 40% of the cost. There may be a limit to how often these services are covered. <u>Contact lenses</u>: **In-network**: 20% of the cost. You are covered for up to 12 every year. **Out-of-network**: 20% of the cost. There may be a limit to how often these services are covered. <u>Eyeglasses (frames and lenses)</u>: **In-network**: 20% of the cost. You are covered for up to 1 every year. **Out-of-network**: 20% of the cost. There may be a limit to how often these services are covered.

Eyeglasses or contact lenses after cataract surgery:

In-network: 20% of the cost

Out-of-network: 40% of the cost

Our plan pays up to $100 every year for contact lenses and eyeglasses (frames and lenses) from an in-network provider. There is a limit to how much our plan will pay from an out-of-network provider.

$0 cost sharing for Diabetic eye exams.

Over-the-counter reading glasses do not apply. Cost is defined as the Medicare-approved amount. To receive Medicare-covered eyewear, the provider must be a Medicare-approved supplier.

Preventive Care

In-network: You pay nothing

Out-of-network: 40% of the cost

Our plan covers many preventive services, including:

- Abdominal aortic aneurysm screening
- Alcohol misuse counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screenings
- Cervical and vaginal cancer screening
- Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)
- Depression screening
- Diabetes screenings
- HIV screening
- Medical nutrition therapy services
- Obesity screening and counseling
- Prostate cancer screenings (PSA)
- Sexually transmitted infections screening and counseling
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
- Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots
- "Welcome to Medicare" preventive visit (one-time)
- Yearly "Wellness" visit

Any additional preventive services approved by Medicare during the contract year will be covered.

Hospice

You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.

Inpatient Care

Inpatient Hospital Care[1]

The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.

Our plan covers 90 days for an inpatient hospital stay.

Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.

In-network:

$300 copay per day for days 1 through 5

You pay nothing per day for days 6 through 90

Out-of-network:

40% of the cost per stay

Inpatient Mental Health Care

For inpatient mental health care, see the "Mental Health Care" section of this booklet.

Skilled Nursing Facility (SNF)[1]

Our plan covers up to 100 days in a SNF.

In-network:

You pay nothing per day for days 1 through 20

$160 copay per day for days 21 through 100

Out-of-network:

40% of the cost per stay

Prescription Drug Benefits

How much do I pay?

For Part B drugs such as chemotherapy drugs[1]:

In-network: 20% of the cost

Out-of-network: 40% of the cost

Other Part B drugs[1]:

In-network: 0-20% of the cost depending on the drug

Out-of-network: 40% of the cost

Part B drugs given in the MH-PCP office are covered at 100%, except specialty drugs. 20% coinsurance for all other Part B drugs, including specialty drugs. Specialty drugs given in all settings require authorization.

Initial Coverage

You pay the following until your total yearly drug costs reach $3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

You may get your drugs at network retail pharmacies and mail order pharmacies.

Standard Retail Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$4 copay	$12 copay
Tier 2 (Generic)	$10 copay	$30 copay
Tier 3 (Preferred Brand)	$47 copay	$141 copay
Tier 4 (Non-Preferred Brand)	$100 copay	$300 copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

Standard Mail Order Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	Not Offered	$12 copay
Tier 2 (Generic)	Not Offered	$30 copay
Tier 3 (Preferred Brand)	Not Offered	$141 copay
Tier 4 (Non-Preferred Brand)	Not Offered	$300 copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

Preferred Mail Order Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	Not Offered	$0 copay
Tier 2 (Generic)	Not Offered	$30 copay
Tier 3 (Preferred Brand)	Not Offered	$141 copay
Tier 4 (Non-Preferred Brand)	Not Offered	$300 copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,310.

After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 58% of the plan's cost for covered generic drugs until your costs total $4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.

Standard Retail Cost-Sharing

Tier	Drugs Covered	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	All	$4 copay	$12 copay
Standard Mail Order Cost-Sharing			
Tier	**Drugs Covered**	**One-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	All	Not Offered	$12 copay
Preferred Mail Order Cost-Sharing			
Tier	**Drugs Covered**	**One-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	All	Not Offered	$0 copay

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,850, you pay the greater of:

5% of the cost, or

$2.95 copay for generic (including brand drugs treated as generic) and a $7.40 copayment for all other drugs.

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-704-0109. Someone who speaks English Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al1-866-704-0109. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-866-704-0109。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-866-704-0109。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-704-0109 Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au1-866-704-0109. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi1-866-704-0109 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter1-866-704-0109. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-704-0109 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону1-866-704-0109. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic[1]:
إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم بمساعدتك. هذه خدمة فوري، ليس عليك سوى الاتصال بنا على[1-866-704-0109]سيقوم شخص ما يتحدث العربية مجانية.

Hindi[1]: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें1-866-704-0109 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero1-866-704-0109. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-866-704-0109. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan1-866-704-0109. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer1-866-704-0109. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには1-866-704-0109にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

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VANTAGE HEALTH PLAN

CONTACT INFORMATION

Toll-Free Medicare Line: 1 (866) 704-0109

Toll-Free General Line: 1 (888) 823-1910

Toll-Free TTY Line: 1 (866) 524-5144
(for the hearing impaired)

LOCATION INFORMATION

Monroe Location

130 DeSiard Street, Suite 300
Monroe, LA 71201

Shreveport Location

855 Pierremont Rd., Suite 109
Shreveport, LA 71106

Baton Rouge Location

5778 Essen Lane
Baton Rouge, LA 70810

For a complete listing or other questions, please contact Vantage Health Plan, Inc., at (866) 704-0109 or for TTY users, (866) 524-5144, 8 a.m. - 8 p.m. seven days a week from October 1, 2015 through February 14, 2016. For all other dates, Member Services is available from 8 a.m. - 8 p.m., Monday - Friday. You may also visit us on the web at www.VantageMedicare.com.