AFFINITY HEALTH NETWORK

Vantage Medicare Advantage | **2019**

Summary *of* Benefits

HMO-POS Plans: Basic, Standard, and Premium

VANTAGE HEALTH PLAN

2019 SUMMARY OF BENEFITS

Vantage Medicare Advantage

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" or visit www.VantageMedicare.com.

☑ Vantage **BASIC**
(HMO-POS)

☑ Vantage **STANDARD**
(HMO-POS)

☑ Vantage **PREMIUM**
(HMO-POS)

HOURS OF OPERATION

October 1, 2018 through March 31, 2019:
Seven (7) Days a Week 8:00 a.m. – 8:00 p.m.

All other dates:
Monday through Friday 8:00 a.m. – 8:00 p.m.

CONTACT INFORMATION

Phone Numbers:
Toll-Free 866-704-0109
TTY **866-524-5144** – *for the hearing impaired*

Website: www.VantageMedicare.com

AFFINITY HEALTH NETWORK

To join a Vantage Medicare Advantage plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in De Soto, East Baton Rouge, East Carroll, Franklin, Morehouse, Ouachita, Richland, St. Helena, Tangipahoa, or West Carroll parishes.

TIPS FOR COMPARING YOUR MEDICARE CHOICES.

This Summary of Benefits booklet gives you a summary of what **Vantage BASIC, Vantage STANDARD,** and **Vantage PREMIUM** cover and what you pay.

- If you want to compare our plans with other Medicare Advantage health plans, ask the other plans for their Summary of Benefits booklets or use the Medicare Plan Finder on ***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 ***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.**

WHICH DOCTORS, HOSPITALS, AND PHARMACIES CAN I USE?

Vantage plans use a network of doctors, hospitals, pharmacies, and other providers. Because our plan is an HMO-POS plan, you can use Point-of-Service (POS) providers that are outside our network for an additional cost. The maximum benefit for services rendered by POS providers is $5,000.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Preferred cost-sharing is available through mail order. You may pay less if you use mail order.

You can see our plan's provider and pharmacy directories on our website ***www.VantageMedicare.com,*** or call us and we will mail a copy to you.

WHAT DO WE COVER?

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

- Our plan members get all of the benefits covered by Original Medicare.
- Our plan members also get more benefits than those covered by Original Medicare. Some of the extra benefits are outlined in this booklet and include vision, dental, hearing, over-the-counter items, transportation, and a fitness program.
- We also cover prescription drugs with no separate premium. You can see the complete formulary (list of Part D prescription drugs) on our website, ***www.VantageMedicare.com,*** or call us and we will mail a copy of the formulary to you.

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 Part D drug stages that occur after you meet your deductible, if applicable: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

WHICH SERVICES REQUIRE PRIOR AUTHORIZATION?

Covered services that need approval in advance are marked by a footnote designated by a [(1)]. Non-emergent services provided by an out-of-network provider require approval in advance.

Benefit Category	Vantage BASIC
Monthly Plan Premium *(Includes Part C and Part D)*	**$0** per month. In addition, you must keep paying your Medicare Part B premium.
Deductibles	This plan does not have a deductible for in-network hospital and medical services. **$500** per year for most out-of-network (POS) hospital and medical services. **$310** per year for Part D prescription drugs, except for drugs listed on Tier 1 and Tier 2, which are excluded from the deductible.
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	**$6,700** annually 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.

Vantage STANDARD	Vantage PREMIUM
$49 per month. In addition, you must keep paying your Medicare Part B premium.	**$169** per month. In addition, you must keep paying your Medicare Part B premium.
This plan does not have a deductible for in-network hospital and medical services. **$500** per year for most out-of-network (POS) hospital and medical services. **$250** per year for Part D prescription drugs, except for drugs listed on Tier 1, Tier 2, and Tier 3, which are excluded from the deductible.	This plan does not have a deductible for in-network hospital and medical services or Part D prescription drugs. **$500** per year for most out-of-network (POS) hospital and medical services.
$5,500 annually 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.	**$3,000** annually 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.

Benefit Category	Vantage BASIC
Inpatient Hospital Coverage[1]	
Inpatient care *Includes substance abuse and rehabilitation services.*	**In-Network: $290** copay per day for days 1–7, per admission. You pay **nothing** per day for days 8 through 90. **Out-of-Network: 50%** of the cost per stay; subject to POS deductible. *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.
Outpatient Hospital Coverage[1]	
Outpatient Surgery at an ambulatory surgical center	**In-Network: $350** copay **Out-of-Network: 50%** of the cost; subject to POS deductible.
Outpatient Surgery at an outpatient hospital	**Affinity Network: $250** copay **In-Network: $350** copay **Out-of-Network: 50%** of the cost; subject to POS deductible.
Doctor Visits	
Medical home-primary care provider (MH-PCP) visit	**Affinity Network: $5** copay **In-Network: $15** copay **Out-of-Network: 50%** of the cost; subject to POS deductible.
Specialist visit[1]	**In-Network: $45** copay **Out-of-Network: 50%** of the cost; subject to POS deductible.

Vantage STANDARD	Vantage PREMIUM
In-Network: $270 copay per day for days 1–7, per admission. You pay **nothing** per day for days 8 through 90. **Out-of-Network**: **50%** of the cost per stay; subject to POS deductible. *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: $250** copay per day for days 1–7, per admission. You pay **nothing** per day for days 8 through 90. **Out-of-Network**: **50%** of the cost per stay; subject to POS deductible. *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: **$250** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**In-Network**: **$150** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.
Affinity Network: $150 copay **In-Network**: **$250** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**Affinity Network: $50** copay **In-Network**: **$150** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.
Affinity Network: $5 copay **In-Network**: **$15** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**Affinity Network: $0** copay **In-Network**: **$10** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.
In-Network: **$45** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**In-Network**: **$40** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.

Benefit Category	Vantage BASIC
Preventive Care	
Preventive care *Other preventive services are available. There are some covered services that have a cost.* *Any additional preventive services approved by Medicare during the contract year will be covered.*	**In-Network**: You pay **nothing.** **Out-of-Network**: **50%** of the cost; subject to POS deductible. *Our plan covers many preventive services, including:* ✓ Bone mass measurement ✓ Breast cancer screening (mammogram) ✓ Cervical and vaginal cancer screening ✓ Colorectal cancer screenings[1] ✓ Diabetes screenings ✓ Glaucoma screenings ✓ Prostate cancer screenings (PSA) ✓ 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)
Emergency Care	
Emergency room care	**$90** 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 "Inpatient Care" for other costs.*
Urgently Needed Services	
Urgent care	**$65** copay

Vantage STANDARD	Vantage PREMIUM
In-Network: You pay **nothing.** **Out-of-Network**: **50%** of the cost; subject to POS deductible. *Our plan covers many preventive services, including:* ✓ Bone mass measurement ✓ Breast cancer screening (mammogram) ✓ Cervical and vaginal cancer screening ✓ Colorectal cancer screenings[1] ✓ Diabetes screenings ✓ Glaucoma screenings ✓ Prostate cancer screenings (PSA) ✓ 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)	**In-Network**: You pay **nothing.** **Out-of-Network**: **50%** of the cost; subject to POS deductible. *Our plan covers many preventive services, including:* ✓ Bone mass measurement ✓ Breast cancer screening (mammogram) ✓ Cervical and vaginal cancer screening ✓ Colorectal cancer screenings[1] ✓ Diabetes screenings ✓ Glaucoma screenings ✓ Prostate cancer screenings (PSA) ✓ 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)
$90 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 "Inpatient Care" for other costs.*	**$90** 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 "Inpatient Care" for other costs.*
$65 copay	**$65** copay

Benefit Category	Vantage BASIC
Diagnostic Services/Labs/Imaging	
Major diagnostic tests (MRIs, CT scans)[1]	**Affinity Network: $250** copay per day **In-Network**: Up to **$350** copay per day **Out-of-Network**: **50%** of the cost; subject to POS deductible.
Diagnostic tests, procedures[1]**, and outpatient x-rays**	**Affinity Network: $250** copay per day **In-Network**: Up to **$350** copay per day **Out-of-Network**: **50%** of the cost; subject to POS deductible.
Lab Services: Facility	**In-Network:** Up to **$40** copay per day **Out-of-Network**: **50%** of the cost; subject to POS deductible.
Lab Services: Non-Facility	**In-Network**: You pay **nothing**. **Out-of-Network**: **50%** of the cost; subject to POS deductible.
Therapeutic radiology services[1]	**In-Network**: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.
Hearing Services	
Exam to diagnose and treat hearing and balance issues[1]	**In-Network**: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.
Routine hearing exam	**In-Network**: **$0** copay **Out-of-Network**: **$0** copay; not subject to POS deductible. You are covered for up to 1 every year. Our plan pays up to **$40** of the cost every year for a routine hearing exam. Cost is defined as the Vantage allowable.

Vantage STANDARD	Vantage PREMIUM
Affinity Network: $150 copay per day **In-Network**: Up to **$250** copay per day **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**Affinity Network: $50** copay per day **In-Network**: Up to **$150** copay per day **Out-of-Network**: **50%** of the cost; subject to POS deductible.
Affinity Network: $150 copay per day **In-Network**: Up to **$250** copay per day **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**Affinity Network: $50** copay per day **In-Network**: Up to **$150** copay per day **Out-of-Network**: **50%** of the cost; subject to POS deductible.
In-Network: Up to **$40** copay per day **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**In-Network:** Up to **$40** copay per day **Out-of-Network**: **50%** of the cost; subject to POS deductible.
In-Network: You pay **nothing**. **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**In-Network**: You pay **nothing**. **Out-of-Network**: **50%** of the cost; subject to POS deductible.
In-Network: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**In-Network**: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.
In-Network: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**In-Network**: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.
In-Network: **$0** copay **Out-of-Network**: **$0** copay; not subject to POS deductible. You are covered for up to 1 every year. Our plan pays up to **$40** of the cost every year for a routine hearing exam. Cost is defined as the Vantage allowable.	**In-Network**: **$0** copay **Out-of-Network**: **$0** copay; not subject to POS deductible. You are covered for up to 1 every year. Our plan pays up to **$40** of the cost every year for a routine hearing exam. Cost is defined as the Vantage allowable.

Benefit Category	Vantage BASIC
Dental Services	
Medicare-covered dental services[1] *(This does not include services in connection with care, treatment, filling, removal, or replacement of teeth.)*	**In-Network**: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.
Dental Services: Preventive Dental	
Cleaning (Wellness)	**In-Network: $0** copay **Out-of-Network**: **$0** copay; not subject to POS deductible. You are covered for up to 1 every six months.
Oral exams	**In-Network**: **$0** copay **Out-of-Network**: **$0** copay; not subject to POS deductible. You are covered for up to 1 every six months.
Preventive dental x-rays (bite wings)	**In-Network**: **$0** copay **Out-of-Network**: **$0** copay; not subject to POS deductible. You are covered for up to 1 every year. Our plan pays **$150** of the cost every six months for preventive dental services from in-network and out-of-network providers. Cost is defined as the Vantage allowable.
Dental Services: Comprehensive Dental	Not Covered

Vantage STANDARD	Vantage PREMIUM
In-Network: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**In-Network**: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.
In-Network: **$0** copay **Out-of-Network**: **$0** copay; not subject to POS deductible. You are covered for up to 1 every six months.	**In-Network**: **$0** copay **Out-of-Network**: **$0** copay; not subject to POS deductible. You are covered for up to 1 every six months.
In-Network: **$0** copay **Out-of-Network**: **$0** copay; not subject to POS deductible. You are covered for up to 1 every six months.	**In-Network**: **$0** copay **Out-of-Network**: **$0** copay; not subject to POS deductible. You are covered for up to 1 every six months.
In-Network: **$0** copay **Out-of-Network**: **$0** copay; not subject to POS deductible. You are covered for up to 1 every year. Our plan pays **$500** of the cost every six months for preventive dental services from in-network and out-of-network providers. Cost is defined as the Vantage allowable.	**In-Network**: **$0** copay **Out-of-Network**: **$0** copay; not subject to POS deductible. You are covered for up to 1 every year. Our plan pays **$700** of the cost every six months for preventive dental services from in-network and out-of-network providers. Cost is defined as the Vantage allowable.
In-Network: **$0** copay **Out-of-Network**: **$0** copay; not subject to POS deductible. *Our plan pays* ***$400*** *of the cost every year for limited comprehensive dental services from in-network and out-of-network providers. Cost is defined as the Vantage allowable. Contact plan for details.*	**In-Network**: **$0** copay **Out-of-Network**: **$0** copay; not subject to POS deductible. *Our plan pays* ***$600*** *of the cost every year for limited comprehensive dental services from in-network and out-of-network providers. Cost is defined as the Vantage allowable. Contact plan for details.*

Benefit Category	Vantage BASIC
Vision Services	
Medicare-covered vision services *(Exam to diagnose and treat diseases and conditions of the eye, including yearly diabetic exams.)*	**In-Network**: **$0–$45** copay ($0 cost sharing for diabetic eye exams.) **Out-of-Network**: **50%** of the cost; subject to POS deductible.
Eyeglasses or contact lenses after cataract surgery	**In-Network**: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.
Routine eye exam	**In-Network**: **$0** copay **Out-of-Network**: **50%** of the cost; not subject to POS deductible. You are covered for up to 1 visit per year.
Contact lenses	**In-Network**: **50%** of the cost **Out-of-Network**: **50%** of the cost; not subject to POS deductible. You are covered for up to 12 pairs every year.
Eyeglasses (frames and lenses)	**In-Network: 50%** of the cost **Out-of-Network**: **50%** of the cost; not subject to POS deductible. You are covered for up to 1 pair every year. Our plan pays **$200** of the cost every year for contact lenses and eyeglasses (frames and lenses) from in-network and out-of-network providers. Over-the-counter reading glasses do not apply. Cost is defined as the Vantage allowable.

Vantage STANDARD	Vantage PREMIUM
In-Network: **$0–$45** copay ($0 cost sharing for diabetic eye exams.) **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**In-Network**: **$0–$40** copay ($0 cost sharing for diabetic eye exams.) **Out-of-Network**: **50%** of the cost; subject to POS deductible.
In-Network: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**In-Network**: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.
In-Network: **$0** copay **Out-of-Network**: **50%** of the cost; not subject to POS deductible. You are covered for up to 1 visit per year.	**In-Network**: **$0** copay **Out-of-Network**: **50%** of the cost; not subject to POS deductible. You are covered for up to 1 visit per year.
In-Network: **50%** of the cost **Out-of-Network**: **50%** of the cost; not subject to POS deductible. You are covered for up to 12 pairs every year. **In-Network: 50%** of the cost **Out-of-Network**: **50%** of the cost; not subject to POS deductible. You are covered for up to 1 pair every year. Our plan pays **$200** of the cost every year for contact lenses and eyeglasses (frames and lenses) from in-network and out-of-network providers. Over-the-counter reading glasses do not apply. Cost is defined as the Vantage allowable.	**In-Network**: **50%** of the cost **Out-of-Network**: **50%** of the cost; not subject to POS deductible. You are covered for up to 12 pairs every year. **In-Network: 50%** of the cost **Out-of-Network**: **50%** of the cost; not subject to POS deductible. You are covered for up to 1 pair every year. Our plan pays **$200** of the cost every year for contact lenses and eyeglasses (frames and lenses) from in-network and out-of-network providers. Over-the-counter reading glasses do not apply. Cost is defined as the Vantage allowable.

Benefit Category	Vantage BASIC
Mental Health Services[1]	
Inpatient care	**In-Network**: **$415** per day for days 1- 4, per admission. You pay nothing per day for days 5 through 90. **Out-of-Network**: **50%** of the cost per stay; subject to POS deductible. 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.
Outpatient group therapy visit	**In-Network**: **$40** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.
Outpatient individual therapy visit	**In-Network**: **$40** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.
Skilled Nursing Facility (SNF)[1]	
Our plan covers up to 100 days in a SNF. Three-day prior hospital stay is required.	**In-Network**: **$0** per day for days 1-20. **$172** copay per day for days 21 - 100. **Out-of-Network**: **50%** of the cost per stay; subject to POS deductible.

Vantage STANDARD	Vantage PREMIUM
In-Network: **$415** per day for days 1- 4, per admission. You pay nothing per day for days 5 through 90. **Out-of-Network**: **50%** of the cost per stay; subject to POS deductible. 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.	**In-Network**: **$415** per day for days 1- 4, per admission. You pay nothing per day for days 5 through 90. **Out-of-Network**: **50%** of the cost per stay; subject to POS deductible. 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.
In-Network: **$40** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**In-Network**: **$40** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.
In-Network: **$40** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**In-Network**: **$40** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.
In-Network: **$0** per day for days 1-20. **$172** copay per day for days 21 - 100. **Out-of-Network**: **50%** of the cost per stay; subject to POS deductible.	**In-Network**: **$0** per day for days 1-20. **$172** copay per day for days 21 - 100. **Out-of-Network**: **50%** of the cost per stay; subject to POS deductible.

Benefit Category	Vantage BASIC
Physical Therapy[1]	
Physical therapy	**In-Network: $40** copay **Out-of-Network: 50%** of the cost; subject to POS deductible.
Speech and language therapy visit	**In-Network: $40** copay **Out-of-Network: 50%** of the cost; subject to POS deductible.
Transportation[1]	
Ground Ambulance services *Copay applies to each one-way trip.*	**In-Network: $250** copay **Out-of-Network: $250** copay; subject to POS deductible.
Non-emergent transportation services *(excludes Ambulance)*	**100%** coverage for twenty-four (24) one-way (12 round-trip) Vantage-approved non-emergent trips per year to travel to or from your appointments and exams.
Medicare Part B Drugs[1]	
Part B drugs such as chemotherapy drugs	**In-Network: 20%** of the cost **Out-of-Network: 50%** of the cost; subject to POS deductible.
Other Part B drugs	**In-Network: 20%** of the cost **Out-of-Network: 50%** of the cost; subject to POS deductible.

Vantage STANDARD	Vantage PREMIUM
In-Network: **$40** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**In-Network**: **$40** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.
In-Network: **$40** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**In-Network**: **$40** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.
In-Network: **$250** copay **Out-of-Network**: **$250** copay; subject to POS deductible.	**In-Network**: **$250** copay **Out-of-Network**: **$250** copay; subject to POS deductible.
100% coverage for twenty-four (24) one-way (12 round-trip) Vantage-approved non-emergent trips per year to travel to or from your appointments and exams.	**100%** coverage for twenty-four (24) one-way (12 round-trip) Vantage-approved non-emergent trips per year to travel to or from your appointments and exams.
In-Network: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**In-Network**: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.
In-Network: **20%** of the cost **Out-of-Network: 50%** of the cost; subject to POS deductible.	**In-Network**: **20%** of the cost **Out-of-Network: 50%** of the cost; subject to POS deductible.

Benefit Category	Vantage BASIC

MEDICARE PART D DRUG STAGES

Prescription drug quantity limitations and restrictions may apply.

DEDUCTIBLE

$310 (For Tier 3, Tier 4, and Tier 5)

INITIAL COVERAGE

You may get your drugs at network retail pharmacies and mail order pharmacies. You can get drugs from an out-of-network pharmacy, but with a possibility of paying more than you would pay at an in-network pharmacy. If you reside in a long-term care facility, you pay the same as a retail pharmacy.

After you pay your yearly deductible, you pay the following until your total yearly drug costs reach **$3,820**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

PHARMACY:	STANDARD RETAIL (31-day)	STANDARD MAIL ORDER (90-day)	SAINT JOHN PHARMACY PREFERRED MAIL ORDER (90-day)
Tier 1 Preferred Generic	$6 copay	$18 copay	$0 copay*
Tier 2 Generic	$15 copay	$45 copay	$45 copay
Tier 3 Preferred Brand	25% coinsurance	25% coinsurance	25% coinsurance
Tier 4 Non-Preferred Brand	25% coinsurance	25% coinsurance	25% coinsurance
Tier 5 Specialty	25% coinsurance	Not available	Not available

COVERAGE GAP

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there is a temporary change in what you will pay for your drugs. The coverage gap begins after the yearly drug cost (including what our plan has paid and what you have paid) reaches $3,820.

After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 37% of the plan's cost for covered generic drugs until your costs total $5,100, which is the end of the coverage gap. Not everyone will enter the coverage gap.

CATASTROPHIC COVERAGE

After your yearly out-of-pocket drug costs reach $5,100, you pay the greater of:

5% of the cost, or

$3.40 copay for generic (including brand drugs treated as generic) and a $8.50 copayment for all other drugs.

*Members can have prescription drugs shipped to their home through the Saint John Pharmacy network mail order delivery program. Once the order is received by Saint John Pharmacy, members should expect to receive their pharmacy order in 5-7 business days. If the requested pharmacy order is not received within the estimated time frame, please contact Vantage Health Plan, Inc. at (866) 704-0109.

Vantage STANDARD	Vantage PREMIUM
$250 (For Tier 4 and Tier 5)	**$0**
After you pay your yearly deductible, you pay the following until your total yearly drug costs reach **$3,820**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.	You pay the following until your total yearly drug costs reach **$3,820.** Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

STANDARD RETAIL (31-day)	STANDARD MAIL ORDER (90-day)	SAINT JOHN PHARMACY PREFERRED MAIL ORDER (90-day)	STANDARD RETAIL (31-day)	STANDARD MAIL ORDER (90-day)	SAINT JOHN PHARMACY PREFERRED MAIL ORDER (90-day)
$4 copay	$12 copay	$0 copay*	$4 copay	$12 copay	$0 copay*
$12 copay	$36 copay	$36 copay	$12 copay	$36 copay	$36 copay
$47 copay	$141 copay	$141 copay	$47 copay	$141 copay	$141 copay
25% coinsurance	25% coinsurance	25% coinsurance	$100 copay	$300 copay	$300 copay
28% coinsurance	Not available	Not available	33% coinsurance	Not available	Not available

Vantage STANDARD	Vantage PREMIUM
After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 37% of the plan's cost for covered generic drugs until your costs total $5,100, which is the end of the coverage gap. Not everyone will enter the coverage gap.	After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and the lesser of a $4 copay or 37% of the plan's cost for Tier 1 Preferred Generic drugs and 37% of the plan's cost for other generic drugs until your costs total $5,100, which is the end of the coverage gap. Not everyone will enter the coverage gap.
After your yearly out-of-pocket drug costs reach $5,100, you pay the greater of: 5% of the cost, or $3.40 copay for generic (including brand drugs treated as generic) and a $8.50 copayment for all other drugs.	After your yearly out-of-pocket drug costs reach $5,100, you pay the greater of: 5% of the cost, or $3.40 copay for generic (including brand drugs treated as generic) and a $8.50 copayment for all other drugs.

*Members can have prescription drugs shipped to their home through the Saint John Pharmacy network mail order delivery program. Once the order is received by Saint John Pharmacy, members should expect to receive their pharmacy order in 5-7 business days. If the requested pharmacy order is not received within the estimated time frame, please contact Vantage Health Plan, Inc. at (866) 704-0109.

Benefit Category	Vantage BASIC
OTHER COVERED SERVICES	
Chiropractic Care[1]	
Chiropractic office visit	**In-Network: $20** copay **Out-of-Network: 50%** of the cost; subject to POS deductible.
Diabetic Supplies and Services	
Diabetes monitoring supplies *Diabetic supplies are limited to Glucocard Shine strips (50 count) and Glucocard Shine meters manufactured by Arkray USA. These meters and strips as well as lancets can be purchased through preferred mail order for 0% coinsurance. 20% coinsurance applies to purchases from standard network providers.*	**Saint John Pharmacy: 100%** covered **In-Network: 20%** of the cost **Out-of-Network: 50%** of the cost; subject to POS deductible.
Diabetes self-management training[1]	**Affinity Network: 100%** covered **In-Network: 20%** of the cost **Out-of-Network: 50%** of the cost; subject to POS deductible.
Therapeutic shoes or inserts[1]	**In-Network: 20%** of the cost **Out-of-Network: 50%** of the cost; subject to POS deductible.
Foot Care (podiatry services)[1]	
Medicare-covered podiatry services	**In-Network: $45** copay **Out-of-Network: 50%** of the cost; subject to POS deductible.

Vantage STANDARD	Vantage PREMIUM
OTHER COVERED SERVICES	
In-Network: **$20** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**In-Network**: **$20** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.
Saint John Pharmacy: **100%** covered **In-Network**: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**Saint John Pharmacy**: **100%** covered **In-Network**: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.
Affinity Network: 100% covered **In-Network**: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**Affinity Network: 100%** covered **In-Network**: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.
In-Network: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**In-Network**: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.
In-Network: $45 copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**In-Network**: **$40** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.

Benefit Category	Vantage BASIC
Home Health Care[1]	
Home health care	**In-Network**: You pay **nothing**. **Out-of-Network**: **50%** of the cost; subject to POS deductible.
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.	You pay **nothing** for hospice care from a Medicare-certified hospice.
Medical Equipment and Supplies[1]	
Durable medical equipment	**In-Network**: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.
Prosthetic devices & related medical supplies *(braces, artificial limbs, etc.)*	**In-Network**: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.
Outpatient Rehabilitation Services[1]	
Cardiac (heart) rehab services *Our plan covers a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks.*	**In-Network**: **$40** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.
Occupational therapy visit	**In-Network**: **$40** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.

Vantage STANDARD	Vantage PREMIUM
In-Network: You pay **nothing**. **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**In-Network**: You pay **nothing**. **Out-of-Network**: **50%** of the cost; subject to POS deductible.
You pay **nothing** for hospice care from a Medicare-certified hospice.	You pay **nothing** for hospice care from a Medicare-certified hospice.
In-Network: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**In-Network**: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.
In-Network: **20%** of the cost **Out-of-Network**: 50% of the cost; subject to POS deductible.	**In-Network**: **20%** of the cost **Out-of-Network**: **50%** of the cost; subject to POS deductible.
In-Network: **$40** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**In-Network**: **$40** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.
In-Network: **$40** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**In-Network**: **$40** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.

Benefit Category	Vantage BASIC
Outpatient Substance Abuse[1]	
Group therapy visit	**In-Network: $50** copay **Out-of-Network: 50%** of the cost; subject to POS deductible.
Individual therapy visit	**In-Network: $50** copay **Out-of-Network: 50%** of the cost; subject to POS deductible.
Over-the-Counter Items (OTC)	
60 credits per quarter of select OTC items (pain relievers, vitamins, toiletries, etc.) delivered to your door at no cost to you. Provided through Saint John Pharmacy only; not available through other retail locations.	You pay **nothing**.
Renal Dialysis[1]	
Renal dialysis	**In-Network: 20%** of the cost **Out-of-Network: 20%** of the cost
Wellness Programs	
SilverSneakers® fitness program by Tivity Health	You pay **nothing**.

Vantage STANDARD	Vantage PREMIUM
In-Network: **$50** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**In-Network**: **$50** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.
In-Network: **$50** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.	**In-Network**: **$50** copay **Out-of-Network**: **50%** of the cost; subject to POS deductible.
You pay **nothing**.	You pay **nothing**.
In-Network: **20%** of the cost **Out-of-Network**: **20%** of the cost	**In-Network**: **20%** of the cost **Out-of-Network**: **20%** of the cost
You pay **nothing**.	You pay **nothing**.

ONLINE DOCUMENTS MADE EASY!

Vantage makes it easy to look up essential documents and information, including the Evidence of Coverage, plan formulary, and our provider and pharmacy directories.

Go to: www.VantageMedicare.com

1 **Step One**

Click the "Documents & Forms" link.

2 **Step Two**

Choose your parish and plan.

3 **Step Three**

Click the PDF links to view or download your document.

- Evidence of Coverage
- Formulary
- Pharmacy Directory
- Provider Directory

If you need additional help finding and using the website, or to request a paper copy of these documents, call Vantage's Member Services toll-free at **1-866-704-0109** or TTY **1-866-524-5144**.

Hours of Operation

October 1, 2018–March 31, 2019:

Seven (7) Days a Week
8:00 a.m. – 8:00 p.m.

All other dates:

Monday through Friday
8:00 a.m. – 8:00 p.m.

How do I enroll with Vantage Health Plan?

Vantage makes it easy and it only takes a few minutes! Call us to enroll over the phone.

(866) 704-0109

Other ways to enroll:

Request a Home Visit – Contact our Member Services Department at **(866) 704-0109** to request a one-on-one home visit and enroll in the comfort of your own home.

Attend a Snack & Learn Meeting – Be our guest at one of our many "Snack & Learn" events in your area. Call **(888) 367-4470** to find a meeting near you.

Visit the Vantage Website – Visit us online at ***www.VantageMedicare.com*** to enroll online or for more information.

Stop By Our Office – See our list of locations on back cover. No appointment necessary.

Medicare beneficiaries may also enroll in a Vantage Medicare Advantage plan through the CMS Online Enrollment Center located at http://www.Medicare.gov.

Nondiscrimination Notice – *Vantage Health Plan is required by federal law to provide the following information.*

Vantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, or any other legally protected characteristic. Vantage does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, age, disability, sex, or any other legally protected characteristic.

Vantage provides free aids and services to people with disabilities to communicate effectively with us. Those services include qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, and other formats).

For people whose primary language is not English, Vantage provides free language translation services. Those services include qualified interpreters and information written in other languages. You can use Vantage's free language translation services by calling the "Members" phone number on the back of your Member ID card. For Members who are deaf or hard of hearing, please call for teletypewriter (TTY) services at (866) 524-5144.

If you believe that Vantage has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, disability, sex, or any other legally protected characteristic, you can file a grievance with Vantage or the U.S. Dept. of Health and Human Services, Office for Civil Rights.

If you would like to file a complaint directly with Vantage, you can reach us in person, by mail, by fax, or by email at the addresses below:

Vantage Health Plan, Inc.
Attention: Civil Rights Coordinator
130 DeSiard Street, Suite 300
Monroe, LA 71201
Phone: (318) 998-2887, TTY (866) 524-5144
Fax: (318) 361-2165
Email: *civilrightscoordinator@vhpla.com*

If you would like to file a complaint directly with the U.S. Dept. of Health and Human Services, Office for Civil Rights, you can contact them by mail, by phone, or by email at the addresses below:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Phone: (800) 368-1019, (800) 537-7697 (TDD)
Online Complaint Portal: *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*
Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html.*

If you need help filing a grievance, our Civil Rights Coordinator is available to help at *civilrightscoordinator@vhpla.com* or by phone at (318) 998-2887.

Vantage has adopted internal grievance procedures for providing prompt and equitable resolution of complaints alleging discrimination on the basis of race, color, national origin, sex, age, or disability. Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age, or disability, may file a grievance under Vantage's grievance procedure. It is against the law for Vantage to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance. Depending on the type of grievance, a 60 day filing limit may apply. To learn more about Vantage's grievance procedure, you can call or email our Civil Rights Coordinator at the addresses above or you can visit our website at *www.vantagehealthplan.com/vhpnondiscriminationgrievanceprocedure.*

Vantage Health Plan, Inc. (Vantage) is an HMO with a Medicare contract. Enrollment in Vantage depends on contract renewal. This information is not a complete description of benefits. Please contact the plan for more information. Limitations, copayments/coinsurance, and restrictions may apply to this plan. Benefits, premiums, and copayments/coinsurance amounts may change on January 1 of each year. You must continue to pay your Medicare Part B premium.

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for extra help, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week. You may also call the Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778. You may also call the Louisiana State Medicaid Office.

Services provided by out-of-network providers may cost more than services provided by in-network providers, unless the services are related to urgent care, an emergency, or out-of-area dialysis. Prescription drug quantity limitations and restrictions may apply.

For more information on Vantage Medicare Advantage Plan benefits, or for information in an alternate format or language, call Member Services at (866) 704-0109 or TTY (866) 524-5144, seven days a week from 8:00 a.m. – 8:00 p.m. CST from October 1, 2018 – March 31, 2019. For all other dates, Member Services representatives are available Monday through Friday from 8:00 a.m. - 8:00 p.m. CST.

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Language Assistance

Vantage Health Plan is required by federal law to provide the following information.

If you, or someone you're helping, have questions about Vantage Health Plan, you have the right to get help and information in your preferred language at no cost. To talk with an interpreter, call Member Services, 866-704-0109 (TTY 866-524-5144).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 866-704-0109 (TTY: 866-524-5144).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 866-704-0109 (ATS: 866-524-5144).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 866-704-0109 (TTY: 866-524-5144).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 866-704-0109（TTY：866-524-5144）。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 866-704-0109(رقم هاتف الصم والبكم:866-524-5144).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 866-704-0109 (TTY: 866-524-5144).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 866-704-0109 (TTY: 866-524-5144)번으로 전화해 주십시오.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 866-704-0109 (TTY: 866-524-5144).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 866-704-0109 (TTY: 866-524-5144).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。866-704-0109（TTY: 866-524-5144）まで、お電話にてご連絡ください。

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں .866-704-0109 (TTY: 866-524-5144)

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 866-704-0109 (TTY: 866-524-5144).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 866-704-0109 (TTY: 866-524-5144)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 0109-704-866 (TTY: 5144-524-866) تماس بگیرید.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 866-704-0109 (телетайп: 866-524-5144).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 866-704-0109 (TTY: 866-524-5144).

Vantage Locations

Monroe
122 St. John Street
Monroe, LA 71201

Shreveport
855 Pierremont Road, Suite 109
Shreveport, LA 71106

Baton Rouge
5778 Essen Lane, Suite B
Baton Rouge, LA 70810

Hammond
219 West Thomas Street
Hammond, LA 70401

For Information On Other Locations:
www.vantagehealthplan.com/locations

Hours of Operation

October 1, 2018 through March 31, 2019:
Seven (7) Days a Week 8:00 a.m. – 8:00 p.m.

All other dates:
Monday through Friday 8:00 a.m. – 8:00 p.m.

Contact

Phone Numbers:
(866) 704-0109 or TTY (866) 524-5144
(for the hearing impaired)

Website:
www.VantageMedicare.com