




The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.**

**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.vantagehealthplan.com](http://www.vantagehealthplan.com) or call (844) 833-7505. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.vantagehealthplan.com](http://www.vantagehealthplan.com) or call (844) 833-7505 to request a copy.

| Important Questions  | Answers  | Why This Matters:  |
|--|--|--|
| <b>What is the overall <a href="#">deductible</a>?</b>                             | \$6,500 Individual/\$13,000 Family, excluding copays, coinsurance, preventive care, office visits.   | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1 <sup>st</sup> ). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. If you have other family members on the plan, each family member must meet their own individual deductible. |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b> | Yes. Preventive care and office visits are not subject to the deductible. Tier I & II Retail Prescription Drugs are not subject to the Prescription Drug Deductible.   | This plan covers some items and services even if you haven't yet met the deductible amount, but a co-payment or co-insurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                     |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>          | Yes. For Out-of-Network: \$8,000 Individual/\$16,000 Family. For Prescription Drugs: \$850 Individual/\$1,700 Family. Applies to Tier III, IV and V.                   | Generally, you must pay all of the costs from out-of-network providers up to the deductible amount before this plan begins to pay. If you have other family members in this plan, they have to meet their own deductible until the overall family deductible has been met. A single family member has met his or her deductible by reaching the individual deductible amount. Other family members' payments combine to meet the remainder of the family deductible.     |
| <b>What is the <a href="#">out-of-pocket limit</a> for this plan?</b>              | For In-network Providers, Out-of-Pocket Max: \$7,350 Individual/\$14,700 Family.   | The out-of-pocket limit is the most you could pay in a year for in-network covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.  |
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>            | Premiums, balance-billing charges, out-of-network, some coinsurance, services this plan doesn't cover.   | Even though you pay these expenses, they don't count toward the out-of-pocket limit.   |
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>            | Yes. Visit <a href="http://www.VantageHealthPlan.com">www.VantageHealthPlan.com</a> and click "Find a Provider" or call (844) 833-7505 or a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.      |
| <b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b> | No.  | You can see the specialist you choose without a referral.  |

\* For more information about limitations and exceptions, see the plan or policy document at [www.vantagehealthplan.com](http://www.vantagehealthplan.com).

 All coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event   | Services You May Need                            | What You Will Pay                                      |  | Limitations, Exceptions, & Other Important Information  |
|--|--|--|--|---|
|  |  | Network Provider<br>(You will pay the least)           | Out-of-Network Provider<br>(You will pay the most) |   |
| <b>If you visit a health care <u>provider's</u> office or clinic</b>   | Primary care visit to treat an injury or illness | \$25 AHN or \$45 copay                                 | 50% coinsurance                                    | None  |
|  | Specialist visit                                 | \$60 AHN or \$90 copay                                 | 50% coinsurance                                    | None  |
|  | Preventive care/screening/immunization           | 100% coverage  | 50% coinsurance                                    | As required by law.   |
| <b>If you have a test</b>  | Diagnostic test (x-ray, blood work)              | 50% coinsurance  | 50% coinsurance                                    | Office labs covered 100%.   |
|  | Imaging (CT/PET scans, MRIs)                     | 50% coinsurance  | 50% coinsurance                                    | Pre-auth required.  |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <u><a href="#">prescription drug coverage</a></u> is available at <a href="http://www.vhpla.com">www.vhpla.com</a> | Tier I & II Prescription Drugs                   | \$3 or \$20 copay per prescription (retail/mail order) | Not covered  | 1 copay for 30 day supply; 2 copays for 31-60 day supply; 3 copays for 61-90 day supply.                            |
|  | Tier III Prescription Drugs                      | 50% coinsurance (retail/mail order)                    | Not covered  | Member pays 50% up to the Out-of-Pocket Maximum. Subject to Prescription Drug Deductible.                           |
|  | Tier IV Prescription Drugs                       | 50% coinsurance (retail/mail order)                    | Not covered  | Member pays 50% up to the Out-of-Pocket Maximum. Subject to Prescription Drug Deductible.                           |
|  | Tier V Prescription Drugs                        | 50% coinsurance (retail only)                          | Not covered  | Member pays 50% up to the Out-of-Pocket Maximum. Subject to Prescription Drug Deductible. Mail order not available. |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center)   | 50% coinsurance  | 50% coinsurance                                    | Pre-auth required.  |
|  | Physician/surgeon fees                           | 50% coinsurance  | 50% coinsurance                                    | Pre-auth required.  |
| <b>If you need immediate medical attention</b>   | Emergency room care                              | 50% coinsurance  | 50% coinsurance                                    | Worldwide emergency coverage.   |
|  | Emergency medical transportation                 | 50% coinsurance  | 50% coinsurance                                    | Emergency criteria required.  |
|  | Urgent care                                      | \$90 copay/visit                                       | 50% coinsurance                                    | Pre-auth required on follow-up visits.  |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)               | 50% coinsurance  | 50% coinsurance                                    | Pre-auth required.  |
|  | Physician/surgeon fees                           | 50% coinsurance  | 50% coinsurance                                    | Pre-auth required.  |

\* For more information about limitations and exceptions, see the plan or policy document at [www.vantagehealthplan.com](http://www.vantagehealthplan.com).

| Common Medical Event   | Services You May Need                     | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information |
|--|---|--|--|--|
|  |   | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$25 AHN or \$45 copay/visit                 | 50% coinsurance                                    | None   |
|  | Inpatient services                        | 50% coinsurance                              | 50% coinsurance                                    | Pre-auth required.                                     |
| <b>If you are pregnant</b>   | Office visits                             | \$25 AHN or \$45 copay/visit                 | 50% coinsurance                                    | Copay on initial visit only.                           |
|  | Childbirth/delivery professional services | No additional coinsurance                    | 50% coinsurance                                    | Covered as part of the inpatient delivery stay.        |
|  | Childbirth/delivery facility services     | 50% coinsurance                              | 50% coinsurance                                    | Pre-auth required.                                     |
| <b>If you need help recovering or have other special health needs</b>            | Home health care                          | 50% coinsurance                              | Not covered  | Pre-auth required.                                     |
|  | Rehabilitation services                   | 50% coinsurance                              | 50% coinsurance                                    | Pre-auth required.                                     |
|  | Habilitation services                     | 50% coinsurance                              | 50% coinsurance                                    | Pre-auth required.                                     |
|  | Skilled nursing care                      | 50% coinsurance                              | 50% coinsurance                                    | Pre-auth required.                                     |
|  | Durable medical equipment                 | 50% coinsurance                              | 50% coinsurance                                    | Pre-auth required.                                     |
|  | Hospice services                          | 50% coinsurance                              | Not covered  | Pre-auth required.                                     |
| <b>If your child needs dental or eye care</b>                                    | Children's eye exam                       | \$60 AHN or \$90 copay/visit                 | 50% coinsurance                                    | Limit 1 visit annually.                                |
|  | Children's glasses                        | 50% coinsurance                              | 50% coinsurance                                    | Limit may apply.                                       |
|  | Children's dental check-up                | 100% coverage                                | 100% coverage                                      | Limit 2 visits annually.                               |

**Excluded Services & Other Covered Services:**

**Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)**

- Acupuncture
- Bariatric surgery
- Cosmetic Surgery
- Hearing aids (Adult)
- Non-emergency care when traveling outside the U.S.
- Infertility Treatment
- Long-term care
- Routine foot care

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- Chiropractic care
- Dental care
- Glasses
- Hearing aids (Children)
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs

\* For more information about limitations and exceptions, see the plan or policy document at [www.vantagehealthplan.com](http://www.vantagehealthplan.com).

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For group health coverage subject to ERISA, insert contact information for the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Vantage at (844) 833-7505. For group health coverage subject to ERISA, insert applicable plan contact information. Also insert contact information for the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). If coverage is insured, also insert applicable State Department of Insurance contact information.

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

If your plan doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-823-1910.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-823-1910.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-823-1910.

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-823-1910.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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**About these Coverage Examples:**



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

| Peg is Having a Baby<br>(9 months of in-network pre-natal care and a hospital delivery)  |                 | Managing Joe's type 2 Diabetes<br>(a year of routine in-network care of a well-controlled condition)   |                | Mia's Simple Fracture<br>(in-network emergency room visit and follow up care)  |                |
|--|-----------------|--|----------------|--|----------------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a>  | \$6,500         | ■ The <a href="#">plan's</a> overall <a href="#">deductible</a>  | \$6,500        | ■ The <a href="#">plan's</a> overall <a href="#">deductible</a>  | \$6,500        |
| ■ Physician office visits  | \$45            | ■ Physician office visits  | \$90           | ■ Physician office visits  | \$90           |
| ■ Hospital (facility)  | 50% Coinsurance | ■ Hospital (facility)  | N/A            | ■ Hospital (facility)  | N/A            |
| ■ Other Coinsurance  | 50%             | ■ Other Coinsurance  | N/A            | ■ Other Coinsurance  | N/A            |
| <b>This EXAMPLE event includes services like:</b><br>Specialist office visits ( <i>prenatal care</i> )<br>Childbirth/Delivery Professional Services<br>Childbirth/Delivery Facility Services<br>Diagnostic tests ( <i>ultrasounds and blood work</i> )<br>Specialist visit ( <i>anesthesia</i> ) |                 | <b>This EXAMPLE event includes services like:</b><br>Primary care physician office visits ( <i>including disease education</i> )<br>Diagnostic tests ( <i>blood work</i> )<br>Prescription drugs<br>Durable medical equipment ( <i>glucose meter</i> ) |                | <b>This EXAMPLE event includes services like:</b><br>Emergency room care ( <i>including medical supplies</i> )<br>Diagnostic test ( <i>x-ray</i> )<br>Durable medical equipment ( <i>crutches</i> )<br>Rehabilitation services ( <i>physical therapy</i> ) |                |
| <b>Total Example Cost</b>  | <b>\$12,731</b> | <b>Total Example Cost</b>  | <b>\$7,583</b> | <b>Total Example Cost</b>  | <b>\$1,942</b> |
| <b>In this example, Peg would pay:</b>   |                 | <b>In this example, Joe would pay:</b>   |                | <b>In this example, Mia would pay:</b>   |                |
| <i>Cost Sharing</i>  |                 | <i>Cost Sharing</i>  |                | <i>Cost Sharing</i>  |                |
| Deductibles  | \$1,720         | Deductibles  | \$1,781        | Deductibles  | \$816          |
| Copayments   | \$0             | Copayments   | \$1,160        | Copayments   | \$270          |
| Coinsurance  | \$5,630         | Coinsurance  | \$2,722        | Coinsurance  | \$816          |
| <i>What isn't covered</i>  |                 | <i>What isn't covered</i>  |                | <i>What isn't covered</i>  |                |
| Limits or exclusions   | \$60            | Limits or exclusions   | \$55           | Limits or exclusions   | \$0            |
| <b>The total Peg would pay is</b>  | <b>\$7,410</b>  | <b>The total Joe would pay is</b>  | <b>\$5,718</b> | <b>The total Mia would pay is</b>  | <b>\$1,902</b> |

## Addendum: Language Access Services

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Vantage Health Plan or the Marketplace, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-888-823-1910.

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Vantage Health Plan or the Marketplace, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-888-823-1910.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Vantage Health Plan or the Marketplace, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-888-823-1910.

如果您，或是您正在協助的對象，有關於[插入 SBM 項目的名稱 Vantage Health Plan or the Marketplace, 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-888-823-1910。

صوصخب قئئسأ هدعاست صخش بدل وأ كيدل ناك نأ، تامولعملاو ددعاسملا بلع لوصحلا يف قحلا كيدلف  
ب لصتا مجرتم عم ئدحتلل. ةفلكت قيا نود نم كتغلب قيرورضلا . 1-888-823-1910.

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Vantage Health Plan or the Marketplace, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-888-823-1910.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Vantage Health Plan or the Marketplace, 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-888-823-1910. 로 전화하십시오.

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Vantage Health Plan or the Marketplace, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-888-823-1910.

ຖ້າທ່ານ, ຫຼື ຄົນ ທ່ານ ກຳລັງ ງ່າຍ ຫຼື ອ, ມີ ຄຳ ຖາມ ກ່ຽວ ກັບ Vantage Health Plan or the Marketplace, ທ່ານ ມີ ສິດ ທີ່ ຈະ ໄດ້ ຮັບ ການ ງ່າຍ ຫຼື ອ ແລະ ບໍ່ ມີ ນ້ຳ ລື ຂອງ ທ່ານ ບໍ່ ມີ ຄ່າ ໃຊ້ ຈ່າຍ. 1-888-823-1910.



ご本人様、またはお客様の身の回りの方でも、Vantage Health Plan or the Marketplace, についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合 1-888-823-1910. までお電話ください。

اے لاؤس وک نوٹوڈ پاروائیہ ہر ے دددم وک یسک پارگانیرک نوٹ 1-888-823-1910، ے پیل ےک Vantage Health Plan or the Marketplace نایز ینپا وک نوٹوڈ پاوت، نیم ےراب ےک ےنرک تاب ےس نامجرت۔ ےقح اک ےنرک لصاح تامولاعم روا ددم تقم نیم

Falls Sie oder jemand, dem Sie helfen, Fragen zum Vantage Health Plan or the Marketplace, haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-888-823-1910 an.

دروم رد لاوس ، دینکیم کمک و ا م ب امش مک یسک ای ،امش رگا، Vantage Health Plan or the Marketplace، کمک مک دیراد ار نیا قح دیشاب متشاد  
دییامن لصاح سامت 1-888-823-1910. دییامن تفایرد ناگیار روط م ب ار دوخ نابز م ب تا علاطا و.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Vantage Health Plan or the Marketplace, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-888-823-1910.

หากคุณ หรือคนที่ตกลงช่วยเหลือมีคำถามเกี่ยวกับ **Vantage Health Plan or the Marketplace**, คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย โปรดดู หมายเลข โทร **1-888-823-1910**.