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 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 or call (844) 833-7505 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; $1,000 Individual/$3,000 Family, excluding preventive care, office visits and prescription drugs.	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 1st). 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.
Are there services covered before you meet your deductible?	Yes. Preventive care, office visits, and prescription drugs are not subject to the medical deductible. Tier I and II Prescription Drugs are not subject to the Retail 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 *https://www.healthcare.gov/coverage/preventive-care-benefits/.*
Are there other deductibles for specific services?	Yes. For Out-of-Network medical covered services: $5,000 Individual/$10,000 Family. For Prescription Drugs: $500 Individual/$1,500 Family.	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.
What is the out-of-pocket limit for this plan?	For In-Network providers: $5,500 Individual/$11,000 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.
What is not included in the out-of-pocket limit?	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.
Will you pay less if you use a network provider?	Yes. Visit www.VantageHealthPlan.com and click "Find a Provider" or call (844) 833-7505 for 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.
Do you need a referral to see a specialist?	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*.

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	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 AHN or $25 copay	50% coinsurance	Cost sharing waived at IHCP or with IHCP referral at non-IHCP.
	Specialist visit	$40 AHN or $50 copay	50% coinsurance	Cost sharing waived at IHCP or with IHCP referral at non-IHCP.
	Preventive care/screening/ immunization	100% coverage	50% coinsurance	As required by law.
If you have a test	Diagnostic test (x-ray, blood work)	100% coverage	50% coinsurance	Cost sharing waived at IHCP or with IHCP referral at non-IHCP.
	Imaging (CT/PET scans, MRIs)	$100 AHN or $200 copay/test	50% coinsurance	Pre-auth required. Cost sharing waived at IHCP or with IHCP referral at non-IHCP.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.vhpla.com	Tier I & II Prescription Drugs	$10 or $30 per prescription (retail/mail order)	Not covered	Cost sharing waived at IHCP or with IHCP referral at non-IHCP.1 copay for 30-day supply; 2 copays for 31-60 day supply; 3 copays for 61-90 day supply.
	Tier III Prescription Drugs	$60 copay per prescription (retail/mail order)	Not covered	Cost sharing waived at IHCP or with IHCP referral at non-IHCP.1 copay for 30-day supply; 2 copays for 31-60 day supply; 3 copays for 61-90 day supply. Subject to Retail Drug Deductible.
	Tier IV Prescription Drugs	$100 copay per prescription (retail/mail order)	Not covered	Cost sharing waived at IHCP or with IHCP referral at non-IHCP.1 copay for 30-day supply; 2 copays for 31-60 day supply; 3 copays for 61-90 day supply. Subject to Retail Drug Deductible.
	Tier V Prescription Drugs	50% coinsurance per prescription (retail only)	Not covered	Cost sharing waived at IHCP or with IHCP referral at non-IHCP. Member pays 50% up to the Out-of-Pocket Maximum. Mail order not available. Subject to Retail Drug Deductible.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 AHN or $400 copay	50% coinsurance	Pre-auth required. Cost sharing waived at IHCP or with IHCP referral at non-IHCP.
	Physician/surgeon fees	100% coverage	50% coinsurance	Pre-auth required. Cost sharing waived at IHCP or with IHCP referral at non-IHCP.
If you need immediate medical attention	Emergency room care	$300 copay	$300 copay	Worldwide emergency coverage. Cost sharing waived at IHCP or with IHCP referral at non-IHCP.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Emergency criteria required. Cost sharing waived at IHCP or with IHCP referral at non-IHCP.
	Urgent care	$50 copay/visit	50% coinsurance	Pre-auth required on follow-up visits. Cost sharing waived at IHCP or with IHCP referral at non-IHCP.

* For more information about limitations and exceptions, see the plan or policy document at www.vantagehealthplan.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-of-Network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	$750 copay/day	50% coinsurance	Pre-auth required. $2,250 copay max. Cost sharing waived at IHCP or with IHCP referral at non-IHCP.
	Physician/surgeon fees	100% coverage	50% coinsurance	Pre-auth required. Cost sharing waived at IHCP or with IHCP referral at non-IHCP.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 AHN or $25 copay/visit	50% coinsurance	Cost sharing waived at IHCP or with IHCP referral at non-IHCP.
	Inpatient services	$750 copay/day	50% coinsurance	Pre-auth required. $2,250 copay max. Cost sharing waived at IHCP or with IHCP referral at non-IHCP.
If you are pregnant	Office visits	$15 AHN or $25 copay/visit	50% coinsurance	Copay on initial visit only. Cost sharing waived at IHCP or with IHCP referral at non-IHCP.
	Childbirth/delivery professional services	No additional coinsurance	50% coinsurance	Covered as part of the inpatient delivery stay. Cost sharing waived at IHCP or with IHCP referral at non-IHCP.
	Childbirth/delivery facility services	$750 copay/day	50% coinsurance	Pre-auth required. $2,250 copay max. Cost sharing waived at IHCP or with IHCP referral at non-IHCP.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Pre-auth required. Cost sharing waived at IHCP or with IHCP referral at non-IHCP.
	Rehabilitation services	$40 copay/visit	50% coinsurance	Pre-auth required. Cost sharing waived at IHCP or with IHCP referral at non-IHCP.
	Habilitation services	$40 copay/visit	50% coinsurance	Pre-auth required. Cost sharing waived at IHCP or with IHCP referral at non-IHCP.
	Skilled nursing care	$100 copay/day	50% coinsurance	Pre-auth required. Cost sharing waived at IHCP or with IHCP referral at non-IHCP.
	Durable medical equipment	20% coinsurance	50% coinsurance	Pre-auth required. Cost sharing waived at IHCP or with IHCP referral at non-IHCP.
	Hospice services	20% coinsurance	Not covered	Pre-auth required. Cost sharing waived at IHCP or with IHCP referral at non-IHCP.
If your child needs dental or eye care	Children's eye exam	$40 AHN or $50 copay/visit	50% coinsurance	Limit 1 visit annually. Cost sharing waived at IHCP or with IHCP referral at non-IHCP.
	Children's glasses	50% coinsurance	50% coinsurance	Limit may apply. Cost sharing waived at IHCP or with IHCP referral at non-IHCP.
	Children's dental check-up	100% coverage	100% coverage	Limit 2 visits annually.

* For more information about limitations and exceptions, see the plan or policy document at www.vantagehealthplan.com.

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)
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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

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*. 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 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*. 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): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-823-1910.

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

* For more information about limitations and exceptions, see the plan or policy document at *www.vantagehealthplan.com*.

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
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,000**
Physician office visits	**$25**
Hospital (facility)	**$750/day**
Other Coinsurance	**20%**

This EXAMPLE event includes services like:
Physician office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$920
Coinsurance	$512
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,492**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's drug deductible	**$1,000**
Physician office visits	**$50**
Hospital (facility)	**N/A**
Other Coinsurance	**N/A**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,583**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$2,530
Coinsurance	$346
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$4,431**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,000**
Physician *copayments*	**$50**
Hospital (facility)	**N/A**
Other Coinsurance	**N/A**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,942**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$510
Coinsurance	$276
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,786**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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 ةلئسأ هدعاست صخش بدل وأ كيدل ناك نإ ،Vantage Health Plan or the Marketplace تامولعملاو ةدعاسملا بلط لوصحلا يف قحلا كيدلف
. 1-888-823-1910. بـ لصتا مجرتم عم ثدحتلل .ةفلكت قيا نود نم كتغلب ةيرورضلا

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 ຄົ ນ ່ທທ ່ ານກ ໍ ລັ ງຊ ່ ວຍເຫຼ ືອ ອ, ມ ່ ຄ ານ ຖ ານ ກ ່ ງ ວ ກ ັ ບ Vantage Health Plan or the Marketplace,
ທ ່ ານ ມ ີ ສ ດ ່ ທ ຈ ະ ໄ ດ ້ ຮ ັ ບ ກ ານ ຊ ່ ວ ຍ ເ ຫ ຼ ື ອ ແ ລ ະ ◌ ໍ ຂ ້ ມ ູ ນ ຂ ່ າ ວ ສ ານ ່ ທ ເ ປ ັ ນ ภ า ส า ข อ ง ท ่ า น ่ บ ม ่ า ใ ช ้ จ ่ า ย. 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。

ےک ےراب ےنیم، وت پا نونود وک ینپا نابز Vantage Health Plan or the Marketplace, ےکےلیے. 1910-823-888-1 نوف کنیرک رگانیا پا یسک وک ددم دد ےہر ےنیہ روا پا نونود وک لاوس ےہ
ےنرک تاب ےس نامجرت .ےہ قح اک ےنرک لصاح تامولاعم روا ددم تفم 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.

متشاد ،کمک هک دیراد ار نیا قح دیشاب Vantage Health Plan or the Marketplace, رگا،امش هک یسک اي هب امش وا کمک دینکیم ، لاوس رد دروم
.و هب تاعلاطا دوخ نابز ار روط ناگیار تفایرد دییامن. 1910-823-888-1 دییامن لصاح سامت

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.

หากคณุ หรือคนที่คณกาลงช่วยเหลือมีคาถามเกี่ยวกบั Vantage Health Plan or the Marketplace, คณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมลในภาษาของคณได้โดยไม่มีค่าใช้จ่าย พดคยุ กบลาม โทร 1-888-823-1910.