




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 toll-free at (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 toll-free at (844) 833-7505 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	The overall medical <a href="#">deductible</a> : For In-Network Providers \$1,600 Individual or \$4,800 Family; for Out-of-Network Providers \$5,000 Individual or \$15,000 Family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Medical Home Primary Care Provider office visits and Wellness and <a href="#">preventive care</a> are not subject to the <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. For some Prescription Drug tiers: \$600 Individual/\$1,800 Family.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services. There are no other specific deductibles.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For In-Network providers: \$6,500 Individual/\$13,000 Family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, cost sharing for out-of-network, some <a href="#">coinsurance</a> , and health care this <a href="#">plan</a> does not cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. Visit <a href="http://VantageHealthPlan.com">VantageHealthPlan.com</a> and click "Find a Provider" or call toll-free at (844) 833-7505 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No, if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> .	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

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

 All [copayment](#) and [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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$20 AHN copay or \$30 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	AHN refers to Affinity Health Network Providers with lower <a href="#">cost sharing</a> .
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> . <a href="#">Deductible</a> does not apply.	You may have to pay for services that are not preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Office lab is covered 100%.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-authorization required.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.vantagehealthplan.com">www.vantagehealthplan.com</a>	Tier I & II Prescription Drugs	\$10 Tier I copay or \$30 Tier II <a href="#">copay</a> per prescription (retail/mail order)	Not covered	1 <a href="#">copay</a> for 30-day supply; 2 <a href="#">copays</a> for 31-60 day supply; 3 <a href="#">copays</a> for 61-90 day supply.
	Tier III Prescription Drugs	20% <a href="#">coinsurance</a> (retail/mail order)	Not covered	1 <a href="#">copay</a> for 30-day supply; 2 <a href="#">copays</a> for 31-60 day supply; 3 <a href="#">copays</a> for 61-90 day supply. Subject to <a href="#">Prescription Drug deductible</a> .
	Tier IV Prescription Drugs	20% <a href="#">coinsurance</a> (retail/mail order)	Not covered	1 <a href="#">copay</a> for 30-day supply; 2 <a href="#">copays</a> for 31-60 day supply; 3 <a href="#">copays</a> for 61-90 day supply. Subject to <a href="#">Prescription Drug deductible</a> .
	Tier V Prescription Drugs	20% <a href="#">coinsurance</a> (retail only)	Not covered	Member pays 20% 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)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-authorization required.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-authorization required.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Worldwide emergency coverage.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Emergency criteria required.
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-authorization required on follow-up visits.

\* 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-authorization required.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-authorization required.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20 AHN copay/visit or \$30 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	None
	Inpatient services	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-authorization required.
<b>If you are pregnant</b>	Office visits	\$20 AHN copay or \$30 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	<a href="#">Copay</a> on initial visit only.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-authorization required.
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-authorization required.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	Not covered	Pre-authorization required.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-authorization required.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-authorization required.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-authorization required.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Pre-authorization required.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	Not covered	Pre-authorization required.
<b>If your child needs dental or eye care</b>	Children's eye exam	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limit 1 visit per benefit period.
	Children's glasses	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limitations may apply.
	Children's dental check-up	No charge. <a href="#">Deductible</a> does not apply.	No charge. <a href="#">Deductible</a> does not apply.	Limit 2 visits per calendar year.

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

- |  |   |   |
|--|---|---|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Cosmetic Surgery</li></ul> | <ul style="list-style-type: none"><li>• Elective abortions (except when provided to save the life of the mother)</li><li>• Hearing aids (Adult)</li><li>• Infertility Treatment</li></ul> | <ul style="list-style-type: none"><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Routine foot care</li></ul> |
|--|---|---|

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

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"><li>• Chiropractic care</li><li>• Dental care (Adult)</li></ul> | <ul style="list-style-type: none"><li>• Hearing aids (Children)</li><li>• Private-duty nursing</li></ul> | <ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Weight loss programs (Vantage Wellness Program only)</li></ul> |
|---|--|---|

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Louisiana Department of Insurance, Office of Consumer Services, P.O. Box 94214, Baton Rouge, LA 70804-9214 or call 1-800-259-5300. 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 Louisiana Department of Insurance, Office of Consumer Services, P.O. Box 94214, Baton Rouge, LA 70804-9214 or call 1-800-259-5300.

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

If you do not have [Minimum Essential Coverage](#) for a month, you will 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](#) does not 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, kwijigo 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](http://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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,600	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,600	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,600
■ Specialist (OB/GYN) copayment	\$30	■ Primary Care Physician copayment	\$30	■ Specialist coinsurance	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%	■ Hospital (facility) <a href="#">coinsurance</a>	20%	■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%	■ Other <a href="#">coinsurance</a>	20%	■ Other <a href="#">coinsurance</a>	20%
<p><b>This EXAMPLE event includes services like:</b>                      Specialist (OB/GYN) office visits (<i>prenatal care</i>)                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services                      Diagnostic tests (<i>ultrasounds and blood work</i>)                      Specialist visit (<i>anesthesia</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>                      Primary care physician office visits (<i>including disease education</i>)                      Diagnostic tests (<i>blood work</i>)                      Prescription drugs                      Durable medical equipment (<i>glucose meter</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>                      Emergency room care (<i>including medical supplies</i>)                      Diagnostic test (<i>x-ray</i>)                      Durable medical equipment (<i>crutches</i>)                      Rehabilitation services (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,800</b>	<b>Total Example Cost</b>	<b>\$7,600</b>	<b>Total Example Cost</b>	<b>\$1,900</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	\$1,600	Deductibles*	\$2,200	Deductibles	\$1,600
Copayments	\$30	Copayments	\$850	Copayments	\$0
Coinsurance	\$1,500	Coinsurance	\$700	Coinsurance	\$0
<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	\$60	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$3,190</b>	<b>The total Joe would pay is</b>	<b>\$3,810</b>	<b>The total Mia would pay is</b>	<b>\$1,600</b>

\*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

## 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。

صو صخب ءلئسأ هءعاست صخش بءل وأ كءءل ناك نأ، Vantage Health Plan or the Marketplace، ءامولعملاو ءءعاسملا بلع لوصحلا بف قحلا كءءلف ب لصءا مءرءم عم ءءحءلل. ءفلءء ءءا نوء نم كءءلب ءءوررضلا . 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 ກຳ ລັ ງ ຊ່ ວຍ ເຫຼື ອ, ມີ ຄຳ ຖາມ ກ່ ຽ ັ ັ ບ Vantage Health Plan or the Marketplace, ທ່ານ ມີ ສິ ດ ທ່ານ ຈະ ໄດ້ ຮັ ບ ການ ຊ່ ວຍ ເຫຼື ອ ຈຳ ັ ັ ມູ ນ ຂ່ າ ວ ສາ ນ ທ ັ ັ ບ ນ ພາ ສາ ຂອງ ທ່ານ ບ ັ ັ ມ ຄ່ າ ໃ ຊ້ ຈ່ າ ຍ. 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、情報を入力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。

ۛه لاوس وک نونود پا روا نيہ ۛه ۛد ددم وک یسک پا رگانیرک نوف 1-823-888-823, Vantage Health Plan or the Marketplace, نابز ینپا وک نونود پاوت ،نیم ۛراب ۛه ۛیل ۛک ۛنرک تاب ۛس نامجرت -ۛه قح اک ۛنرک لصاح تامولاعم روا ددم تفعم نیم، 1910.

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 وا ۛب امش ۛک یسک ای ،امش رگا ، Vantage Health Plan or the Marketplace, کمک ۛک دیراد ار نیا قح دیشاب ۛتشاد دییامن لصاح سامت 1-823-888-1910. دییامن تغایرد ناگیار روط ۛب ار دوخ نابز ۛب تااعلاطا 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 หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Vantage Health Plan or the Marketplace, คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย โปรดคุย กบลาม โทร 1-888-823-1910.