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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	The overall medical deductible: For In-Network Providers $3,000 Individual or $9,000 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 deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Primary Care and Specialty Care Provider office visits and Wellness and Preventive care are not subject to the deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance 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 some Prescription Drug tiers: $500 Individual/$1,500 Family.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. There are no other specific deductibles.
What is the out-of-pocket limit for this plan?	For In-Network providers: $6,800 Individual/$13,600 Family.	The out-of-pocket limit is the most you could pay in a year for 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?	Copayments and coinsurance on certain services, premiums, balance-billing charges, cost sharing for out-of-network, and health care this plan does not 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 *VantageHealthPlan.com* and click "Find a Provider" or call toll-free at (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, if you use a provider in the plan's network.	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 **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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 AHN copay or $30 copay. Deductible does not apply.	50% coinsurance	AHN refers to Affinity Health Network Providers with lower cost sharing.
	Specialist visit	$50 AHN copay or $60 copay. Deductible does not apply.	50% coinsurance	None
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	50% coinsurance. Deductible does not apply.	You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$200 AHN copay/test or $300 copay /test	50% coinsurance	Lab and x-ray services performed in an office setting is covered at no charge. Deductible may apply.
	Imaging (CT/PET scans, MRIs)	$200 AHN copay/test or $300 copay /test	50% coinsurance	Pre-authorization required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at *www.vantagehealthplan.com*	Tier I & II Prescription Drugs	$10 Tier I copay or $30 Tier II copay per prescription (retail/mail order)	Not covered	1 copay for 30-day supply; 2 copays for 31-60 day supply; 3 copays for 61-100 day supply.
	Tier III Prescription Drugs	$60 copay per prescription (retail/mail order)	Not covered	1 copay for 30-day supply; 2 copays for 31-60 day supply; 3 copays for 61-100 day supply. Subject to Prescription Drug deductible.
	Tier IV Prescription Drugs	$100 copay per prescription (retail/mail order)	Not covered	1 copay for 30-day supply; 2 copays for 31-60 day supply; 3 copays for 61-100 day supply. 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.

* 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$900 AHN copay or $1,000 copay	50% coinsurance	Pre-authorization required.
	Physician/surgeon fees	No charge	50% coinsurance	Pre-authorization required.
If you need immediate medical attention	Emergency room care	$400 copay	$400 copay	Worldwide emergency coverage.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Emergency criteria required.
	Urgent care	$60 copay/visit. Deductible does not apply.	50% coinsurance	Pre-authorization required on follow-up visits.
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,500 copay/day	50% coinsurance	Pre-authorization required. $4,500 copay max.
	Physician/surgeon fees	No charge	50% coinsurance	Pre-authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 AHN copay/visit or $30 copay/visit. Deductible does not apply.	50% coinsurance	None
	Inpatient services	$1,500 copay/day	50% coinsurance	Pre-authorization required. $4,500 copay max.
If you are pregnant	Office visits	$20 AHN copay or $30 copay. Deductible does not apply.	50% coinsurance	Copay on initial visit only. Cost sharing does not apply for preventative services. Depending on the type of services, a deductible, copay, or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	50% coinsurance	Pre-authorization required.
	Childbirth/delivery facility services	$1,500 copay/day	50% coinsurance	Pre-authorization required. $4,500 copay max.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	Pre-authorization required.
	Rehabilitation services	$30 copay/visit	50% coinsurance	Pre-authorization required.
	Habilitation services	$30 copay/visit	50% coinsurance	Pre-authorization required.
	Skilled nursing care	$150 copay/day	50% coinsurance	Pre-authorization required.
	Durable medical equipment	30% coinsurance	50% coinsurance	Pre-authorization required.
	Hospice services	30% coinsurance	Not covered	Pre-authorization required.

* 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$50 AHN copay/visit or $60 copay/visit. Deductible does not apply.	50% coinsurance	Limit 1 visit per benefit period.
	Children's glasses	50% coinsurance. Deductible does not apply.	50% coinsurance	Limitations may apply.
	Children's dental check-up	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Limit 2 visits per calendar year.

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
- Elective abortions (except when provided to save the life of the mother)
- 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 (Adult)
- Hearing aids (Children)
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs (Vantage Wellness Program only)

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or *www.dol.gov/ebsa/healthreform* or 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* 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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or *www.dol.gov/ebsa/healthreform* or Louisiana Department of Insurance, Office of Consumer Services, P.O. Box 94214, Baton Rouge, LA 70804-9214 or call 1-800-259-5300.

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

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 (TTY 711).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-823-1910 (TTY 711).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-823-1910 (TTY 711).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-823-1910 (TTY 711).

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)		**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 plan's overall deductible**	**$3,000**	■ **The plan's overall deductible**	**$3,000**	■ **The plan's overall deductible**	**$3,000**
■ **Specialist (OB/GYN) copayment**	**$30**	■ **Primary Care Physician copayment**	**$30**	■ **Specialist copayment**	**$60**
■ **Hospital (facility) copayment**	**$1,500/day**	■ **Hospital (facility) copayment**	**$1,500/day**	■ **Hospital (facility) copayment**	**$1,500/day**
■ **Other coinsurance**	**30%**	■ **Other coinsurance**	**30%**	■ **Other coinsurance**	**30%**
This EXAMPLE event includes services like:		**This EXAMPLE event includes services like:**		**This EXAMPLE event includes services like:**	
Specialist (OB/GYN) office visits (*prenatal care*)		Primary care physician office visits (*including disease education*)		Emergency room care (*including medical supplies*)	
Childbirth/Delivery Professional Services		Diagnostic tests (*blood work*)		Diagnostic test (*x-ray*)	
Childbirth/Delivery Facility Services		Prescription drugs		Durable medical equipment (*crutches*)	
Diagnostic tests (*ultrasounds and blood work*)		Durable medical equipment (*glucose meter*)		Rehabilitation services (*physical therapy*)	
Specialist visit (*anesthesia*)					
Total Example Cost	**$12,800**	**Total Example Cost**	**$7,600**	**Total Example Cost**	**$1,900**
In this example, Peg would pay:		**In this example, Joe would pay:**		**In this example, Mia would pay:**	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$3,000	Deductibles*	$1,300	Deductibles	$1,900
Copayments	$1,500	Copayments	$1,200	Copayments	$200
Coinsurance	$0	Coinsurance	$0	Coinsurance	$0
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$60	Limits or exclusions	$20	Limits or exclusions	$0
The total Peg would pay is	**$4,560**	**The total Joe would pay is**	**$2,520**	**The total Mia would pay is**	**$2,100**

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

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

Addendum: Language Access Services

If you, or someone you're helping, have questions about Vantage Health Plan or the Marketplace, you have the right to get help and information in your preferred language at no cost. To talk with an interpreter, call Member Services, 1-888-823-1910 (TTY 711).

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 (TTY 711).

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 (TTY 711).

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 (TTY 711).

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 (TTY 711)。

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 (TTY 711).بـ لصتا مجرتم عم ثدحتلل .ةفلكت ةيا 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 (TTY 711).

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 (TTY 711). 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 (TTY 711).

ຖ້າທ່ານ, ຫຼື ຄົນ ທ່ທ່ ານກໍ າລັ ງຊ່ ວຍເຫຼືອ ອ, ມ ຄ ຖ ມກ່ ງ ກັ ບ Vantage Health Plan or the Marketplace,
ທ່ ານມ ສ ທ ຈ ໄ ຮັ ບ ກ ນ ຊ່ ວຍເຫຼືອ ຕ ລ ະ ຂ ມູ ນ ຂ່ າ ວ ສ ນ ທ ປ ນ ພ າ ສ າ ຂ ອ ງ ທ່ ານ ໃ ຊ ຈ່ ຍ. 1-888-823-1910 (TTY 711).

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 (TTY 711). までお電話ください。

اگر آپ، یا کوئی ایسا شخص جس کی آپ مدد کر رہے ہیں، وانٹیج ہیلتھ پلان یا مارکیٹ پلیس کے بارے میں سوالات کرتے ہیں، تو آپ کو اپنی پسندیدہ زبان میں مدد اور
معلومات کسی قیمت پر حاصل کرنے کا حق حاصل ہے۔ ترجمان سے بات کرنے کے لئے، ممبر سروسز کو کال کریں، 1-888-823-1910 ٹی ٹی وائی 711

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
(TTY 711) an.

اگر شما، یا کسی که شما در حال کمک به، سوالاتی در مورد طرح بهداشت و درمان Vantage و یا بازار، شما حق دریافت کمک و اطلاعات در زبان مورد علاقه خود را بدون هیچ هزینه
ای. برای صحبت با یک مترجم، با خدمات عضو، 1-888-823-1910 (TTY 711) تماس بگیرید.

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 (TTY 711).

หากคณุ หรือคนที่คณุกาลงช่วยเหลือมีคาถามเกี่ยวกบั Vantage Health Plan or the Marketplace,
คณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมลในภาษาของคณได้โดยไม่มีค่าใช้จ่าย พดคยุ กบลาม โทร 1-888-823-1910 (TTY 711).