**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?** | $0 | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | Yes. | This plan covers items and services even if you haven't yet met the deductible amount. |
| **Are there other deductibles for specific services?** | No. | You do not have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Not Applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| **What is not included in the out-of-pocket limit?** | Not Applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| **Will you pay less if you use a network provider?** | Not Applicable. | This plan does not use a provider network. You can receive covered services from any provider. |
| **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*.

| 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 | No charge | No charge | None |
| | Specialist visit | No charge | No charge | None |
| | Preventive care/screening/ immunization | No charge | No charge | None |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge | No charge | None |
| | Imaging (CT/PET scans, MRIs) | No charge | No charge | 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 I Prescription Drug | No charge (retail/mail order) | Not covered | None |
| | Tier II Prescription Drug | No charge (retail/mail order) | Not covered | None |
| | Tier III Prescription Drug | No charge (retail/mail order) | Not covered | None |
| | Tier IV Prescription Drug | No charge (retail/mail order) | Not covered | None |
| | Tier V Prescription Drug | No charge (retail only) | Not covered | Mail Order not available. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge | No charge | Pre-authorization required. |
| | Physician/surgeon fees | No charge | No charge | Pre-authorization required. |
| **If you need immediate medical attention** | Emergency room care | No charge | No charge | Worldwide emergency coverage. |
| | Emergency medical transportation | No charge | No charge | Emergency criteria required. |
| | Urgent care | No charge | No charge | Pre-authorization required on follow-up visits. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge | No charge | 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) | |
| | Physician/surgeon fees | No charge | No charge | Pre-authorization required. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No charge | No charge | None |
| | Inpatient services | No charge | No charge | Pre-authorization required. |
| **If you are pregnant** | Office visits | No charge | No charge | None |
| | Childbirth/delivery professional services | No charge | No charge | Pre-authorization required. |
| | Childbirth/delivery facility services | No charge | No charge | Pre-authorization required. |
| **If you need help recovering or have other special health needs** | Home health care | No charge | Not covered | Pre-authorization required. |
| | Rehabilitation services | No charge | No charge | Pre-authorization required. |
| | Habilitation services | No charge | No charge | Pre-authorization required. |
| | Skilled nursing care | No charge | No charge | Pre-authorization required. |
| | Durable medical equipment | No charge | No charge | Pre-authorization required. |
| | Hospice services | No charge | Not covered | Pre-authorization required. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | No charge | Limit 1 visit per benefit period. |
| | Children's glasses | No charge | No charge | Limitations may apply. |
| | Children's dental check-up | No charge | No charge | Limit 2 visits per calendar year. |

* 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
- Elective abortions (except when provided to save the life of the mother)
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.

**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
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- 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* Mississippi Insurance Department, Consumer Services Division, P.O. Box 79, Jackson, MS 39205 or call 1-800-562-2957. 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 Mississippi Insurance Department, Consumer Services Division, P.O. Box 79, Jackson, MS 39205 or call 1-800-562-2957.

**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*.

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist (OB/GYN) copayment | $0 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

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

| | |
|---|---|
| **Total Example Cost** | **$12,700** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$0** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Primary Care Physician copayment | $0 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**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** | **$5,600** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$0** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $0 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

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

| | |
|---|---|
| **Total Example Cost** | **$2,800** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$0** |

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 بلع لوصحلا يف قحلا كيدلف
. 1-888-823-1910 (TTY 711). بـ لصتا مجرتم عم ثدحتلل .ةفلكت ةيا نود نم كتغلب ةيروريضلا

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 ານ ລັ ງຊ່ ວຍເຫຼືອ ອ, ມ ຄ ຖ ມກ ່ ງ 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 ພ າ ສ າ ຂ ອ ງ ທ ່ ານ ໂ ດ ຍ ບ ່ ມ ີ ຄ ່ າ ໃ ຊ ້ ຈ ່ າ 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).