
 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 (844) 833-7505 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	For In-Network Providers \$4,100 Individual or \$8,200 Family; for <a href="#">Out-of-Network Providers</a> \$5,000 Individual or \$15,000 Family.	Generally, you must pay all of the costs from <a href="#">providers</a> 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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Primary Care</a> and <a href="#">Specialty Care Provider</a> 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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You do not have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For In-Network providers: \$7,200 Individual/\$14,400 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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Copayments</a> and <a href="#">coinsurance</a> on certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, <a href="#">cost sharing</a> for out-of-network, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://VantageHealthPlan.com">VantageHealthPlan.com</a> and click "Find a Provider" or call (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 <a href="#">plan's 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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	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)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$30 AHN <a href="#">copay</a> or \$40 <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	\$70 AHN <a href="#">copay</a> or \$80 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply.	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 aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Lab and x-ray services performed in an office setting is covered at no charge. <a href="#">Deductible</a> may apply.
	Imaging (CT/PET scans, MRIs)	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.vantagehealthplan.com">www.vantagehealthplan.com</a>	Tier I <a href="#">Prescription Drugs</a>	\$10 Tier I <a href="#">copay</a> /prescription (retail/mail order) <a href="#">Deductible</a> does not apply.	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 61-100 day supply.
	Tier II <a href="#">Prescription Drugs</a>	\$20 Tier II <a href="#">copay</a> /prescription (retail/mail order) <a href="#">Deductible</a> does not apply.	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 61-100 day supply.
	Tier III <a href="#">Prescription Drugs</a>	\$40 <a href="#">copay</a> /prescription (retail/mail order) <a href="#">Deductible</a> does not apply.	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 61-100 day supply..
	Tier IV <a href="#">Prescription Drugs</a>	\$80 <a href="#">copay</a> /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 61-100 day supply.
	Tier V <a href="#">Prescription Drugs</a>	\$125 <a href="#">copay</a> /prescription (retail only)	Not covered	1 <a href="#">copay</a> for 30-day supply. Mail order not available.

\* 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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
If you need immediate medical attention	<a href="#">Emergency room care</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Worldwide emergency coverage.
	<a href="#">Emergency medical transportation</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Emergency criteria required.
	<a href="#">Urgent care</a>	\$60 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required on follow-up visits.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 AHN <a href="#">copay</a> /office visit or \$40 <a href="#">copay</a> /office visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	None
	Inpatient services	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
If you are pregnant	Office visits	\$30 AHN <a href="#">copay</a> or \$40 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	<a href="#">Copay</a> on initial visit only. <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">deductible</a> , <a href="#">copay</a> , or <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
	Childbirth/delivery facility services	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Pre-authorization</a> required.
	<a href="#">Rehabilitation services</a>	\$40 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
	<a href="#">Habilitation services</a>	\$40 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
	<a href="#">Skilled nursing care</a>	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
	<a href="#">Durable medical equipment</a>	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
	<a href="#">Hospice services</a>	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Pre-authorization</a> required.
If your child needs dental or eye care	Children’s eye exam	\$70 AHN <a href="#">copay</a> /visit or \$80 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	Limit 1 visit per benefit period.
	Children’s glasses	50% <a href="#">coinsurance</a> . <a href="#">Deductible</a> does not apply.	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.

**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)

\* 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. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa> 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](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 on how 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**

[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 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 (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, kwijigo 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.* —————

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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)		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>	\$4,100	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$4,100	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$4,100
■ <a href="#">Specialist</a> (OB/GYN) <a href="#">copayment</a>	\$40	■ <a href="#">Primary Care Physician</a> <a href="#">copayment</a>	\$40	■ <a href="#">Specialist</a> <a href="#">copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	40%	■ Hospital (facility) <a href="#">coinsurance</a>	40%	■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">coinsurance</a>	40%	■ Other <a href="#">coinsurance</a>	40%	■ Other <a href="#">coinsurance</a>	40%
<p><b>This EXAMPLE event includes services like:</b>  <a href="#">Specialist</a> (OB/GYN) office visits (<i>prenatal care</i>)                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services  <a href="#">Diagnostic tests</a> (<i>ultrasounds and blood work</i>)  <a href="#">Specialist visit</a> (<i>anesthesia</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>  <a href="#">Primary care physician</a> office visits (<i>including disease education</i>)  <a href="#">Diagnostic tests</a> (<i>blood work</i>)  <a href="#">Prescription drugs</a>  <a href="#">Durable medical equipment</a> (<i>glucose meter</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>  <a href="#">Emergency room care</a> (<i>including medical supplies</i>)  <a href="#">Diagnostic test</a> (<i>x-ray</i>)  <a href="#">Durable medical equipment</a> (<i>crutches</i>)  <a href="#">Rehabilitation services</a> (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</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>	
<a href="#">Deductibles</a>	\$4,100	<a href="#">Deductibles</a>	\$900	<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$50	<a href="#">Copayments</a>	\$1,100	<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$2,300	<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$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	\$20	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$6,510</b>	<b>The total Joe would pay is</b>	<b>\$2,020</b>	<b>The total Mia would pay is</b>	<b>\$2,400</b>

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)]。

صو صخب ءلئسأ هءعاست صخش بءل وأ كءءل ناك نأ، Vantage Health Plan or the Marketplace، ءامولعملاو ءءعاسملا بلع لوصحلا ىف قحلا كءءلف ب لصءا مءرءم عم ءءءءل. ءفلءء ءءا نوء نم كءءلب ءءرورضلا. 1-888-823-1910 (TTY 711).

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 ນ່າທ່ານ ກໍາລັງ ຈຸດ ວຍເຫຼືອ, ມໍຄາຖາມກ່ຽວກັບ Vantage Health Plan or the Marketplace, ທ່ານມີສ່ວນທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທັງໝົດ ນພາສາຂອງທ່ານ ບໍ່ມີຄ່າໃຊ້ຈ່າຍ. 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، وائٹج ہیلتھ پلان یا مارکیٹ پلےس 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 (TTY 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 کہ 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).

หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Vantage Health Plan or the Marketplace, คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย โปรดคุยกับเรา โทร 1-888-823-1910 (TTY 711).