MEMBER
CERTIFICATE OF COVERAGE

SHORT-TERM ESSENTIAL

VANTAGE HEALTH PLAN

2023
Welcome to Vantage Health Plan!

Thank you for enrolling with Vantage. We look forward to serving you. Our goal is to make our Members well and then keep them that way through quality preventive care. Vantage has a strong network of Physicians, Hospitals, and other Providers that offer a broad range of services for your medical needs.

As a Vantage Member, we want you to understand your benefits and coverage. This Certificate of Coverage contains the information you need to know about your coverage with Vantage. Please review this Certificate of Coverage and supplemental materials.

If you have any questions about your coverage, please do not hesitate to contact Vantage’s Member Services department. Member Services can be reached by calling toll-free (855) 934-6847 or emailing shortterm@vhpla.com. For any Member who is deaf or hard of hearing, please call teletypewriter (TTY) services at 711.

It is our pleasure to serve you.

Sincerely,

P. Gary Jones, M.D.
President/CEO, Chief Medical Director
This Certificate of Coverage ("Certificate") sets forth in detail your rights and obligations as a Member enrolled in Vantage Health Plan, Inc. ("Vantage") or Vantage Health Plan. It is important that you READ YOUR CERTIFICATE CAREFULLY and familiarize yourself with its terms and conditions. For reference, a table of contents has been included on the inside of this Certificate.

This coverage is not required to comply with certain federal marketplace requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

A review period is allowed, from the date of receipt of this Certificate, to examine its provisions. If this policy was solicited by deceptive advertising or negotiated by deceptive, misleading, or untrue statements of Vantage or any agent on behalf of Vantage, you may return this Certificate within the review period. Any Premium advanced by the Member, upon surrender of this Certificate, shall be immediately returned to the Member and the Health Insurance Coverage through Vantage will be void.

The length of the review period differs based on current coverage through another short-term, limited duration or limited benefit plan. If this short-term policy is replacing another short-term, limited duration or limited benefit plan, the review period for this policy is thirty (30) days. If this short-term policy is not replacing another short-term, limited duration or limited benefit plan, the review period for this policy is ten (10) days.

This Plan’s coverage will begin at 12:01 AM (Central Time) on the effective date and end at 11:59 PM (Central Time) on the last day of the Benefit Period. Coverage under this Plan will automatically terminate at the earlier of a) 364 days from the policy’s effective date, b) the end of the calendar year or c) at a date determined by the Member. Upon termination (break in coverage), Members must reapply for coverage under this Plan.

If you need additional information, please contact Vantage Health Plan, Inc., 130 DeSiard St., Ste. 300, Monroe, LA 71201, call toll-free (855) 934-6847, or e-mail shortterm@vhpla.com. For language assistance services, please contact Vantage’s Member Services department. For any Member who is deaf or hard of hearing, please call teletypewriter (TTY) services at 711. Vantage offers some language translation, sign language and TTY services to Members.
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This table of contents is designed only to help you locate answers to your questions more quickly. The table of contents does not cover every topic in this Certificate and may not list all the page numbers where references to the topics listed can be found. This table of contents does not change your benefit coverage or specifications.
**WELCOME TO VANTAGE HEALTH PLAN!**

You are now a Member of Vantage Health Plan. Vantage is an active participant in helping you receive quality, comprehensive medical care at a reasonable cost.

Your Member materials contain important information that should answer most of your questions about your benefits, as well as your rights and responsibilities as a Member.

Please read carefully when you see this symbol. This symbol will help you identify important information and help you use this Plan. This symbol is only to assist you and does not lessen the importance or make null and void any other Plan requirements.

Your Member materials are available to you online via your secure Member Portal at [https://members.vantagehealthplan.com/](https://members.vantagehealthplan.com/). If you prefer printed materials, please contact Member Services at (855) 934-6847 to submit your request.

**MEMBER CERTIFICATE OF COVERAGE**

This Member Certificate of Coverage is being issued to you on an individual basis and is the contract between you and Vantage. Please read this Certificate carefully. This Certificate explains what is covered and what is not covered by Vantage, as well as the rights and obligations of both parties. Any service not listed as a Covered Service is not covered. If you or Vantage fails to enforce any provision of this contract, it will not be considered a waiver of the provision or any other provisions in the future.

**COST SHARE SCHEDULE**

The Cost Share Schedule (enclosed with this Certificate) details the Deductible, Co-payment and Co-insurance amounts or percentages that are your financial responsibility and are based on the type of Covered Service and the Provider network. All Deductible and Co-insurance amounts are based on the Vantage Allowable or actual payments made after any discounts and/or reductions. Charges above the Vantage Allowable for Covered Services provided by Out-of-Network Providers do not apply to the Deductible or to the In-Network Out-of-Pocket Maximum.

**IDENTIFICATION CARDS**

The Vantage identification card (Member ID Card) is to be shown each time you receive services at a Physician’s office, Hospital, other Provider or pharmacy. Not showing your Member ID Card could result in bills being sent to you instead of to Vantage. Your Member ID Cards for the upcoming Benefit Period will be mailed to you prior to your effective date of coverage.

A sample image of the Member ID Card is shown on the following page.
Your unique Member ID number is located on the front of the Member ID Card next to your name.

The Deductibles shown on your Member ID Card are the amounts you must pay each Benefit Period before certain medical benefits are payable under the Plan. There are two (2) Deductibles: In-Network Medical and Out-of-Network Medical.

The Co-insurance percentages and the “Primary Care” Co-payment amount is your cost responsibility based on the type of Covered Service.

The In-Network Out-of-Pocket Maximum (OOP Max) shown on your Member ID Card is the maximum amount you will pay out-of-pocket for In-Network Benefit Level Covered Services. The In-Network Out-of-Pocket Maximum includes the In-Network Deductible, In-Network Co-insurance and Primary Care Co-payments.

READ THE INFORMATION IN THIS PACKET NOW, AND KEEP IT FOR FUTURE REFERENCE.

If you do not receive all of this information, or if the information is incorrect, please contact Vantage Member Services at (855) 934-6847 immediately.
Section I: Vantage Patient-Centered Medical Home

The Patient-Centered Medical Home (PCMH) is an approach to providing cost effective and comprehensive primary health care for children, youth and adults. The PCMH creates partnerships between individual patients and their personal Physicians, and when appropriate, the patient’s family.

Medical Home Primary Care Provider (MH-PCP)
Each Vantage Member has an ongoing relationship with a personal Primary Care Provider trained to provide first contact and assist you in obtaining access to ongoing and comprehensive health care. The Medical Home Primary Care Provider (MH-PCP) will personally work with you to coordinate all of your health care. Your MH-PCP leads a team of clinical health care professionals who collectively take responsibility for your immediate and ongoing health care needs. PCMH health care professionals may also include other clinical professionals, such as nurses and nutritionists. Your MH-PCP will also be responsible for arranging appropriate care with other qualified health care professionals, Specialty Care Providers or facilities, such as radiologists, laboratories, surgeons, and Hospitals.

Vantage requires the designation of a MH-PCP by all Plan Members. A MH-PCP will be assigned to coordinate your health care if you do not make a designation when you enroll. You may change your designated or assigned MH-PCP at any time by contacting Vantage. You have the right to designate any In-Network MH-PCP who is available to accept you as a patient. Children may designate an In-Network pediatrician as the MH-PCP. A woman may receive her primary care services through an In-Network obstetrician-gynecologist provider. To select a MH-PCP or to receive a list of In-Network Providers, visit us online at https://members.vantagehealthplan.com/ or contact Vantage toll-free at (855) 934-6847.

When your MH-PCP arranges for you to see a Specialty Care Provider or have a diagnostic test, the reports from that visit or test are automatically sent to your MH-PCP. If you see a Specialty Care Provider or have a diagnostic test that is not arranged by your MH-PCP, then you will need to ask that your reports be sent to your MH-PCP. Always make sure your MH-PCP is aware of all of your medical treatments and your other Health Care Providers. Referrals to In-Network Specialty Care Providers and OB/GYN’s are not required in this Plan.

A simple illustration of the Vantage Patient-Centered Medical Home Model on the following page shows how each Vantage Member’s care is coordinated by the MH-PCP. In the model, you can see that Vantage Medical Management provides information and assists the MH-PCP to coordinate care, and then the MH-PCP provides additional treatment and services by facilitating access to a wide variety of Specialty Care Providers, Hospitals, outpatient services and referral centers of excellence whenever it is necessary.
PATIENT-CENTERED MEDICAL HOME MODEL

This simple illustration of the Patient-Centered Medical Home Model shows how your care is coordinated by your MH-PCP. In the Model, you can see how Medical Management provides information and assists the MH-PCP to coordinate your care, and then the MH-PCP provides additional treatment and services by facilitating access to a wide variety of specialists, hospitals, outpatient services and Referral Centers of Excellence when medically necessary.

Member (You)

Care Coordination
Case Management
Health Risk Assessment

Medical Management

Patient-Centered Medical Home

Your Medical Home-Primary Care Provider (MH-PCP):
Family/General Practice
Internal Medicine
Pediatrician

Centers of Excellence

Cardiology
Chiropractic
Dermatology
Ear Nose & Throat
Endocrinology
Gastroenterology
Gynecology
Hematology/Oncology
Hospitals
Home Health

Laboratories
Infusion Therapy
Neonatology
Nephrology
Obstetrics
Outpatient Centers
Occupational Therapy Centers
Orthopaedics
Pharmacy

Physical Therapy
Pulmonology
Radiology
Skilled Nursing Facility
Social Services
Speech Therapy
Surgery
Treatment Centers
Urology

Referral Centers:
Arkansas Children’s Hospital
Children’s Hospital in New Orleans, LA
M.D. Anderson Cancer Center
St. Jude Children’s Research Hospital
University of Alabama at Birmingham Hospital
University of Mississippi Medical Center
Transplant Centers
SECTION II: HOW TO USE THIS PLAN

As a Patient-Centered Medical Home HMO, Vantage provides more of the comprehensive health services you need to get well and stay well. However, there are a few basic rules you must keep in mind to make sure you are receiving the full benefits of the coverage available.

**Vantage Member Identification Card**
When you join the Plan, you are sent a Vantage Member identification card (Member ID Card). A sample Member ID Card is located on page 5 of this Certificate of Coverage.

Your Member ID Card should be kept with you at all times. Each time services are rendered, you should present your Member ID Card. For details about the Cost Share for which you are responsible, please refer to Section IV of this Certificate of Coverage, your Cost Share Schedule, the front of your Member ID Card or visit us online at [https://members.vantagehealthplan.com/](https://members.vantagehealthplan.com/). You may also contact the Member Services department toll-free at (855) 934-6847.

Your Member ID Card is for identification purposes only. Any person receiving benefits or services to which they are not entitled will be financially responsible for any charges.

If you need extra Member ID Cards or lose your Member ID Card, visit the My Account link in your Member Portal ([https://members.vantagehealthplan.com/](https://members.vantagehealthplan.com/)) to order another set.

**Network Design**
The In-Network benefits described in this Certificate of Coverage relate to Covered Services performed by Participating Providers (also referred to as In-Network Providers) who have current and valid agreements with Vantage. Members seeing In-Network Providers pay any Deductibles, Co-payments and Co-insurance as shown in the In-Network column in Section IV of this Certificate of Coverage, the Cost Share Schedule and/or the Member ID Card. Tier I Providers cannot balance-bill the Member.

Vantage may contract with a nationwide Provider network available to Members living outside of the Vantage Service Area (state of Louisiana). These Participating Providers are considered Tier II Providers and cannot balance-bill the Member. The Pre-Authorization requirements for In-Network Covered Services as shown in Section IV of this Certificate of Coverage also apply to Tier II Providers.

Members living in the Vantage Service Area (state of Louisiana) do not have access to the Tier II Network. If in-state Members receive services from Providers, they will be responsible for the Out-of-Network Cost Share. In addition, they may be balance-billed by these Tier II Providers. Always check a Provider’s network status prior to receiving services.

A Provider’s status (In-Network Provider, Tier II Provider and Out-of-Network Provider) is subject to change at any time.

In-Network Providers are bound by an agreed-upon fee schedule and may not bill Members for amounts in excess of the fee schedule for Covered Services. In order to avoid being faced with non-payment of services, Members should always verify whether their Physician, Hospital, or pharmacy is a Participating Provider before receiving services. Participating Providers are subject to change at any time without prior notice.

If you receive services from an Out-of-Network Provider, the charges may be significantly more than Participating Provider fees and/or the Vantage Allowable. You may be balance-billed for the cost of services exceeding the Vantage Allowable. It is the Member’s responsibility to verify a Provider’s participation status prior to receiving services and to find out what the Vantage Allowable is for a Covered Service provided by an Out-of-Network Provider.
Medical Management

Vantage assists the MH-PCP by providing additional health information and coordination data related to your health history, such as Prescription Drug coverage and medical treatments provided. Vantage collects and organizes all of the available health information for each Member. The goal of the Vantage Medical Management department is to support the MH-PCP in compiling a complete and accurate health profile of each Member and to facilitate access to whatever health care services are required to improve each Member’s health status in consultation with the MH-PCP. Remember, the MH-PCP is your personal Medical Home Primary Care Provider.

A. Pre-Authorization

Pre-Authorization means written authorization from Vantage before receiving certain health services. It can mean the difference between a claim being paid or denied. Pre-Authorizations help Vantage to control and monitor those health services that are most costly. Providers of services requiring a Pre-Authorization are required to assist in obtaining the Pre-Authorization, but the Member remains ultimately responsible. Pre-Authorizations are subject to Plan requirements, benefit limits, and Member eligibility at the time services are rendered.

Pre-Authorization requirements for Covered Services rendered by In-Network Providers are shown in Section IV of this Certificate of Coverage. NOTE: This list of services requiring Pre-Authorization is subject to change. You may call Member Services toll-free at (855) 934-6847 for a current list of services that require Pre-Authorization. All Out-of-Network Covered Services require Pre-Authorization except Emergency Medical Services.

Referrals to In-Network Specialty Care Providers and OB/GYN’s are not required in this Plan.

B. Vantage Medical Utilization Review Program

Vantage has worked to develop programs that can reasonably contain costs while maintaining the quality of care. One such program is Utilization Review.

What Is Utilization Review?

Utilization Review is a process to ensure that you, your Physician, and your health plan work together to provide quality health care that avoids unnecessary hospitalization, inconvenience, and cost. It is an added benefit to assist in making decisions about your medical care.

How Does Utilization Review Work?

When your Physician recommends that you be hospitalized, you or the Physician must call Vantage and outline the planned treatment. As you know, a Hospital is not always the most appropriate place to receive treatment and is generally more expensive. By reviewing requests for hospitalization, the Vantage Medical Management staff makes sure that a Hospital stay is Medically Necessary and appropriate for inpatient care. Many diagnostic and surgical procedures are routinely performed in an outpatient setting, which can be easier for you and less costly. Vantage will also coordinate the plan of care with your MH-PCP to ensure the services being recommended are consistent with your health history.

If elective hospitalization is planned or you know ahead of time that a Hospital stay is needed, you or your Physician must call Vantage before your admission. If you are admitted on an Emergency basis, you or your Physician must contact Vantage within 24 hours (or the next working day if on a weekend or holiday) of the admission.

What is the Procedure for Utilization Review?

A single phone call sets the process in motion.

When the call is made, a Vantage Medical Management nurse will request certain basic information about you, and the reasons for the proposed admission. Vantage uses established, Physician-approved, medical and surgical criteria to determine the Medical Necessity of all Hospital admissions.
In the vast majority of cases, a nurse reviewer can review and approve a request. If the Medical Management nurse has questions about the necessity of the admission, they will consult with the Vantage Medical Director (a medical doctor) who will review the medical data. The Vantage Medical Director or a nurse may also inquire further about the treatment plan by contacting the Physician recommending the admission/treatment as well as contacting your MH-PCP.

In some instances it may be determined that your care can be more appropriately provided in an outpatient setting. If so, the Medical Director will recommend alternatives to hospitalization. Your Plan provides coverage for Medically Necessary outpatient or home care services, often with lower cost to you. These options may be discussed with your Physician and MH-PCP.

If your Hospital admission is authorized, an authorization number is given to you or your Physician and the Hospital. Your continued Hospital stay is reviewed by the Medical Management nurse to determine if further inpatient care is necessary beyond the initial days certified. This will also assure appropriate discharge planning, so follow-up or home care needs can be addressed.

Vantage does not compensate Medical Management nurses, Medical Directors, UM Committee members, and/or any other professionals who are involved in Utilization Review decisions for denials, does not offer incentives to encourage denials, and does not encourage decisions that result in underutilization. Vantage ensures independence and impartiality in making referral decisions and attests that involvement will not influence compensation, hiring, termination, promotion or any other similar matters for the Medical Management nurses, Medical Directors, UM Committee members, and/or any other professionals who are involved in Utilization Review decisions in the Utilization Review process based upon the likelihood or perceived likelihood that the Medical Management nurses, Medical Directors, UM Committee members, and/or any other professionals who are involved in Utilization Review decisions will support or tend to support the denial of benefits.

Is the Vantage Decision Final?
If you or your Physician disagrees with a Vantage denial, you may request an Appeal. Member Appeal processes are outlined in this Certificate of Coverage in Section XI.

What Is My Responsibility?
Your role is to show your Member ID Card to your Physician when a Hospital admission is being discussed. This alerts your Physician to call Vantage if a Hospital admission is planned. Following this process is essential to ensure that a Hospital stay is covered.

How Do I Benefit From Utilization Review?
If you are paying any portion of the Premiums on your health Plan, Utilization Review will help control rate increases that could result from unnecessary Hospital stays. If Vantage requires you to pay a part of the cost of treatment, Utilization Review assures that you will be treated in the most cost-effective way while maintaining quality health care.

In Summary
Ask your Physician to call the Vantage Medical Management department to begin the Pre-Authorization process. Pre-Authorization is required for all planned, non-Emergency admissions. Emergency hospitalization must be certified the next working day after admission or when reasonably possible.

C. Evaluation of New Technology
Vantage has developed a medical policy for the purpose of providing guidelines for determining coverage criteria for specific recently developed and/or practiced medical and behavioral health care technologies, including procedures, equipment, pharmaceuticals, devices, and services. In order to be eligible for coverage, all services must be Medically Necessary. To the extent there are any conflicts between Vantage's medical policy guidelines and this Plan’s language, the Plan’s language prevails.
Issues are selected for medical policy development through referrals from Vantage staff, the Provider community, and Members. The technology assessment process is applied to both the development of new medical policies and updates to existing medical policies. In order to determine whether a medical technology may be considered Medically Necessary, literature searches are conducted and the published scientific evidence related to each technology is reviewed.

Vantage medical policies are submitted for review to Vantage Medical Directors. Upon review, the Medical Directors will engage external practicing Physicians including Specialty Care Providers in the Vantage Service Area based on the areas of technology being evaluated and/or the specific medical discipline. Additional external resources may be utilized according to the complexity of the technology being evaluated. Opinions from these external sources will be compiled along with scientific evidence and the Medical Director summaries for the final approval process.

All policy drafts, including analyses of the scientific evidence and summaries of the external expert opinion, are presented to the Vantage Utilization Management Committee for final approval and implementation.

D. Continuity Of Care
In order to ensure continuity of care, Vantage must—

1. Make a good faith effort to provide written notice of discontinuation of a Health Care Provider thirty (30) days prior to the effective date of the change or otherwise as soon as practicable, to Members who are patients seen on a regular basis by the Health Care Provider or who receive primary care services from a PCP whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal;

2. In cases where a Health Care Provider is terminated without cause, allow a Member in an active course of treatment to continue treatment until the treatment is complete or for ninety (90) days, whichever is shorter, at the Member’s In-Network Cost Share. Active course of treatment means:
   A. An ongoing course of treatment for a Life-Threatening Illness;
   B. An ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the Member is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits;
   C. The Member has been diagnosed as being in a high-risk pregnancy or is past the twenty-fourth week of pregnancy and shall be allowed to continue receiving covered health care services, subject to the consent of the treating health care provider, through the delivery and postpartum period related to the pregnancy and delivery; or
   D. An ongoing course of treatment for a health condition for which a treating Health Care Provider attests that discontinuing care by that Health Care Provider would worsen the condition or interfere with anticipated outcomes.

Continuity of Care is not covered by Vantage under the following conditions:

(1) The reason for such termination is due to suspension, revocation, or applicable restriction of the Health Care Provider’s license to practice at such location by the applicable State Board of Medical Examiners or for another documented reason related to quality of care.

(2) The Member chooses to change Health Care Provider.

(3) The Member moves out of the geographic service area of Vantage or a Health Care Provider.

(4) The Member requires only routine monitoring for a chronic condition but is not in an acute phase of the condition.

Any continuity of care decision made by Vantage is subject to the internal and external Grievance and Appeal processes in accordance with state or Federal law or regulations.

E. How to Obtain Emergency Care and After Office Hours Care
As a Member, it is up to you to use your Vantage coverage wisely. Vantage is not an insurance program that reimburses you for whatever health care services you may desire. Your MH-PCP will work with you to assure that you receive the medical care you need in an appropriate, cost-effective manner.
Call your MH-PCP immediately when you require medical attention, even if you are traveling outside the Vantage Service Area. Your MH-PCP can advise you of the best course of action based on his/her knowledge of your medical history and your present symptoms. However, when a Member’s medical condition of recent onset and severity, including severe pain, would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in the serious jeopardy of one’s health or the health of an unborn child, serious impairment to bodily function or serious dysfunction of any bodily organ or part, the Member should call 911 and seek Emergency Medical Services. Emergencies do not require Pre-Authorization.

Emergency hospitalization must be authorized by Vantage on the next working day after admission or when reasonably possible. Pre-Authorization is required for all planned, non-Emergency admissions.

Members may visit an after-hours clinic or other facility primarily engaged in treating patients whose conditions require medical attention after normal office hours for non-Emergency Medical Services. Pre-Authorization is required for follow-up visits.

F. How to Obtain Coverage outside of the Vantage Service Area
Our Plan does offer Out-of-Network coverage for certain Covered Services. Members traveling or living outside of the state of Louisiana should contact the Vantage Medical Management department toll-free at (855) 934-6847 prior to receiving non-Emergency Covered Services from Out-of-Network Providers. All non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. Out-of-country services (excluding Emergency Medical Services) are not covered.

Members living outside of the state of Louisiana have access to the Tier II Provider network for certain Covered Services. However, should these Members receive non-Emergency Covered Services from an Out-of-Network Provider, the Member must contact the Vantage Medical Management department toll-free at (855) 934-6847 prior to receiving such services for Pre-Authorization.

G. Member Rights and Responsibilities
As a Member of Vantage Health Plan, you have the following rights and responsibilities:

► A right to receive information about Vantage, its services, its Health Care Providers and your rights and responsibilities as a Member.

► A right to be treated with fairness, respect and recognition of your dignity and right to privacy.

► A right to participate with Health Care Providers in making decisions about your health care.

► A right to candid discussion of appropriate or Medically Necessary treatment options for your conditions, regardless of cost or benefit coverage.

► A right to voice Grievances or file Appeals about Vantage, coverage decisions, its Health Care Providers, or the care provided.

► A right to make recommendations regarding Vantage’s Member rights and responsibilities policy.

► A right to receive timely access to your Eligible Charges.

► A right to privacy and the protection of your personal health information, in accordance with state and federal law.

► A responsibility to supply information (to the extent possible) that Vantage and its Health Care Providers need in order to provide care.
► A responsibility to follow treatment plans and instructions for care that you have agreed to with your Health Care Provider.

► A responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

IMPORTANT RULES TO HELP YOU USE THIS PLAN:

ALWAYS carry your Member ID Card and present it before receiving health services.

ALWAYS pay any Co-payments at the time you receive services.

ALWAYS remember, Covered Services provided by Out-of-Network Providers will be covered at a reduced benefit and you may be Balance-Billed for substantial amounts. Claims for Out-of-Network Providers must be received by Vantage Health Plan within one year from the date of service.

ALWAYS obtain Pre-Authorization (written authorization before services are received) from the Vantage Medical Management department for those services that require Pre-Authorization. Services requiring Pre-Authorization are identified, where applicable, in Section IV: Schedule of Covered Services & Benefits. Such Pre-Authorization requirements for In-Network Covered Services also apply to Tier II Providers.

NOTE: This list of services requiring Pre-Authorization is subject to change. You may call Member Services toll-free at (855) 934-6847 for a current list of services that require Pre-Authorization.

ALWAYS obtain Pre-Authorization for all Out-of-Network Covered Services (except Emergency Medical Services).

This Plan offers Out-of-Network coverage. When you seek treatment from an Out-of-Network Provider, the charges may be significantly more than the Vantage Allowable. You may be Balance-Billed for substantial amounts. You may contact Vantage’s Member Services department toll-free at (855) 934-6847 to find out what the estimated Vantage Allowable is for any given Covered Service. Charges above the Vantage Allowable incurred by a Member for Covered Services provided by Out-of-Network Providers do not apply toward any Deductibles or to the Out-of-Pocket Maximum.

Pre-Authorization is required for all planned, non-Emergency admissions.

Emergency hospitalization must be certified the next working day after admission or when reasonably possible.

The Vantage Member Services department is available to assist you in using this Plan. Call toll-free (855) 934-6847, Monday-Friday, 8:00 a.m. - 6:00 p.m. For language assistance services, please contact Vantage’s Member Services department. For any Member who is deaf or hard of hearing, please call TTY (711). Vantage offers some language translation, sign language and teletypewriter (TTY) services to Members. The Language Translation Addendum is available upon request and is located online at: https://www.vantagehealthplan.com/documents/Compliance/VHPTranslationServicesTaglines.pdf.
**SECTION III: DEFINITIONS**

*Accident* means bodily injury caused by a sudden and unforeseen event, definite as to time and place.

*Accidental Bodily Injury* means injury by an Accident of external, sudden and unforeseen means.

*Adverse Determination* means any of the following:

a. A determination by Vantage that, based upon the information provided, a request for a benefit under the health insurance issuer's health benefit plan upon application of any utilization review technique does not meet Vantage’s requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.

b. The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by Vantage of a Member's eligibility to participate in the health insurance issuer's health benefit plan.

c. Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit under a health benefit plan.

d. A Rescission of coverage determination.

*Appeal* means the type of complaint a Member files with Vantage to request that Vantage reconsider and change a decision related to Covered Services, (including a denial of, reduction in, or termination of a Covered Service or a failure to make a payment in whole or in part for a Covered Service), or a Rescission of coverage under this Plan.

*Authorized Representative* means any of the following:

a. A person to whom a Member has given express written consent to represent the Member. It may also include the Member's treating Health Care Provider if the Member appoints the Health Care Provider as his Authorized Representative and the Health Care Provider waives in writing any right to payment from the Member other than any applicable Cost Share amount. In the event that the service is determined not to be Medically Necessary, and the Member or his Authorized Representatives, except for the Member's treating Health Care Provider, thereafter requests the services, nothing shall prohibit the Health Care Provider from charging usual and customary charges for all non-Medically Necessary services provided.

b. A person authorized by law to provide substituted consent for a Member.

c. An immediate family member of the Member or the Member's treating Health Care Provider when the Member is unable to provide consent.

d. In the case of an urgent care request, a Health Care Provider with knowledge of the Member's medical condition.

*Balance-Billing* means an Out-of-Network provider may bill you for more than the plan’s allowed cost-sharing amount. In-Network providers cannot Balance-Bill or otherwise charge you more than the amount of cost-sharing your plan says you must pay for Covered Services.

*Benefit Level* means the level at which a Member’s Cost Share is paid. Each level (In-Network and Out-of-Network) has a different Cost Share for the Member as indicated in Section IV of this Certificate of Coverage and/or in the Cost Share Schedule.

*Benefit Period* means the contract period for which benefits are covered for this Plan. The Benefit Period begins at 12:01 AM (Central Time) on the effective date and ends at 11:59 PM (Central Time) on the last day of the Benefit Period. Coverage under this Plan will automatically terminate at the earlier of a) 364 days from the policy’s effective date, b) the end of the calendar year or c) at a date determined by the Member. The
Benefit Period resets on any break in coverage or if the Member enrolls in another Vantage plan during the current calendar year.

*Centers for Medicare and Medicaid Services (CMS)* means the federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs, and the federally facilitated Marketplace or Exchange.

*Chronic Condition or Chronic* refers to a medical illness, disease or physical ailment of long duration (three (3) month duration or longer according to U.S. National Center for Health Statistics) or frequent recurrence, associated with slow progress and long continuance.

*Co-insurance* means the percentage of the Vantage Allowable the Member is required to pay based on the type of Covered Service and may be due at the time of service. Co-insurance percentages are listed in the Cost Share Schedule and/or in Section IV: *Schedule of Covered Services & Benefits* of the Certificate of Coverage. Co-insurance applies after and does not apply toward any Deductibles.

*Co-payment* means the amount the Member is required to pay based on the type of Covered Service and is due at the time of service. Co-payment amounts are listed in the Cost Share Schedule and do not apply toward any Deductibles.

*Combined Benefit Maximum* means the maximum amount Vantage will pay for total In-Network and Out-of-Network Covered Services during a Benefit Period. After the combined Benefit Maximum is met, the Member will pay 100% of charges for the remainder of the Benefit Period.

*Cosmetic Purposes* means services rendered to alter the texture or configuration of the skin, or the configuration or relationship with contiguous structures of any feature of the human body for primarily personal or emotional reasons.

*Cost Share* means the Deductible, Co-payment and Co-insurance amounts or percentages that are the Member’s financial responsibility and are based on the type of Covered Service and the Provider network. Member medical Cost Share amounts apply in the following order: 1) Co-payment, 2) Deductible, 3) Co-insurance.

*Cost Share Schedule* means the document that details the Deductible, Co-payment, Co-insurance, and Out-of-Pocket Maximum amounts or percentages that are the Member’s financial responsibility and are based on the type of Covered Service and the Provider network.

*Covered Service(s)* means any Medically Necessary services and supplies received upon the recommendation and approval of a Physician and required for the treatment of a Member, subject to the exclusions and limitations listed elsewhere in this Certificate of Coverage.

*Deductible* means the amount shown on the Cost Share Schedule that the Member must pay each Benefit Period before certain medical benefits are payable under the Plan. A Member has met his/her Deductible by reaching their Deductible amount. Co-insurance and Co-payments do not apply toward any Deductible. Charges above the Vantage Allowable for services provided by Out-of-Network Providers do not apply toward any Deductible. There are two (2) possible Deductibles: In-Network Medical and Out-of-Network Medical.

  a) The *In-Network Medical Deductible* applies to Eligible Charges to be paid by each Member for In-Network benefits during the Benefit Period and are based on the Benefit Level of the rendering Provider. The In-Network Medical Deductible applies to the In-Network Out-of-Pocket Maximum.

  b) The *Out-of-Network Medical Deductible* applies to Eligible Charges to be paid by each Member for Out-of-Network benefits during the Benefit Period. All Out-of-Network Eligible Charges are subject to the Out-of-Network Deductible except Emergency Medical Services. The Out-of-Network Medical Deductible does not apply to the In-Network Out-of-Pocket Maximum. There is no Out-of-Network Out-of-Pocket Maximum.
**Developmental Condition or Developmental Disorder** refers to an impairment in normal development of language, cognitive and/or motor skills, generally recognized before age eighteen (18) which is expected to continue indefinitely and involves a failure or delay in progressing through the normal developmental stages of childhood.

**Drug(s)** refers to all prescription Drugs and non-prescription Drugs, including narcotics.

**Durable Medical Equipment (DME)** is an item that serves a medical purpose only and is Medically Necessary for the treatment of Illness or injury, can withstand long-term repeated use, and is appropriate for home use.

**Effective Date** is the date when the Plan Participant’s coverage begins under this Benefit Plan as determined by the Schedule of Eligibility. Benefits will begin at 12:01 A.M. on this date.

**Eligible Charges** means the charges for Covered Services.

**Emergency Medical Condition or Emergency** is a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in: (1) Placing the health of the individual in serious jeopardy; (2) Serious impairment to bodily function; or (3) Serious dysfunction of any bodily organ or part.

**Emergency Medical Services** are those medical services necessary to screen, evaluate, and Stabilize an Emergency Medical Condition.

**Enrollment Date** is defined as the date of enrollment of a Member in this Plan.

**Expedited Appeal** means an Appeal related to a claim for urgent medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could 1) seriously jeopardize the life or health of the Member; 2) jeopardize the ability of the Member to regain maximum function; or 3) in the opinion of a Physician with knowledge of the Member’s medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

**Final Adverse Determination** means an Adverse Determination, including medical judgment, involving a Covered Service that has been upheld by Vantage, or its designee utilization review organization, at the completion of Vantage's internal claims and Appeals process procedures provided pursuant to La. R.S. 22:2401.

**Genetic Information** means information about genes, gene products and inherited characteristics that may derive from an individual or family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes of chromosomes.

**Genetic Testing or Assessment** means the examination of Genetic Information contained inside a person’s cells to determine if that person has or will develop a certain disease or could pass a certain disease to his or her offspring.

**Grievance** means the type of complaint a Member files with Vantage for complaints related to Vantage or a Participating Provider about the quality of care received. Grievances may also be submitted to the Louisiana Department of Insurance for review. See Section XI of this Certificate of Coverage for information regarding grievances.

**Health Care Provider(s)** may include a Hospital, medical doctor (MD), dentist (DDS or DMD), osteopath (DO), pharmacist (RPh) or pharmacy, registered nurse (RN), nurse practitioner (CNP), physician assistant
(PA), registered nurse first assistant (RNFA), occupational therapist, physical therapist, speech therapist, chiropractor, podiatrist (DPM), optometrist (OD), anesthetist, including certified registered nurse anesthetist (CRNA), or a psychologist licensed by the proper regulatory agency of the state. Health Care Provider(s) may also include a network(s) of any of the Providers listed above.

**Health Insurance Coverage** means benefits consisting of medical or surgical services, provided directly through insurance or reimbursement, or otherwise and including items and services paid for as medical care, under any Hospital or medical service policy or certificate, Hospital or medical service plan contract, preferred provider organization, or health maintenance organization contract offered by a health insurance issuer.

**HIPAA** means the Health Insurance Portability and Accountability Act of 1996 (U.S. Public Law 104-191) and federal regulations promulgated pursuant thereto.

**Hospital** means an institution engaged in providing care and treatment for sick and injured people as bed-patients, which provides care by registered, graduate nurses, on duty or on call doctors available at all times, and has on its immediate premises (except in the case of a Hospital specializing in the care and treatment of Mental or Nervous Disorders) an operating room and related equipment for performing surgery.

Hospital does not include any establishment (even though it may be called a Hospital) or any part of any establishment which is primarily a place for any of the following: rest, convalescence, Custodial Care, the care or treatment of Drug addicts or alcoholics, rehabilitation, training, schooling or Occupational Therapy.

**Illness** means a disorder or disease of the body, or Mental or Nervous Disorder.

**In-Network** means services obtained from In-Network Providers.

**In-Network Cost Share** means the Co-payments, Medical Deductible and Co-insurance referred to in the “In-Network” column in Section IV of this Certificate of Coverage.

**In-Network Out-of-Pocket Maximum** - means the maximum out-of-pocket amount related to services obtained from In-Network Providers. See also Out-of-Pocket Maximum definition.

**In-Network Provider(s)** – See Participating Provider(s) definition.

**Independent Review Organization (IRO)** means an entity that conducts independent external reviews of Adverse Determinations and Final Adverse Determinations.

**Life-Threatening Illness** means a disease or condition for which the likelihood of death is probable.

**Medical Deductible** – Medical Deductible applies to Eligible Charges to be paid by each Member during the Benefit Period. See Deductible definition.

**Medical Home Primary Care Provider (MH-PCP) or Primary Care Provider (PCP)** means a Participating family practice, general practice, general pediatrician or general internal medicine Physician, or a nurse practitioner or physician assistant practicing in those fields, who is selected by a Vantage Member and provides the Member with entry into the health care system. A Primary Care Provider: (1) evaluates the Member’s total health needs; (2) provides personal medical care in one or more medical fields; (3) when Medically Necessary, preserves continuity of care and coordinates care with other Providers of health care services; and (4) coordinates Member care with the Vantage Medical Management department.

**Medical Necessity or Medically Necessary** means services or supplies, which under the provisions of the contract, are determined to be (1) appropriate and necessary for the symptoms, diagnosis or treatment of the
medical condition; (2) provided for the diagnosis or direct care and treatment of the medical condition; (3) within standards of accepted medical practice within the organized medical community; (4) not primarily for the convenience of the Member, the Member’s Physician or other Provider; and (5) the most appropriate supply or level of service that can be safely provided.

For Hospital stays, this means that acute care as an inpatient is necessary due to the kinds of services the Member is receiving or the severity of the Member’s condition, and that safe and adequate care cannot be received as an outpatient or in a less acute care medical setting.

**Member(s)** means the individuals who are eligible to receive Covered Services under this Plan and for whom the necessary application forms have been completed, enrollment accepted into this Plan, and for whom the required Premiums have been paid.

**Mental or Nervous Disorder(s)** means a mental, emotional or behavioral disorder, including, but not limited to, neurosis, psychoneurosis, psychosis, personality disorder, and alcohol or Drug addiction.

**Minimum Essential Coverage** means the type of coverage an individual needs to have to meet the individual responsibility requirement under PPACA.

**Occupational Therapy** means a healthcare service to evaluate and treat individuals in order for the individual to participate in the things they want and need to do through the therapeutic use of everyday activities (occupations). Common occupational therapy interventions include helping people recovering from injury to regain skills and providing support for older adults experiencing physical and cognitive changes.

**Out-of-Network** means services obtained from Out-of-Network Providers.

**Out-of-Network Benefit Maximum** means the maximum amount Vantage will pay for all Out-of-Network Covered Services during a Benefit Period. After the Out-of-Network Benefit Maximum is met, the Member will pay 100% of Out-of-Network charges for the remainder of the Benefit Period.

**Out-of-Network Provider(s) or Non-Participating Provider(s)** means those Health Care Providers who do not have a current and valid contract with Vantage at the time services are rendered. Out-of-Network Providers may balance-bill a Member.

**Out-of-Pocket Maximum** means the specified dollar amount listed in the Cost Share Schedule for which a Member is responsible for In-Network Covered Services. The Out-of-Pocket Maximum does not include charges for services provided by Out-of-Network Providers. There is no Out-of-Pocket Maximum for Out-of-Network Eligible Charges. Other exclusions and limitations are described in Section V of this Certificate of Coverage.

**Participating Provider(s) or Participating** – See In-Network Provider definition.

**Patient Protection and Affordable Care Act (PPACA)** refers to the federal law enacted on March 23, 2010, along with the Health Care and Education Reconciliation Act of 2010, and all rules and regulations issued thereunder. This law is also sometimes referred to as the Healthcare Reform Law.

**Physical Therapy** means a healthcare service including evaluation and treatment of any physical or medical condition to restore normal function of the neuromuscular, musculoskeletal, cardiovascular and/or integumentary systems or prevent disability with the use of physical or mechanical means, including therapeutic exercise, mobilization, passive manipulation, therapeutic modalities and activities.

**Physician** means a medical doctor (MD) or osteopath (DO).

**Plan** means the health care Plan as offered in this Certificate of Coverage.
Pre-Authorization means written authorization from Vantage before receiving certain health services.

Preexisting Condition means a condition, whether physical or mental, regardless of the cause of the condition, which (i) would have caused an ordinary prudent person to seek medical advice, diagnosis, care or treatment during the 12 months immediately preceding the effective date of coverage; or (ii) medical advice, diagnosis, care or treatment was recommended or received during the 12 months immediately preceding the effective date of coverage. Genetic information shall not be treated as a Preexisting Condition in the absence of a diagnosis of a condition related to such information. Pregnancy shall be considered a Preexisting Condition.

Prescription Drugs means any medicine that requires a prescription from a Health Care Provider who is authorized by federal or state law to prescribe or refill the medicine. This Plan allows Members to receive covered Prescription Drugs at the Vantage Allowable fee schedule. The Member is responsible for the full amount of the Vantage Allowable.

Premium or Premium Payment means the amount of money due to Vantage each month for medical and prescription drug coverage.

Provider(s) - see Health Care Provider(s) definition.

Reconstructive Services means reparative or therapeutic surgery or services done to restore the patient’s function and appearance to pre-injury or pre-Illness state.

Recurrent Condition means defective state of health returning or happening time after time.

Rescission means cancellation or discontinuance of coverage under Vantage that has a retroactive effect. The term shall not include a cancellation or discontinuance of coverage under a health benefit plan if either:

(a) The cancellation or discontinuance of coverage has only a prospective effect.
(b) The cancellation or discontinuance of coverage is effective retroactively to the extent that it is attributable to a failure to timely pay required Premiums or contributions towards the cost of coverage.

Specialty Care Provider is a medical or surgical Physician, nurse practitioner, or physician assistant other than gynecologists and those providers defined as Primary Care Providers.

Speech Therapy means a healthcare service to evaluate, treat, and diagnose speech, language, cognitive-communication and swallowing disorders in individuals of all ages from infants to the elderly.

Stabilize means to provide treatment that assures that no material deterioration of the condition is likely to result from or occur during the transfer of the Member from a facility.

Tier II Provider or Tier II – A nationwide Provider network available to Members living outside of the Vantage Service Area (state of Louisiana). Tier II Providers outside the Vantage Service Area cannot balance-bill out-of-state Members. Members living in the Vantage Service Area do not have access to the Tier II Provider network.

Urgent Care Center means a Physician’s office, clinic or other facility primarily engaged in treating patients whose conditions require immediate medical attention. The term Urgent Care Center does not include a Hospital emergency department, other outpatient emergency department or other outpatient Hospital facility.

Utilization Management (UM) means a function performed by Vantage or its designee to review and approve or deny authorization or payment for Covered Services as to the Medical Necessity and quality of the care and compliance with agreed-upon policies, procedures and protocols established by Vantage.
**Vantage Allowable** means the amount Vantage would pay to an In-Network Provider for the Covered Service as specified in the Provider contract or the amount set forth in the Vantage Allowable fee schedule, as determined by Vantage.

**Vantage Service Area** means the geographic area (the state of Louisiana) served by Vantage as approved by the Louisiana Department of Insurance.
**SECTION IV: SCHEDULE OF COVERED SERVICES & BENEFITS**

Coverage will be provided for the Covered Services listed. Covered Services are the Medically Necessary services and supplies received upon the recommendation and approval of a Physician and required for the treatment of a Member, subject to the exclusions and limitations listed in Section V of this Certificate of Coverage.

The Benefit Level is usually determined by the Provider’s network status. However, the Benefit Level for services cannot be better than the network status of the ordering Physician for outpatient services and the admitting Physician for inpatient services.

Covered Services are subject to the Deductibles, Co-payments and Co-insurance shown in the Cost Share Schedule and/or in this Section IV. These amounts are based on the Vantage Allowable. Deductibles, Co-payments, and Co-insurance are a Member’s responsibility and may be due at the time services are rendered.

**NOTICE: YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES**

The Out-of-Pocket Maximum described below will limit the amount a Member will pay out-of-pocket for In-Network Benefit Level Eligible Charges each Benefit Period subject to the exclusions and limitations listed below.

**Deductibles**

**In-Network Medical Deductible**

The In-Network Medical Deductible is the amount that the Member must pay each Benefit Period before certain In-Network medical benefits are payable under the Plan.

The In-Network Medical Deductible that applies to this Plan is specified in the Cost Share Schedule. In-Network Eligible Charges which are subject/not subject to the In-Network Deductible are noted in the applicable benefits in this Section.

The In-Network Medical Deductible for In-Network Benefit Level Eligible Charges is the amount specified in the Cost Share Schedule. After a Member’s payments for In-Network Eligible Charges during a Benefit Period equal the In-Network Medical Deductible, the Member will pay In-Network Eligible Charges at the Cost Share amount stated in the Cost Share Schedule.

**Out-of-Network Medical Deductible**

The Out-of-Network Deductible is the amount that the Member must pay each Benefit Period before most Out-of-Network medical benefits are payable under the Plan. Charges above the Vantage Allowable for services provided by Out-of-Network Providers do not apply toward the Out-of-Network Deductible.

All Out-of-Network Eligible Charges are subject to the Out-of-Network Deductible except Emergency Medical Services.

The Out-of-Network Deductible for Out-of-Network Benefit Level Eligible Charges is the amount specified in the Cost Share Schedule. After a Member’s Out-of-Network Benefit Level Eligible Charges to be paid during a Benefit Period equals the Out-of-Network Deductible, the Plan will pay Out-of-Network Benefit Level Eligible Charges for the Member at the Out-of-Network Co-insurance listed on the Cost Share Schedule.
Out-of-Pocket Maximum

In-Network Out-of-Pocket Maximum

The In-Network Out-of-Pocket Maximum described below will limit the amount a Member will pay out-of-pocket for In-Network Benefit Level Covered Services each Benefit Period subject to the exclusions and limitations listed below.

The Out-of-Pocket Maximum for In-Network Benefit Level Covered Services is the amount specified in the Cost Share Schedule. After a Member’s share of In-Network Benefit Level Covered Services to be paid during a Benefit Period equals the applicable In-Network Out-of-Pocket Maximum, the Plan will pay In-Network Benefit Level Covered Services for that Member at 100% of the Vantage Allowable for the remainder of the Benefit Period subject to the exclusions and limitations listed below.

Exclusions and limitations for In-Network Out-of-Pocket Maximum

Out-of-Network Eligible Charges as well as certain other Member payments (shown below) are excluded from the In-Network Out-of-Pocket Maximum. Charges incurred by a Member for the following will NOT be applied to the In-Network Out-of-Pocket Maximum:

i. Services performed by Out-of-Network Providers (except for Emergency Medical Services)
ii. Charges in excess of the maximum benefit available
iii. Charges that are not Covered Services
iv. Charges above the Vantage Allowable for Covered Services performed by Out-of-Network Providers
v. Monthly Premium payments

Out-of-Network Out-of-Pocket Maximum

There is no Out-of-Pocket Maximum for Out-of-Network Covered Services.

Benefit Maximums

The Combined Benefit Maximum is the amount specified in the Cost Share Schedule. After the Plan’s share of In-Network and Out-of-Network Covered services paid during the Benefit Period equals the Combined Benefit Maximum, the Member will pay 100% of charges for all Covered Services for the remainder of the Benefit Period.

The Out-of-Network Benefit Maximum is the amount specified in the Cost Share Schedule and is included in the Combined Benefit Maximum. Vantage will not pay for Out-of-Network Covered Services in excess of the Out-of-Network Benefit Maximum.

The In-Network benefits that appear on the following pages must be arranged by your PCP and indicate whether In-Network Pre-Authorization is required.

If you receive services from an Out-of-Network Provider, the charges may be significantly more than an In-Network Provider’s fees and/or the Vantage Allowable. You may be balance-billed by the Out-of-Network Provider for the cost of services exceeding the Vantage Allowable. In-Network Providers cannot balance-bill Members. Charges above the Vantage Allowable for Covered Services provided by Out-of-Network Providers do not apply to any Deductibles or to the Out-of-Pocket Maximum.

All Out-of-Network Eligible Charges are subject to the Out-of-Network Deductible and require Pre-Authorization, except for Emergency Medical Services.

Conditions developed during a Benefit Period that are Covered Services will be covered through the duration of the Benefit Period. Services other than Covered Services are not covered, regardless of the timing of diagnoses or development of conditions.

This Plan is only valid for the current Benefit Period. Coverage for any future Benefit Period will be based on a new application (i.e., this Plan does not automatically renew).
Please refer to the following important information concerning Co-payments, Deductibles, Co-insurance, the Out-of-Pocket Maximum, and the Benefit Maximums when reviewing this section.

► Covered Services are subject to the Co-payment, Deductibles, Co-insurance and maximums as shown in the Cost Share Schedule.

► Member Medical Cost Share amounts apply in the following order: 1) Out-of-Network Medical Deductible, 2) Out-of-Network Co-insurance, 3) In-Network Co-payments, 4) In-Network Medical Deductible, and 5) In-Network Co-insurance.

► Co-payments, Deductibles and Co-insurance are a Member’s responsibility and may be due at the time services are rendered.

► Co-payment and Co-insurance amounts do not apply toward any Deductible.

► There is no Out-of-Pocket Maximum for Out-of-Network Benefit Level Covered Services.

► This Plan has Benefit Maximums.
### Physician Office Services

Physician office services are Medically Necessary services for the treatment of Accidental Bodily Injury, Illness, injury or disease that are rendered in the Physician’s office.

<table>
<thead>
<tr>
<th>COVERED SERVICE</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Provider (PCP) Office Visits:</strong> Family practice, general internal medicine, general pediatrician or general practice Physicians, and nurse practitioners or physician assistants practicing in those fields.</td>
<td>100% Coverage of Vantage Allowable less applicable Primary Care Provider office visit Co-payment. Not subject to In-Network Deductible. See Cost Share Schedule.</td>
<td>Member pays Out-of-Network Co-insurance. Subject to Out-of-Network Deductible. See Cost Share Schedule.</td>
</tr>
<tr>
<td><strong>Gynecology Office Visits:</strong></td>
<td>100% Coverage of Vantage Allowable less applicable Primary Care Provider office visit Co-payment. Not subject to In-Network Deductible. See Cost Share Schedule.</td>
<td>Member pays Out-of-Network Co-insurance. Subject to Out-of-Network Deductible. See Cost Share Schedule.</td>
</tr>
<tr>
<td>Adults 19 and older:</td>
<td>Member pays In-Network Co-insurance. Subject to In-Network Deductible. See Cost Share Schedule.</td>
<td>Member pays Out-of-Network Co-insurance. Subject to Out-of-Network Deductible. See Cost Share Schedule.</td>
</tr>
</tbody>
</table>

* When you receive treatment from an Out-of-Network Provider, the charges may be more than the Vantage Allowable. The Out-of-Network Provider may balance-bill you for any charges over the Vantage Allowable. In-Network Providers cannot balance-bill Members. All services except Emergency Medical Services performed by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.
### Physician Office Services (continued)

<table>
<thead>
<tr>
<th>COVERED SERVICE</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Care Provider Office Visits (including consultation visits): Medical or surgical Physicians, nurse practitioners, and physician assistants other than gynecologists and those providers defined as Primary Care Providers.</td>
<td>Member pays In-Network Co-insurance.</td>
<td>Member pays Out-of-Network Co-insurance.</td>
</tr>
<tr>
<td></td>
<td>Subject to In-Network Deductible.</td>
<td>Subject to Out-of-Network Deductible.</td>
</tr>
<tr>
<td>Office Procedures and Diagnostic Services: Lab and x-ray services performed in the Physician office.</td>
<td>Member pays In-Network Co-insurance.</td>
<td>Member pays Out-of-Network Co-insurance.</td>
</tr>
<tr>
<td>► Lab</td>
<td>Subject to In-Network Deductible.</td>
<td>Subject to Out-of-Network Deductible.</td>
</tr>
<tr>
<td>► Specified other lab <strong>Requires Pre-Authorization.</strong></td>
<td>See Cost Share Schedule.</td>
<td>See Cost Share Schedule.</td>
</tr>
<tr>
<td>► X-rays, other office procedures¹, and diagnostic services, excluding major diagnostic testing. <strong>May require Pre-Authorization.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>► Major diagnostic testing (See list of services in the Outpatient Hospital Services category.) <strong>Requires Pre-Authorization.</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹May require Pre-Authorization.

### Inpatient Hospital Services

Providers’ services which are Medically Necessary for the treatment of Accidental Bodily Injury, Illness, injury or disease rendered while admitted as an inpatient to a facility. Perioperative services rendered by a Registered Nurse First Assistant RNFA) will be covered if the same service would be covered when rendered by an advanced practice nurse, physician assistant, or a Physician other than the operating surgeon. Inpatient Hospital services include the rooms, equipment, Drugs, blood transfusions, and medical supplies. The following are also included when the services are rendered by facility-based Physicians: anesthesia, diagnostic services, Physical Therapy and psychological testing when ordered by the attending Physician.

<table>
<thead>
<tr>
<th>COVERED SERVICE</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Semi-Private Room:</td>
<td>Member pays In-Network Co-insurance.</td>
<td>Member pays Out-of-Network Co-insurance.</td>
</tr>
<tr>
<td>Including Intensive Care Units (ICU) and Cardiac Care Units (CCU).</td>
<td>Subject to In-Network Deductible.</td>
<td>Subject to Out-of-Network Deductible.</td>
</tr>
<tr>
<td>Physician Services: Surgery, pre- and post-operative medical visits, assistant surgeon services if warranted, approved anesthesia services by CRNA or Physician, consultations, concurrent care, and in-Hospital visits.</td>
<td>Member pays In-Network Co-insurance.</td>
<td>Member pays Out-of-Network Co-insurance.</td>
</tr>
<tr>
<td>Required Pre-Authorization</td>
<td>Subject to In-Network Deductible.</td>
<td>Subject to Out-of-Network Deductible.</td>
</tr>
</tbody>
</table>

* When you receive treatment from an Out-of-Network Provider, the charges may be more than the Vantage Allowable. The Out-of-Network Provider may balance-bill you for any charges over the Vantage Allowable. In-Network Providers cannot balance-bill Members. All services except Emergency Medical Services performed by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.
### Ambulatory Surgery Unit (ASU) or Outpatient Surgery

Providers’ services which are Medically Necessary for the treatment of Accidental Bodily Injury or Illness, injury or disease rendered in a Hospital or a free-standing surgical facility, whether affiliated with a Physician’s office or not.

<table>
<thead>
<tr>
<th>COVERED SERVICE</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Surgery Unit (ASU) or Outpatient Surgery:</td>
<td>Member pays In-Network Co-insurance.</td>
<td>Member pays Out-of-Network Co-insurance.</td>
</tr>
<tr>
<td>Requires Pre-Authorization.</td>
<td>Subject to In-Network Deductible.</td>
<td>Subject to Out-of-Network Deductible.</td>
</tr>
<tr>
<td>Physician Services:</td>
<td>Member pays In-Network Co-insurance.</td>
<td>Member pays Out-of-Network Co-insurance.</td>
</tr>
<tr>
<td>Surgery, pre- and post-operative medical visits, assistant surgeon services if warranted, approved anesthesia services by CRNA or Physician, and consultations.</td>
<td>Subject to In-Network Deductible.</td>
<td>Subject to Out-of-Network Deductible.</td>
</tr>
</tbody>
</table>

### After-Hours/Walk-In Clinics and Urgent Care Centers

Prior to receiving services at an After-Hours/Walk-In Clinic or Urgent Care Center, please confirm the “specialty” type in the Provider Directory online at VantageHealthPlan.com or contact Vantage’s Member Services department. Your Cost Share may differ based on the “specialty” type.

<table>
<thead>
<tr>
<th>COVERED SERVICE</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK*</th>
</tr>
</thead>
<tbody>
<tr>
<td>After-Hours/Walk-In Clinics:</td>
<td>100% Coverage of Vantage Allowable less applicable</td>
<td>Member pays Out-of-Network Co-insurance.</td>
</tr>
<tr>
<td></td>
<td>Primary Care Provider office visit Co-payment.</td>
<td>Subject to Out-of-Network Deductible.</td>
</tr>
<tr>
<td></td>
<td>Not subject to In-Network Deductible.</td>
<td>See Cost Share Schedule.</td>
</tr>
<tr>
<td></td>
<td>See Cost Share Schedule.</td>
<td></td>
</tr>
<tr>
<td>Urgent Care Centers:</td>
<td>Member pays In-Network Co-insurance.</td>
<td>Member pays Out-of-Network Co-insurance.</td>
</tr>
<tr>
<td><img src="image" alt="Follow-up visits require Pre-Authorization." /></td>
<td>Subject to In-Network Deductible.</td>
<td>Subject to Out-of-Network Deductible.</td>
</tr>
</tbody>
</table>

* When you receive treatment from an Out-of-Network Provider, the charges may be more than the Vantage Allowable. The Out-of-Network Provider may balance-bill you for any charges over the Vantage Allowable. In-Network Providers cannot balance-bill Members. All services except Emergency Medical Services performed by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.
## Outpatient Services

<table>
<thead>
<tr>
<th>COVERED SERVICE</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Observation Stay:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>► Facility</td>
<td>Member pays In-Network Co-insurance.</td>
<td>Member pays Out-of-Network Co-insurance.</td>
</tr>
<tr>
<td>► Physician Services</td>
<td>Subject to In-Network Deductible.</td>
<td>Subject to Out-of-Network Deductible.</td>
</tr>
<tr>
<td><strong>Major Diagnostic Testing:</strong></td>
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<tr>
<td>Including, but not limited to:</td>
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</tr>
<tr>
<td>► Bone scan</td>
<td>Member pays In-Network Co-insurance.</td>
<td>Member pays Out-of-Network Co-insurance.</td>
</tr>
<tr>
<td>► Cardiac stress test</td>
<td>Subject to In-Network Deductible.</td>
<td>Subject to Out-of-Network Deductible.</td>
</tr>
<tr>
<td>► CAT scan</td>
<td>See Cost Share Schedule.</td>
<td>See Cost Share Schedule.</td>
</tr>
<tr>
<td>► Echocardiogram</td>
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<tr>
<td>► EEG</td>
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<td></td>
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<tr>
<td>► EMG</td>
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<tr>
<td>► Event monitor</td>
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<tr>
<td>► HIDA scan</td>
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<tr>
<td>► Holter monitor</td>
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<tr>
<td>► MRI</td>
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<tr>
<td>► Nerve conduction study</td>
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<tr>
<td>► Nuclear cardiac stress test</td>
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<tr>
<td>► Nuclear medicine test</td>
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<tr>
<td>► PET scan</td>
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<td></td>
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<tr>
<td>► Pulmonary function test</td>
<td></td>
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<tr>
<td>► Sleep study</td>
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<tr>
<td><strong>Requires Pre-Authorization.</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Other Outpatient and Diagnostic Services:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>► Lab</td>
<td>Member pays In-Network Co-insurance.</td>
<td>Member pays Out-of-Network Co-insurance.</td>
</tr>
<tr>
<td>► Specified other lab</td>
<td>Subject to In-Network Deductible.</td>
<td>Subject to Out-of-Network Deductible.</td>
</tr>
<tr>
<td>► X-rays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>► Other diagnostic testing and outpatient services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>not listed elsewhere in this Section IV and not</td>
<td></td>
<td></td>
</tr>
<tr>
<td>performed in an office visit setting</td>
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</tr>
<tr>
<td><strong>Requires Pre-Authorization.</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Emergency Medical Services

Emergency Medical Services are those medical services necessary to screen, evaluate, and Stabilize an Emergency Medical Condition. Coverage is available for Accidental Bodily Injury or sudden onset of an acute illness (see Emergency criteria below). **Return visits** to the Emergency facility for follow-up care are **not covered**. Payments of claims for Emergency Medical Services rendered by a Non-Participating Health Care Provider are not made directly to the Member.

Examples of Emergency criteria include:
- Severe pain or the sudden onset of pain. Examples include: chest pain, headache with neurological changes or acute severe abdominal pain.
- Severe bleeding
- Respiratory distress
- Accidental Bodily Injuries. Examples include: 2nd & 3rd degree burns, lacerations requiring sutures, or bone fractures.
- Unconsciousness
- Convulsions

If you receive Emergency Medical Services from any Out-of-Network Provider, including ambulance services, your Cost Share is based on the Vantage Allowable. In addition, you may be balance-billed.

<table>
<thead>
<tr>
<th>COVERED SERVICE</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Room Service and Supplies:</strong></td>
<td>Member pays In-Network Co-insurance. Emergency room Co-insurance is waived if admitted. Subject to In-Network Deductible. See Cost Share Schedule.</td>
<td>Member pays In-Network Co-insurance. Emergency room Co-insurance is waived if admitted. Subject to In-Network Deductible. See Cost Share Schedule.</td>
</tr>
<tr>
<td><strong>Ground Ambulance Service:</strong></td>
<td>Member pays In-Network Co-insurance. Subject to In-Network Deductible. See Cost Share Schedule.</td>
<td>Member pays In-Network Co-insurance. Subject to In-Network Deductible. See Cost Share Schedule.</td>
</tr>
<tr>
<td>Ground ambulance service provided by a professional ambulance service for local ground transportation to a Hospital for a covered medical Emergency. Air ambulance, non-emergent transportation, and transport services are not covered.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>COVERED SERVICE</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-cancer Therapy:</td>
<td>Member pays In-Network Co-insurance. Subject to In-Network Deductible.</td>
<td>Member pays Out-of-Network Co-insurance. Subject to Out-of-Network Deductible.</td>
</tr>
<tr>
<td>Includes intravenous and injected medications.</td>
<td>See Cost Share Schedule.</td>
<td>See Cost Share Schedule.</td>
</tr>
<tr>
<td>Requires Pre-Authorization.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Management for New Onset Diabetes:</td>
<td>Member pays In-Network Co-insurance. Subject to In-Network Deductible.</td>
<td>Member pays Out-of-Network Co-insurance. Subject to Out-of-Network Deductible.</td>
</tr>
<tr>
<td>Outpatient self-management training (including the initial equipment and supplies) and education/medical nutrition therapy for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes if prescribed by the primary attending Physician. Such outpatient training and nutrition therapy programs shall be provided by a health care professional in compliance with the National Standards for Diabetes Self-Management Education Program, as developed by the American Diabetes Association. Additional training may be covered based on Medical Necessity. Maximum of ten (10) visits during the initial Benefit Period.</td>
<td>See Cost Share Schedule.</td>
<td></td>
</tr>
<tr>
<td>Requires Pre-Authorization.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis:</td>
<td>Member pays In-Network Co-insurance. Subject to In-Network Deductible.</td>
<td>Member pays Out-of-Network Co-insurance. Subject to Out-of-Network Deductible.</td>
</tr>
<tr>
<td>Treatment must be obtained from a certified Dialysis Treatment Center. Treatments covered may include hemodialysis, peritoneal dialysis and hemofiltration.</td>
<td>See Cost Share Schedule.</td>
<td>See Cost Share Schedule.</td>
</tr>
<tr>
<td>Requires Pre-Authorization.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional Counseling:</td>
<td>Member pays In-Network Co-insurance. Subject to In-Network Deductible.</td>
<td>Member pays Out-of-Network Co-insurance. Subject to Out-of-Network Deductible.</td>
</tr>
<tr>
<td>Maximum of four (4) visits per Benefit Period.</td>
<td>See Cost Share Schedule.</td>
<td>See Cost Share Schedule.</td>
</tr>
<tr>
<td>Requires Pre-Authorization.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### Other Covered Services (continued)

<table>
<thead>
<tr>
<th>COVERED SERVICE</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Rehabilitation Services:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>► <strong>Occupational and Speech Therapy:</strong></td>
<td>Member pays In-Network Co-insurance.</td>
<td>Member pays Out-of-Network Co-insurance.</td>
</tr>
<tr>
<td>Services after Illness or injury to restore pre-existing function. Services must be obtained from a licensed occupational or speech therapist, other than an individual who resides in the Member’s home or who is a family member. Requires Pre-Authorization.</td>
<td>Subject to In-Network Deductible.</td>
<td>Subject to Out-of-Network Deductible.</td>
</tr>
<tr>
<td>Maximum combined total of twenty (20) visits per Benefit Period for Occupational and Speech Therapy.</td>
<td>See Cost Share Schedule.</td>
<td>See Cost Share Schedule.</td>
</tr>
<tr>
<td><strong>Physical Therapy:</strong></td>
<td>Member pays In-Network Co-insurance.</td>
<td>Member pays Out-of-Network Co-insurance.</td>
</tr>
<tr>
<td>Services provided by a licensed physical therapist other than an individual who resides in the Member’s home or who is a family member. Not covered for Chronic or Recurrent Conditions. (Example: Fibromyalgia and muscle tension headaches). Requires Pre-Authorization.</td>
<td>Subject to In-Network Deductible.</td>
<td>Subject to Out-of-Network Deductible.</td>
</tr>
<tr>
<td>Maximum combined total of twenty (20) visits per Benefit Period for Physical Therapy and Spinal Manipulation and Adjustment.</td>
<td>See Cost Share Schedule.</td>
<td>See Cost Share Schedule.</td>
</tr>
<tr>
<td>► <strong>Spinal Manipulation and Adjustment:</strong></td>
<td>100% Coverage of Vantage Allowable less applicable Primary Care Provider office visit Co-payment.</td>
<td>Member pays Out-of-Network Co-insurance.</td>
</tr>
<tr>
<td>Treatment of dislocation, subluxation or misplacement of vertebrae and/or strains and sprains of soft tissues related to the spine provided by a Health Care Provider. Requires Pre-Authorization.</td>
<td>Not subject to In-Network Deductible.</td>
<td>Subject to Out-of-Network Deductible.</td>
</tr>
<tr>
<td>Maximum combined total of twenty (20) visits per Benefit Period for Physical Therapy and Spinal Manipulation and Adjustment.</td>
<td>Member pays In-Network Co-insurance.</td>
<td>See Cost Share Schedule.</td>
</tr>
<tr>
<td>Requires Pre-Authorization.</td>
<td>Subject to In-Network Deductible.</td>
<td></td>
</tr>
<tr>
<td>Cost Share is dependent on the In-Network Provider type and the services rendered.</td>
<td>See Cost Share Schedule.</td>
<td></td>
</tr>
</tbody>
</table>

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### Explanation of Approved Transplant Services  
(NO TIER II OR OUT-OF-NETWORK COVERAGE)

- It is the Member’s responsibility to ensure that all requested services are reviewed and authorized by Vantage prior to provision of those services. Failure to do so for any transplant-related service will result in non-payment of those services. In order to be approved by Vantage for payment, the transplant services must be included in Vantage coverage (see below) and performed at a designated Vantage transplant facility and deemed Medically Necessary and appropriate for the medical condition for which the transplant is proposed.

- Approved Transplant Services is defined to include all Medically Necessary health services and supplies rendered at a Designated Transplant Facility (defined below) during the Benefit Period which are related to transplantation, and approved in writing by Vantage prior to the delivery of any services. Such services shall include, but are not limited to, Hospital charges, Physician charges, organ procurement and tissue typing, and ancillary services rendered during the Benefit Period. Only for the purposes of this benefit, a Benefit Period is defined as the period of time from the date the Member receives prior authorization and an initial evaluation for the transplant procedure, until the earliest of: (a) one year from the date the transplant procedure was actually performed; (b) the date coverage under this Plan terminates; or (c) the date of the Member’s death.

- A Designated Transplant Facility is defined as a facility that has entered into an agreement with Vantage to render Approved Transplant Services. The Designated Transplant Facility will be determined by Vantage and may or may not be located within the Member’s geographic area. Applications from transplant facilities shall be considered and approved by Vantage in accordance with the requirements of Louisiana R.S. 22:1231 and 22:1232.

- Approved Transplant Services include: (a) kidney; (b) bone marrow or peripheral stem cell transplantation (except in conjunction with High Dose Chemotherapy for the treatment of solid tumors including breast cancer unless coverage is extended by the Utilization Management Committee); (c) liver; (d) heart; (e) heart-lung; (f) pancreas; (g) lung (single/double); (h) kidney/pancreas; and (i) small bowel.

- The following tissue transplants are also covered: (a) blood transfusions; (b) autologous parathyroid transplants; (c) corneal transplants; (d) bone and cartilage grafting; (e) skin grafting; and (f) autologous islet cell transplants.

Other tissue/solid organ transplant procedures which Vantage determines have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures will be considered on a case-by-case basis.

- Immunosuppressive Drugs after Approved Transplant Services are not covered.

- No benefits are payable under this Transplant Benefit for: (a) organ transplants which are not listed as Approved Transplant Services; (b) animal to human transplants; (c) artificial or mechanical devices designed to replace human organs; and (d) services required to keep a donor alive for the transplant.

- Vantage does not cover any medical condition that was diagnosed or presented symptoms, regardless of disclosure of the condition to a Provider or Vantage, prior to coverage under this Plan.

Approved Transplant Services are subject to the In-Network Deductible and Member pays applicable In-Network Co-insurance. See Cost Share Schedule.

Approved Transplant Services require Pre-Authorization.

There is no Tier II or Out-of-Network coverage for Approved Transplant Services.
# Clinical Trials
(No Out-of-Network Coverage)

Vantage shall provide coverage for the cost of healthcare services, treatments or testing, that are incurred as part of the protocol treatment being provided to the Member for purposes of a clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. Costs for investigational treatments and protocol related patient care shall be covered if all of the following criteria are met:

- The treatment is being provided with a therapeutic or palliative intent for patients with cancer or other life-threatening disease or condition, or for the prevention or early detection of cancer or other life-threatening disease or condition; and

- The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer or other life-threatening disease or condition; and

- The treatment is being provided in accordance with a clinical trial approved by one of the following entities:
  - The United States National Institutes of Health (NIH)
  - A cooperative group funded by the NIH
  - The Federal Food and Drug Administration in the form of an investigational New Drug Application
  - The United States Department of Veteran Affairs
  - The United States Department of Defense
  - A federally funded general clinical research center
  - The Coalition of National Cancer Cooperative Groups; and

- The proposed protocol has been reviewed and approved by a qualified institutional review board which operates in this state and which has a multiple project assurance contract approved by the office of protection from research risks; and

- The facility and personnel providing the protocol provided the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience; and

- There is no clearly superior, non-investigational approach; and

- The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-investigational alternative; and

- The Member has signed an institutional review board approved consent form.

**Subject to the In-Network Cost Share and included in the In-Network Out-of-Pocket Maximum.**

**Requires Pre-Authorization.**

Any costs related to procedures, services, research, Drugs, treatments, or supplies which are experimental or investigational in nature and certain newly introduced technologies, Drugs or other treatments are not covered.
Section V: Exclusions & Limitations

Coverage shall not be provided and no payment shall be made under this Plan for services or expenses incurred in connection with:

1. Treatment and services provided to Members for Preexisting Conditions.

2. Charges in excess of the Vantage Allowable.

3. Accidental Bodily Injury or sickness arising out of, or in the course of, employment entitling the Member to benefits under Workers’ Compensation, Occupational Disease or any similar Federal or State law.

4. Any incidental procedure, unbundled procedure, or mutually exclusive procedure.

5. Losses, injuries, or contracted diseases which are due to insurrection, war, or any act of war, whether declared or undeclared.

6. Losses or injuries, excluding those received by victims of domestic abuse, suffered as a result of participating in a riot, civil disturbance, illegal occupation or while committing or attempting to commit a felony or treatment of any Member convicted of a criminal offense and confined in a prison, jail, or other penal institution.

7. Treatment or care for which there is no legal obligation of Vantage or the Plan to pay. The existence of this Plan will not create an obligation to pay.

8. Coordination of Covered Services with other health insurance plans.

9. Planned or elective procedures for conditions that existed prior to or at the time of enrollment, regardless of whether diagnosed or reported prior to enrollment. Vantage does not cover any medical condition that was diagnosed or presented symptoms, regardless of disclosure of the condition to a Provider or Vantage, prior to coverage under this Plan.

10. Services, equipment, or supplies, which are not Medically Necessary for the treatment of Illness, injury, or symptomatic complaint. The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make it Medically Necessary to make the charge a Covered Service, even though the service or supply is not specifically listed as an exclusion. The final approval and discretion for determining whether services or supplies or days of care are Medically Necessary lies with Vantage.

11. Services, surgery, supplies, treatment or expenses which are performed by or upon the direction of a Health Care Provider, Physician or allied health professional acting outside the scope of his license.

12. Services performed by, or upon the direction of, a social worker.

13. Services performed by, or upon the direction of, a dietician.

14. Any dental treatment or services, including those rendered for orthodontic, periodontic, orthognathic, including temporomandibular joint (TMJ), or dental implants.
15. Services, surgery, supplies, treatment, or expenses received from a dental or medical department maintained by or on behalf of an Employer, a mutual benefit association, labor union, trust, or similar person or group.

16. Vision exams and services, including, but not limited to, eyeglasses and contact lenses.

17. Corneal surgery (except corneal transplants).

18. Interpreter services for the deaf or hard of hearing.

19. Hearing aids, related exams or testing and follow-up.

20. Services, surgery, supplies, treatment, or expenses in connection with or related to:
   a. Eye exercises, visual training, or orthoptics;
   b. The correction of refractive errors of the eye, including, but not limited to, radial keratotomy and laser surgery; or
   c. Visual therapy.

21. Services or supplies for purely Cosmetic Purposes (including cosmetic surgery) or for complications resulting from treatment/procedures for Cosmetic Purposes (including Reconstructive Services secondary to a cosmetic procedure and excluding treatments related to cleft lip and cleft palate):
   a. To change the texture or appearance of the skin (including, but not limited to, the treatment of acne);
   b. To change the relative size or position of any part of the body (such as enlargement, reduction, or implantation) when such surgery is performed primarily to improve an individual’s physical appearance and does not improve the function or usefulness of the body;
   c. To modify the physical body in order to improve psychological, mental, or emotional well-being;
   d. To eliminate psychological stress or impairment;
   e. Treatment the sole purpose of which is to promote or stimulate hair growth;
   f. Removal of excess fat or skin, or services at a health spa or similar facility; or
   g. Hair pieces, wigs, or hair implants.

   NOTE: Reconstructive Services and supplies will be covered if Medically Necessary and due to Accidental Bodily Injury or organic Illness suffered if incurred while covered under this Plan. Reconstruction to produce a symmetrical appearance of the breasts following a mastectomy will only be covered if the Member was diagnosed and treated under this Plan for breast cancer and mastectomy.

22. Services, surgery, supplies, treatment, or expenses in connection with or related to, or complications from the following regardless of claim of Medical Necessity:
   a. rhinoplasty;
   b. blepharoplasty services identified by CPT codes 15820, 15821, 15822, 15823; brow ptosis identified by CPT code 67900; or any revised or equivalent codes;
   c. gynecomastia;
   d. breast enlargement or reduction;
   e. implantation, removal and/or re-implantation of breast implants and services, Illnesses, conditions, complications and/or treatment in relation to or as a result of breast implants;
   f. implantation, removal and/or re-implantation of penile Prosthesis and services, Illnesses, conditions, complications and/or treatment in relation to or as a result of penile Prosthesis;
   g. diastasis recti; or
   h. idiopathic short stature.
NOTE: Reconstructive Services and supplies will be covered if Medically Necessary and due to Accidental Bodily Injury or organic Illness suffered if incurred while covered under this Plan. Reconstruction to produce a symmetrical appearance of the breasts following a mastectomy will only be covered if the Member was diagnosed and treated under this Plan for breast cancer and mastectomy.

23. Surgical and medical treatment for snoring in the absence of obstructive sleep apnea, including laser-assisted uvulopalatoplasty (LAUP).

24. Penile implant devices and related supplies.

25. Treatment of and services related to pregnancy, childbirth, or maternity-related medical conditions, including but not limited to fetal reduction surgery or abortions.

26. Charges for children under two (2) years of age.

27. Paternity tests and tests performed for legal purposes.


29. Treatment of and services related to infertility, including surgical procedures to reverse voluntarily induced sterilization, in vitro fertilization and artificial insemination, and treatment and services related to surrogate pregnancies or parenting, and Drugs related to treatment of infertility.

30. Personal comfort and convenience items.

31. Homemaker services including but not limited to, basic household assistance, light housekeeping, or light meal preparation.

32. Any costs related to procedures, services, research, Drugs, treatments, or supplies, which are experimental or investigational in nature and certain newly introduced technologies, Drugs or other treatment. The fact that a Physician may prescribe, order, recommend or approve a procedure, service, Drug or supply does not mean that such service or supply is not experimental or investigational. The final determination as to whether any given service or supply is excluded under this section lies within the discretion of Vantage. For purposes of this section, “experimental or investigational” shall include and be defined as any treatment, service or supply for which:
   a. there is no consensus in the medical community as to safety or effectiveness of the technology as applied to the particular circumstances of the Member or for treatment of the patient’s particular medical problem;
   b. there is insufficient evidence to determine its appropriateness in a given situation;
   c. the technology warrants further study or is in the process of undergoing clinical trials, particularly if undergoing Phase I, II, III, or IV clinical trials, except as covered in Section IV under the Clinical Trials benefit; use of the technology for the given indication in the specified patient population is confined largely to research protocols; or
   d. the Physician or facility rendering the treatment classifies the treatment as experimental or investigational for purposes of obtaining an informed consent.

33. Gym memberships.

34. Drugs and surgical procedures related to weight loss. Treatment of complications secondary to surgery for weight loss (e.g., gastric bypass and lap band procedures), including, but not limited to, nutritional deficits, bowel obstructions, and abdominal pain.

35. Services or supplies for the treatment of eating disorders.
36. Food or food supplements, formulas and medical foods, including those used for gastric tube feedings or inherited metabolic diseases.

37. Any services or supplies related to:
   a. immunosuppressive Drugs after Approved Transplant Services;
   b. organ transplants which are not listed as Approved Transplant Services;
   c. animal to human transplants;
   d. artificial or mechanical devices designed to replace human organs;
   e. services to keep a donor alive for the transplant operation;
   f. charges related to donor services; or
   g. transplants otherwise excluded by this Plan.

38. Hospitalization primarily for Physical Therapy or hydrotherapy.

39. Services or supplies for physical examination for employment, licensing, travel, school, insurance, adoption, participation in athletics, or examination or treatment ordered by a court.

40. Services or supplies, which were provided prior to Member’s effective date with Vantage or after Member’s termination date for coverage with Vantage.

41. Services, surgery, supplies, treatment, or expenses rendered by a Provider who is the Member’s spouse, child, stepchild, parent, stepparent or grandparent.

42. Whole blood and blood products that are covered under a Member’s blood bank program (autologous blood bank services).

43. Services or supplies for the prophylactic storage of cord blood.

44. Megavitamin therapy, biofeedback, psychosurgery and nutrition-based therapy.

45. Salabrasion, chemosurgery or other such skin abrasion procedures associated with removal of scars, tattoos, and/or which are performed as a treatment of acne scarring.

46. Services, surgery, supplies, treatment, complications from or expenses in connection with or related to sexual transformation, sexual function, sexual dysfunctions or sexual inadequacies, regardless of claim of Medical Necessity.

47. Covered Services performed via transmitted electronic imaging or telemedicine.

48. Services or supplies in connection with charges for failure to keep a scheduled visit, charges for completion of a claim form, telephone consultations or charges, or charges to obtain medical records.

49. Standby availability of a Health Care Provider when no treatment is rendered.

50. Services, supplies or treatment not specifically listed as a Covered Service. This includes, but is not limited to, the following:
   a. travel or transportation, whether recommended by a Physician or not;
   b. self-help training and other forms of non-medical care;
   c. charges for anesthesia for non-Covered Services;
   d. over the counter support hose, ace or elastic bandages, and pressure garments other than those prescribed as Medically Necessary;
   e. corrective footwear or orthotics;
   f. routine foot care for non-diabetic Members;
g. wigs or hairpieces;
h. prosthetic garments or apparel;
i. wet nurse or milk bank services;
j. holistic medical services;
k. treatment of hyperhidrosis (excessive sweating);
l. allergy testing;
m. disposable supplies; or
n. supportive devices for the foot, except when used in the treatment of diabetic foot disease.

51. Treadmill, swimming pool, or special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program.

52. Contraceptive devices and Drugs.

53. Implantable Drugs for the use of birth control, hormone replacement therapy, pain control or any other reason.

54. Services or supplies for treatment related to and/or complications resulting from a non-Covered Service.

55. Out-of-country services (excluding Emergency Medical Services).

56. Emergency department visits for injections, Drugs, removal of sutures, or any other non-Emergency service.

57. Air ambulance and any non-emergent transportation or transfer service.

58. Services rendered by a micro-hospital or free-standing emergency room that is not associated with a hospital.

59. Admission to a Hospital primarily for diagnostic services which could have been provided safely and adequately in some other setting, e.g., outpatient department of a Hospital or Physician’s office.

60. Counseling services including, but not limited to, career counseling, marriage counseling, divorce counseling, parental counseling and job counseling.

61. Diagnosis or care and treatment of:
   a. weak, strained, unstable or flat feet;
   b. toenails (except for the diabetic patient or treatment of ingrown toenails);
   c. cutting or removal of superficial lesions of the feet such as corns, calluses or hyperkeratosis (except as warranted for the diabetic patient);
   d. tarsalgia, metatarsalgia or bunions, except surgery which involves exposure of bones, tendons, or ligaments; or
   e. other services performed in the absence of localized Illness or injury.

62. Body piercing or complications due to body piercing. Injuries related to objects being inserted or removed from a pierced body part whether accidental or purposeful. Reconstructive Services or surgery to repair damage due to body piercing whether directly or indirectly. Tattoos, not including tattoos related to breast reconstruction diagnosed and treated while covered under this Plan, and the treatment of complications from tattoos including, but not limited to, infections and Hepatitis.
63. Magnet therapy, external bone growth stimulators, spinal cord stimulators, artificial spinal disc, electro-muscular stimulators and implanted devices for pain control.

64. Therapy received from recreational programs, recreational therapy, or other therapy primarily to enhance athletic abilities.

65. Physical Therapy for Chronic or Recurrent Conditions, including fibromyalgia and muscle tension headaches. Physical Therapy is not covered when maintenance level of therapy is attained as determined by your Physician and/or a Vantage Medical Director.

66. Occupational Therapy is not covered when maintenance level of therapy is attained as determined by your Physician and/or a Vantage Medical Director.

67. Alternative treatments, except as specifically covered, including acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, reiki, Rolfing, yoga, and other alternative treatments defined by the Office of Alternative Medicine of the National Institutes of Health.

68. Alternative or complementary medicine using non-orthodox practices, including but not limited to wilderness or outdoor therapy, boot camp, and equine therapy.

69. Naturopath services.

70. Professional charges for clinical lab.

71. Anodyne (infrared) treatments.

72. Treatment for varicose veins and telangiectasia by any method including, but not limited to, endovenous laser treatments, sclerosis or surgical stripping.

73. Pulmonary rehabilitation.

74. Cardiac rehabilitation.

75. The cost of health care services, treatment or testing for clinical trials except as provided for in Section IV of this Certificate.

76. Botox used for Cosmetic Purposes or for the treatment of hyperhidrosis, migraine headaches, musculoskeletal pain, fibromyalgia or other conditions not specifically listed as covered.

77. Separate anesthesia charges for endoscopies.

78. Custodial Care.

79. Home health and hospice.

80. Services and treatments performed in extended care facilities, such as long-term acute care (LTAC), skilled nursing facility (SNF), or rehabilitation facilities.

81. Fees charged for care by your immediate relatives or members of your household.

82. Outpatient private-duty nursing.

83. Psychological or educational testing services for any reason including, but not limited to, testing services related to the diagnosis or treatment of Developmental Disorder or delay, learning
disorders or disability, including the diagnosis or treatment of autism spectrum disorders, attention deficit disorders or hyperactivity.

84. Education services and supplies including training or re-training for a vocation, except as specifically provided in this Plan for diagnosis, testing, or treatment for remedial reading and learning disabilities, including dyslexia.

85. Applied Behavior Analysis (ABA).

86. Services or supplies for pre-implantation genetic diagnosis and pre-genetic determination.

87. Any Durable Medical Equipment, disposable or non-durable medical equipment, defibrillators, items and supplies.

88. Listening therapy or auditory therapy.

89. Anti-aging treatment, including but not limited to office visits, laboratory tests, hormone treatments, and other services associated with anti-aging treatment.

90. Drug screenings performed solely to ensure compliance with medical treatments.

91. Member reimbursements other than those submitted for Covered Services with itemized procedures and diagnoses documented by a Provider.

92. Blood product injection therapies (e.g., autologous blood, platelet rich plasma, bone marrow plasma).

93. Suboxone and methadone dispensed by free standing clinics for treatment for opioid dependence.

94. Sleep studies, limited to Medically Necessary home or laboratory sleep studies and associated professional claims. Only sleep studies performed in the home or sleep studies performed in a sleep laboratory that is accredited by the Joint Commission or the American Academy of Sleep Medicine (AASM) are eligible for coverage.

95. Industrial or employment-related testing or self-help programs including, but not limited to stress management programs, work hardening programs and/or functional capacity evaluation, including driving evaluations, etc.

96. Inpatient pain rehabilitation and inpatient or outpatient pain management and/or control programs, including Drugs, therapy, and other treatments.

97. Diabetic testing monitors and/or supplies.

98. Expenses resulting from intoxication, as defined by state law where the Illness or injury occurred, or while under the influence of illegal narcotics, alcohol, or controlled substances, unless administered or prescribed by a Physician.

99. Treatment, services or injuries related to mental health or substance abuse.

100. Leaving against medical advice and/or self-inflicted wounds or conditions.

101. Continuous glucose monitoring systems for long-term use. Includes sensors, transmitters, and receivers.
102. For injuries sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others (whether or not paid to participate or instruct) in any of the following:
   a. Sports (professional, or semi-professional, or intercollegiate);
   b. Parachute jumping;
   c. Hang-gliding;
   d. Racing or speed testing any motorized vehicle or conveyance;
   e. Scuba/skin diving (when diving 60 or more feet in depth);
   f. Skydiving;
   g. Bungee jumping;
   h. Rodeo sports.

103. For injuries sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following if the covered person is paid to participate or to instruct:
   a. Operating or riding on a motorcycle;
   b. Racing or speed testing any non-motorized vehicle or conveyance;
   c. Horseback riding;
   d. Rock or mountain climbing;
   e. Skiing (water or snow); or
   f. Snowboarding/skateboarding/kneeboarding.

104. Drugs, including but not limited to over-the-counter medication, experimental or investigational Drugs, compounded Drugs, nutritional or dietary supplements, herbal supplements and treatments, cosmetic agents, vitamins and mineral products.
SECTION VI: ELIGIBILITY AND ENROLLMENT

A. Eligibility and Enrollment

Eligibility for coverage under this Plan is determined and authorized by Vantage. Vantage will rely upon information properly submitted by the Member to determine eligibility status.

This Plan is only valid during the current calendar year. Coverage for the following year will be based on a new application for that year (i.e., this Plan does not automatically renew).

Members must complete a new application which is subject to review and approval after any break in coverage or if the Member enrolls in another Vantage short-term plan.

Members who have had enrollment terminated for cause pursuant to this Certificate will not be eligible under this Plan for subsequent coverage.

Children under two (2) years of age are not eligible for coverage. A Member’s second birthday must be prior to the Plan’s effective date.

Adults over sixty-five (65) years of age are not eligible for coverage.

After an application for coverage is submitted, Vantage will notify the applicant of his/her eligibility for coverage. Vantage will generate a Premium invoice which will be available on the Member Portal if the applicant is deemed eligible.

B. Effectuation of Coverage and Premiums

The effective date of coverage for a Member will be determined by Vantage and will be the date that the benefits described in this Certificate are effective. Depending on the date the application is received by Vantage, coverage effective dates are either the first of the following month or the first of the second following month. This Plan’s coverage will begin at 12:01 AM (Central Time) on the effective date and end at 11:59 PM (Central Time) on the last day of the Benefit Period.

Premiums are based on a Member’s gender and age at the time of effectuation. A Member’s monthly Premium remains the same throughout the current Benefit Period. There is no Premium proration for partial months of coverage.

Vantage requires a valid credit card for monthly Premium payments. Monthly Premium payments will be automatically applied to the credit card on file on or around the 20th of each month as payment for the following month of coverage. It is the Member’s responsibility to maintain a valid credit card on file with Vantage for automatic Premium payments. The Premium for the Member’s initial month of coverage must be paid prior to the coverage becoming effective.
Section VII: Termination of Coverage

Per federal regulation, the maximum length of coverage under this Plan is 364 days. Days of coverage in December may be adjusted to maintain compliance. As a result, coverage under this Plan will automatically terminate at the earlier of a) 364 days from the policy’s effective date, b) the end of the calendar year or c) at a date determined by the Member.

This Plan is only valid during the current calendar year. Coverage for the following year will be based on a new application for that year. Members must complete a new application which is subject to review and approval after any break in coverage or if the Member enrolls in another Vantage short-term plan.

A. Grace Period

This Plan has a thirty (30)-day grace period. This provision means that if any required Premium is not paid on or before the date it is due, it may be paid during the grace period.

Premium payments are due on or around the 20th day of each month and will be charged to the Member’s credit card on file. In the event a credit card payment is declined, the Member’s coverage is in grace period. The Member is responsible for supplying Vantage with updated credit card information and ensuring payment is made by the end of the grace period.

During the grace period, claims for Members covered by this Plan may, at the option of Vantage, be held and suspended from processing until the full Premium has been paid by the Member. This Plan will be considered terminated unless both the past due and current Premiums are fully paid by the end of the grace period. This Certificate of Coverage constitutes notice of the termination and the necessary action for reinstatement.

In the event that Vantage does not receive the required Premium payment fifteen (15) days prior to the end of the grace period, Vantage will send a notice to the Member. The notice shall state that if the Premium has not been paid by the end of the grace period, coverage will lapse as provided by the provisions of this policy. If the Member fails to contact Vantage by the end of the grace period and submit updated credit card information, the Member’s coverage will be terminated under this Plan. If updated credit card information is submitted and all outstanding Premiums are paid to Vantage, coverage will be reinstated; however, the reinstated policy shall cover only loss resulting from accidental injury thereafter sustained or loss due to sickness beginning more than ten (10) days after the date of such acceptance.

Vantage will not be liable for loss of notices, communications or materials sent by Vantage to Members when such notices, communications or materials are properly addressed to the Member’s last known address, as provided in writing or via telephone to Vantage by the Member.

B. Termination

A Member’s coverage will terminate on the first to occur of the following:

1. the last day of the period covered by the last Premium payment that was paid by the due date or within the specified grace period;

2. for any specific benefit, the date the benefit maximum is reached or that he or she is no longer eligible for that benefit;

3. the date the Member becomes eligible for Medicare;
4. the date the Member is ineligible due to an intentional material misrepresentation on the 
application as determined by Vantage or is otherwise noncompliant with Vantage policies and 
procedures.

Vantage may choose to rescind coverage or terminate a Member’s coverage if a Member performs an act 
or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the 
terms of this Plan. The issuance of this coverage is conditioned on the representations and statements 
contained at application and enrollment. All representations made are material to the issuance of this 
Plan. Any information provided on the application or enrollment form or intentionally omitted therefrom, 
as to any proposed or covered Member, shall constitute an intentional misrepresentation of material 
fact. A Member’s coverage may be rescinded retroactively to the effective date or terminated 
immediately for fraud or intentional misrepresentation of material fact.

A Member may notify Vantage of his/her wish to end coverage under this Plan in writing. Voluntary 
terminations should be submitted to Vantage prior to the date the monthly Premium payment is due for 
the subsequent month of coverage. There is no Premium proration for partial months of coverage.

Under Louisiana law LSA-R.S. 22:1023(B)(2), Vantage may not require a Member to be the subject of 
a genetic test, release genetic test information, or to be subjected to questions relating to the medical 
conditions of persons not covered by this Certificate. The results of any genetic tests, including genetic 
test information, shall not be used as the basis to terminate, restrict, refuse, limit, or otherwise apply 
conditions to the coverage of a Member, or restrict the sale of this policy or plan to a Member; or establish 
differentials in Premium rates or cost sharing for coverage; or otherwise discriminate against a Member 
in the provision of insurance.

The Member will be notified by Vantage of coverage termination at his/her last known address, 60 
days prior to cancellation. The Member is responsible for the cost of all benefits which are provided 
after the date of termination of coverage. Vantage will not be liable for loss of notices, 
communications or materials sent by Vantage to Members when such notices, communications or 
materials are properly addressed to the Member’s last known address, as provided to Vantage.
A. **Proof of Services**

If a Member incurs a charge for which benefits are payable under this Plan as the primary carrier, written proof of such charge must be furnished to Vantage within ninety (90) days after the charge is incurred. Failure to furnish such proof within 90 days of the date the charge was incurred shall not invalidate nor reduce any claim if, it was not reasonably possible for the member to give proof within such time. However, in such cases, proof must be furnished as soon as reasonably possible and in no event can a member provide proof later than one year and ninety days (90) after the charge was incurred. Written proof for medical claims must consist of procedures and diagnoses itemized by the Provider on a claim form (CMS-1450 or CMS-1500) or a superbill along with documentation of any payments you have made. When a Member must first file claims with another primary carrier, Vantage being the secondary plan, the explanations of benefits from the primary carrier must be submitted to Vantage within twelve (12) months of the date the member receives the explanation of benefits from the primary carrier.

Mail your request for payment, together with the written proof for claims, to Vantage at the address below. It is a good idea to make a copy of this documentation for your records.

Vantage Health Plan, Inc.
Attn: Member Services Department
130 DeSiard Street, Suite 300
Monroe, LA  71201

Contact Member Services toll-free at (855) 934-6847 if you have any questions or if you want to give us more information about a request for payment you have already sent to Vantage.

B. **Payment of Claims**

All Vantage-approved benefits for services of In-Network Providers must be received from and paid directly to the institution or person rendering the service.

Vantage-approved benefits for services of Out-of-Network Providers may be paid directly to the institution or person rendering the service or, if payment by the Member was required at the time of service, may be reimbursed to the Member as outlined in Section A above.

Payment of claims for emergency services provided by noncontracted health care providers A. If a health care provider that does not contract with a health insurance issuer files a claim with a health insurance issuer for emergency services rendered, the health insurance issuer shall directly pay such a claim by a noncontracted provider in the amount as determined pursuant to the plan or policy provisions between the enrollee or insured and the health insurance issuer, less any amount representing coinsurance, copayments, deductibles, noncovered services, or any other amounts identified by the health insurance issuer pursuant to the plan or policy provisions, as an amount for which the insured or enrollee is liable. Payment of such claim by the health insurance issuer shall in no circumstances be made directly to the patient, insured, or enrollee.

If such benefits are not paid as of the date the Member dies, or if the Member is a minor or is not capable of giving a legally binding receipt for the payment of any benefits, Vantage, at its option, may pay the benefit to:

- the person or institution rendering the service; or
- one or more of the following individuals: Member’s legal representative, his/her spouse or parent(s) or child(ren) or brother(s) or sister(s), or the Member’s beneficiary or estate.
Any payments made in this manner will discharge Vantage of its duty to the extent of such payments. Vantage will not be liable as to the application of such payment.

The Member may NOT assign benefits to Providers. However, the Member understands that Participating Providers reserve the ability to directly pursue any third parties who cause accidental injury or Illness to the Members for the full amount of the cost of the medical services rendered to the Member and forego submitting claims to Vantage for payment. In the event that a Participating Provider elects to pursue a third party recovery and not submit a claim or proof of services to Vantage, prior written consent of the Member must be obtained and the Member may be responsible for any unpaid Participating Provider charges not compensated by the third parties.

Vantage shall pay claims timely and in accordance with the state law. Electronic clean claims received from all Health Care Providers shall be paid within twenty-five (25) days from date of receipt by Vantage. Non-electronic clean claims received from Participating Providers within forty-five (45) days from the date of service shall be paid within thirty (30) days from date of receipt by Vantage. Non-electronic clean claims received from Participating Providers after forty-five (45) days from the date of service shall be paid within thirty (30) days of date of receipt by Vantage. All non-electronic clean claims received from Non-Participating Providers shall be paid within thirty (30) days from date of receipt by Vantage.

C. Examination
Vantage will have the right, at its own expense, to have a Physician examine any Member whose Illness or injury is the basis of a claim under this Plan. Such examinations will be performed as often as Vantage may reasonably require while a claim is pending.

D. Authorization to Examine Health Records
The Member consents to and authorizes any Participating Provider or Out-of-Network Provider of Covered Services to permit the examination and copying of any portion of the Member’s Hospital or medical records when requested by Vantage. Information from medical records of Members and information received from Physicians or Hospitals incident to the Physician-patient relationship or Hospital-patient relationship shall be kept confidential. Processing of related claims may be pended until such information is provided.

E. Legal Actions
No action at law or in equity may be brought to recover under this Plan before the expiration of sixty (60) days after written proof of services has been furnished in accordance with the requirements of this Plan. Under no conditions may any legal action be brought after the expiration of one (1) year after the time written proof of services is required to be furnished, or prior to completion by the Member of the Appeal and Grievance Procedures under this Plan.
**SECTION IX: SUBROGATION**

**Recovery of the Cost of Benefits**
If a Member is injured or becomes ill through the act of another person or entity and Vantage provides benefits for the injury or Illness, Member is entitled to benefits under this Plan and Vantage shall have the right under this Plan to repayment of the cost of any and all benefits paid on behalf of the Member that are associated with the injury or Illness for which the other person or entity is liable.

**Subrogation**
Subrogation means that Vantage can regain by legal action, if necessary, the cost of benefits paid by Vantage from any person or entity against whom the Member may have a claim. Subrogation will result in savings for the benefit of all Vantage Plan Members because the cost of treatment for sickness or injury will be paid by the persons or entities legally responsible for such payment. To the extent that benefits are provided under this Plan, Vantage shall be subrogated to all rights of recovery which a Member may acquire against any other party for the recovery of the amount paid under this Plan. To the extent Vantage is required by state and/or federal law to ensure that a member is fully compensated before exercising its recovery rights, then Vantage will comply with such laws. In the absence of full compensation laws being applicable or in the event federal law preempts state law, Vantage’s right to recovery will not be secondary to a member’s compensation. At Vantage’s request, the Member shall provide the information needed (as determined by Vantage) to secure and protect Vantage’s subrogation rights. The Member also has an obligation to execute and deliver any documentation Vantage deems necessary to secure and protect its subrogation rights. The Member further agrees to cooperate with Vantage and/or representatives of Vantage, including its attorneys, in completing any forms and in giving such documentation and information surrounding any Accident or incident the Member was involved in, as Vantage or its representatives deem necessary to fully investigate the Accident or incident. Vantage agrees to pay its portion of the Member’s attorney’s fees or other costs associated with a claim or lawsuit to the extent Vantage recovers any portion of the benefits paid under this Plan pursuant to Vantage’s right of subrogation. Members also have the following obligations under this subrogation provision:

- To notify Vantage within thirty (30) days of any event which could result in legal action, a claim by or against a third party, or a claim against the Member’s own insurance. If the Member is in an automobile accident, he/she should contact Vantage within five (5) business days to coordinate the payment of the Member’s claims. Vantage shall pay claims related to the Member’s injury and shall be reimbursed by any and all available insurance policies covering the responsible party(ies).
- To seek recovery from the responsible person or entity (or his/her/its insurer) of all amounts in connection with benefits paid by Vantage under this Plan and to notify Vantage within five (5) business days of any such actions taken by the Member.
- To refrain from any action or inaction which would delay, impair, prejudice, discharge or otherwise compromise Vantage’s rights of subrogation, which would include, but not be limited to accepting any settlement offer from any responsible person or entity (or his/her/its insurer) without the prior written consent of Vantage.
- To fully cooperate and assist Vantage, as is deemed necessary by Vantage, to enforce Vantage’s rights of subrogation. This obligation to assist Vantage will apply to Member’s legal representatives, agents, and attorneys.
- To notify Vantage of and pay to Vantage any amounts received by the Member or Member’s legal representatives, agents, or attorneys to the extent of the cost of the benefits provided by Vantage to which Vantage is entitled to because of its rights of subrogation.

**Reimbursement**
Vantage has the right to be reimbursed by its Members the cost of any and all benefits that were paid by Vantage that are associated with the Member’s injury or Illness caused by another person or entity. This right of reimbursement will apply where Vantage has paid benefits and the Member and/or the Member’s
representative has been reimbursed any amounts by another person or entity or by any other source as set forth below. If a Member, or any other person or entity on the Member’s behalf, that has been paid, does not properly refund the full amount to Vantage for the cost of benefits paid by Vantage, Vantage may reduce the amount of any future benefits that are payable for the Member under this Plan. Vantage’s right of reimbursement to a Member is limited, however, to the extent of the actual cost of the benefits provided by Vantage.

**Lien**
Vantage, by paying any benefits under this Plan, is granted a lien on the proceeds of any settlement, judgment or other payment received by the Member. The Member hereby consents to Vantage’s lien and agrees to take whatever steps are necessary to assist Vantage in securing and protecting its lien.

**Assignment**
Vantage, by the payment of any benefits under this Plan, is granted an assignment of the proceeds of any settlement, judgment or other payment received by the Member or Member’s representatives, agents, or attorneys to the extent of the benefits paid. By accepting benefits hereunder, the Member consents to Vantage’s assignment and authorizes and directs his or her attorney, personal representative or any insurance company to directly reimburse Vantage or its designee to the extent of the cost of the benefits paid. Any such assignment is effective and binding upon the Member’s attorney, personal representative or any insurance company upon notice of this provision.

**Participating Providers’ Subrogation Rights**
If they have obtained written consent of the member, Participating Providers have a contractual right to pursue third parties for the full recovery of the cost of the medical services rendered to Member in lieu of submitting claims to Vantage for payment. In such an instance, and only with the written consent of the Member, Participating Providers may request appropriate information from the Member regarding the third parties responsible for the injury or Illness of the Member, and the Member shall cooperate in providing this information to Participating Providers. Participating Providers who elect to pursue third parties for a recovery shall not, under any circumstances submit their claims to Vantage for payment, but may only pursue the third parties for recovery. In such an event, and if full recovery is not made by the Participating Providers, the Member understands that he or she may have a further financial responsibility to Participating Providers for the cost of medical services not recovered from the third parties. If the Participating Provider did not obtain written consent from the Member to seek recovery from third parties, then Participating Provider may not bill the Member for any amounts that were not recovered from the third parties.

**Other Vantage Rights**
The subrogation and reimbursement rights of Vantage, including the foregoing right of assignment, is applicable to any recoveries made by, or on behalf of, the Member as a result of the injuries or Illnesses sustained including, but not limited to, the following sources:

- Payments made directly by the tortfeasor or any insurance company on behalf of the tortfeasor or any other payments on behalf of the tortfeasor.
- Any payments, settlements, judgment or arbitration awards paid by any insurance company under an uninsured or underinsured motorists coverage policy, whether on behalf of a Member or other person.
- Any workers’ compensation award or settlement.
- Medical payments coverage under any automobile insurance policy.
- Premises or homeowners insurance coverage including premises or homeowners medical payments coverage.
- Any other payments from any other source designed or intended to compensate a Member for injuries sustained as a result of negligence or alleged negligence of any person or entity.

Vantage’s right to recover, whether by subrogation or reimbursement, shall also apply to the Member’s dependents and minor children, whether or not adjudged incompetent or disabled, heirs, and any settlement or recovery attributable thereto.
To the extent Vantage is legally required by state law to apply full compensation rules, and such rules are not preempted by federal law, Vantage will not attempt to subrogate until the Member is made whole and Vantage will pay its portion of attorney’s fees therewith. In connection therewith, the Member has the obligation of establishing whether he/she has been made whole. No Member shall enter into any type of settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the cost of benefits provided by Vantage. Vantage’s recovery rights shall not be defeated or impaired in any respect by an allocation of settlement proceeds exclusively to non-medical expense damages. Further, no Member shall incur any expenses on behalf of Vantage in pursuit of Vantage’s rights hereunder.

Vantage shall recover the full amount of benefits provided under this Plan without regard to any claim of fault on the part of any Member, whether by comparative negligence or otherwise. Benefits payable by Vantage under this Plan are secondary to any coverage under no fault or similar insurance.

In the event that a Member fails or refuses to comply with the terms of this Plan and, specifically, the provisions of this Section IX, the Member shall reimburse Vantage for any and all costs and expenses including attorney fees incurred by Vantage in enforcing its rights hereunder. If a Member, or any other person or entity on the Member’s behalf, that has been paid does not properly refund the full amount to Vantage for the cost of benefits paid by Vantage, Vantage may reduce the amount of any future benefits that are payable for the Member under this Plan. Further, the failure of any Member to comply and/or assist Vantage with its subrogation rights may result in termination of the Member’s participation in this Plan and the Member shall be responsible for the cost of all benefits and services paid by Vantage related to the injury. It is specifically recognized that this Plan and the rights of Vantage and its Members are governed by ERISA, unless otherwise exempted.

The Member acknowledges and agrees that the use of this policy of health insurance is subject to the terms and conditions set forth in the policy’s Certificate of Coverage including, but not limited to, Vantage’s right to subrogation.
Vantage recognizes its responsibility to provide Members with adequate methods to make inquiries and express concerns regarding Vantage or a Health Care Provider. Members are encouraged to contact Vantage’s Member Service department for assistance with complaints or suggestions concerning the Plan.

As a Member of this Plan, you have the right to file a complaint if you have concerns related to:

(a) Availability, delivery, or quality of health care services, including a complaint regarding an Adverse Determination made by Vantage’s Utilization Review procedures;
(b) Claims payment, handling, or reimbursement for health care services; or
(c) Matters pertaining to your contract with Vantage.

Members also have the right to notices of the decisions rendered on claims and Appeals to be provided in a culturally and linguistically appropriate manner, of available internal and external Appeals processes and the availability of the Louisiana Department of Insurance to assist with the Appeals process. You have the right, upon request and free of charge, to review and have copies of all documents relevant to the claim for benefits and to submit comments and documents relating to the claim, without regard to whether that information was submitted or considered in the initial benefit determination, and to receive continued coverage pending the outcome of the Appeals process where required by applicable law of the Plan.

Vantage considers a Grievance to be the type of complaint you file if you have any concerns related to the quality of care or services received from Vantage or a Health Care Provider. Examples of a Grievance:

(a) Unpleasant attitudes or behavior at a Health Care Provider;
(b) Lengthy wait times in a Health Care Provider’s facility;
(c) Difficulty scheduling an appointment or contacting a Health Care Provider;
(d) Complaints that a procedure or item during a course of treatment did not meet accepted standards for delivery of health care; or
(e) Concerns or difficulty when contacting Vantage or communicating with a Vantage employee.

To file a Grievance, you may call Vantage’s Member Services department Monday through Friday from 8:00 a.m. to 6:00 p.m. by calling toll-free at (855) 934-6847. A Member Services Representative will attempt to resolve the Grievance at the time of the call.

Members always have the right to file a Grievance with the Louisiana Department of Insurance.

An Appeal is the type of complaint you file when you want Vantage to reconsider an Adverse Determination made by Vantage. Examples of an Appeal:

(a) A determination that a request for a benefit does not meet Vantage’s requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.
(b) Vantage’s denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit due to your eligibility to participate in our Plan.
(c) Any pre-service or post-service review where Vantage denies, reduces, or terminates or fails to provide or make payment, in whole or in part for a benefit.
(d) A Rescission of coverage determination, meaning if Vantage cancels or discontinues coverage after services have already been provided, except for circumstances when coverage is terminated due to a failure to timely pay your required Premiums or contributions towards the cost of coverage.
APPEAL AND GRIEVANCE PROCEDURES
Any Member that wishes to file an Appeal or Grievance should call Vantage’s Member Service department. Member Services is available Monday through Friday from 8:00 a.m. to 6:00 p.m. by calling toll-free (855) 934-6847.

The Vantage Member Services Representative will review the situation and can often resolve the complaint during the call. If the Member’s complaint is resolved, a report of the communication, description of the findings, and the resolution or actions taken will be placed in the Member’s file.

If the Member Services Representative is unable to resolve the complaint to the Member’s satisfaction, the Member may file a formal Appeal or Grievance.

First Level Internal Review
Members may file a formal Appeal or Grievance for further review of a complaint. A formal Appeal or Grievance must be submitted within **one hundred eighty (180) days** from the date of the initial decision. Written requests for review can be faxed, mailed or hand-delivered to:

Vantage Health Plan, Inc.
Attn: Appeals and Grievances
130 DeSiard Street, Suite 300
Monroe, LA  71201
Grievance Fax: 318-361-2159
Standard Appeal Fax: 318-361-2181
Expedited Request Fax: 318-361-2170

Please include the following:

- Member’s name, address and Member identification number
- A summary of the reason for the review
- A description of the solution desired by the Member
- Signature of the Member or Authorized Representative

The letter will be forwarded to the Vantage Medical Director and will be adjudicated in a manner designed to ensure independence and impartiality without regard to the initial denial. The Medical Director will review the letter and information related to the complaint. If any evidence generated by Vantage is utilized in connection with the review to which the Member does not have access, Vantage will, if needed, make that information available to the Member and allow Members, upon request and free of charge, to review and have copies of all documents relevant to the claim for benefits and to submit comments and documents relating to the claim, without regard to whether that information was submitted or considered in the initial benefit determination, prior to a decision being rendered. The Medical Director will determine the resolution for the complaint and respond in writing to the Member within fifteen (15) days from the date of receipt of pre-service requests and within thirty (30) days from the date of receipt of post-service requests or as allowed by law.

Second Level Review (Voluntary Level) Appeals
Should the Member decline to accept an adverse First Level Internal decision of his/her Appeal, the Member may request a second level voluntary review in writing. The Second Level Review is voluntary, meaning that the Member may choose to request an External Review after receipt of determination of the First Level Internal Decision. The Member must file a formal written request to the Appeals Committee within **thirty (30) days** of the adverse First Level Internal review decision. This can be faxed, mailed or hand-delivered.

The Appeals Committee will review all the information submitted by the Member. The Member will be notified in writing of the Appeals Committee decision within fifteen (15) days from the date of receipt of pre-
service requests and within thirty (30) days from the date of receipt of post-service requests, or as allowed by law.

Appeals may also be submitted to the Office of Consumer Services of the Louisiana Department of Insurance. Contact information is as follows:

Louisiana Department of Insurance
Office of Consumer Services
P.O. Box 94214
Baton Rouge, LA 70804-9214
Phone: (225) 219-0619 or (800) 259-5300
www.ldi.la.gov

**Grievances**

Vantage’s Member Services department includes a Grievances team for Grievance research, responses, analytics and trends, which also serves as a resource for areas of improvement.

Grievance experiences are reviewed within Member Services and rarely require additional reviews. However, in the event that a Second Level Review is necessary, the Director of Member Services and other involved Vantage personnel shall review a Grievance to ensure appropriate actions and responses were provided to the Member.

Grievances may also be submitted to the Office of Consumer Services of the Louisiana Department of Insurance. Contact information is as follows:

Louisiana Department of Insurance
Office of Consumer Services
P.O. Box 94214
Baton Rouge, LA 70804-9214
Phone: (225) 219-0619 or (800) 259-5300
www.ldi.la.gov

**Expedited Review**

If a complaint involves an urgent care request, a Member or Authorized Representative may request a first or second level review orally or in writing. An urgent care request is one that should not be handled in the standard process because it could seriously jeopardize a Member’s life or health or ability to regain maximum function. Or, would in the opinion of a Physician with knowledge of a Member’s medical condition, subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of a Member’s request. All requests for urgent care submitted on a Member’s behalf will be considered urgent and will be handled as soon as possible, taking into account a Member’s medical situation, but in no case later than **seventy-two (72) hours** from receipt of the expedited review request.

**DUPLICATE REQUESTS TO APPEAL THE SAME CLAIM, SERVICE, ISSUE, OR DATE OF SERVICE WILL NOT BE CONSIDERED.**
Section XI: HIPAA Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this carefully.

At Vantage Health Plan, Inc. (Vantage), we respect the confidentiality of your health information and will protect it in a responsible and professional manner. We consider this information private and confidential and have policies and procedures in place to protect the information against unlawful use and disclosure.

This Notice describes what types of information we collect, explains when and to whom we may disclose it, and provides you with additional important information. We are allowed by law to use and disclose your health information to carry out the operations of our business. We are required by law to maintain the privacy of your health information, to provide you with this Notice, and abide by the Notice in effect. This Notice also informs you of your rights with respect to your health information and how you can exercise those rights.

What is Protected Health Information or PHI?
When we talk about “information” or “health information” in this Notice we mean Protected Health Information or PHI. PHI is any information, including Genetic Information, which identifies an individual enrolled in a Vantage benefit Plan. It relates to the person’s participation in the Plan, the person’s past, present or future physical or mental health or condition, the provision of health care to that person, or the past, present or future payment for the provision of health care to that person. PHI also includes information which identifies the person or for which there is a reasonable basis to believe it could be used to identify the person. This information includes many common identifiers (e.g., name, address, birth date, social security number). It does not include publicly available information, or information that is available or reported in a summarized fashion that does not identify any individual person.

What types of personal information do we collect?
Like all health benefits companies, we collect the following types of information about you and your Dependents:

- Information we receive directly or indirectly from you or a third party administrator through applications, surveys, or other forms, in writing, in person, by telephone, or electronically, including our website (e.g., name, address, social security number, date of birth, marital status, Dependent information, employment information, medical history).
- Information about your relationship and transactions with us, our affiliates, our Providers, our agents, and others (e.g., health care claims and encounters, medical history, eligibility information, payment information, service request, and Appeal and Grievance information).
- Information we receive from the Centers for Medicare & Medicaid Services (CMS) and other authorized federal and state regulatory agencies.

How do we protect this information?
We have policies that limit internal and external sharing of PHI to only those persons who have a need for it to provide benefit services to you and your Dependents. We maintain physical, electronic and procedural safeguards to protect PHI against unauthorized access and use. For example, access to our facilities is limited to authorized personnel and we protect information electronically through a variety of technical tools. We also have established a Privacy Committee, which has overall responsibility for the development, implementation, training, oversight and enforcement of policies and procedures to safeguard PHI against inappropriate access, use and disclosure, consistent with applicable law. If there is a reportable breach of unsecured PHI, we will notify you.

How may we use or share your information?
To effectively operate your health benefit plan, we may use and share PHI about you to:
▪ Perform certain duties, which may involve claims review and payment or denial; Coordination of Benefits; Utilization Review; Medical Necessity review; coordination of care; response to Member inquiries or requests for services; conduct of Grievance, Appeals, and external review programs; benefits and program analysis and reporting; risk management; detection and investigation of fraud and other unlawful conduct; auditing; underwriting as permitted by law (Genetic Information may not be used or disclosed for underwriting purposes); administration and coordination of reinsurance contracts.

▪ Operate preventive health programs, early disease detection programs, disease management programs and case management programs in which we or our affiliates or contractors send educational materials and screening reminders to eligible Members and Providers; perform health risk assessments; identify and contact Members who may benefit from participation in disease or case management programs; and send relevant information to those Members who enroll in the programs, and their Providers.

▪ Conduct quality improvement activities, such as the credentialing of Participating network Providers; and accreditation by the National Committee for Quality Assurance (NCQA), CMS, and/or other independent organizations, where applicable.

▪ Conduct performance measurement and outcomes assessment; health claims analysis and reporting.

▪ Provide data to outside contractors who help us conduct our business operations. We will not share your PHI with these outside contractors unless they agree in writing to keep it protected.

▪ Manage data and information systems.

▪ Perform mandatory licensing, regulatory compliance/reporting, and public health activities; responding to requests for information from regulatory authorities, responding to government agency or court subpoenas as required by law, reporting suspected or actual fraud or other criminal activity; conducting litigation, arbitration, or similar dispute resolution proceedings; and performing third-party liability and subrogation activities.

▪ Change policies or contracts from and to other insurers, HMOs, or third party administrators with compliant business associate agreements.

Provide data to the employer that sponsors the benefit Plan through which you receive health benefits. We will not share your PHI with a third party administrator except for deidentified summary health information, enrollment and disenrollment information, specific information authorized by you and any information necessary to administer the Plan. De-identified means PHI that does not identify an individual and there is no reasonable basis to believe that the information could be used to identify an individual.

We consider the activities described above as essential for the operation of our health Plan. For example, we may feature:

▪ Cancer screening reminder programs that promote early detection of breast, ovarian, and colorectal cancer, when these illnesses are most treatable.

▪ Disease management programs that help Members work with their Physicians and other Providers to effectively manage Chronic conditions like asthma, diabetes, and heart disease to improve quality of life and avoid preventable emergencies and hospitalizations.

▪ Quality assessment programs that help us review and improve the services we provide.

▪ Outreach programs that help us educate Members about the programs and services that are available to them, and let Members know how they can make the most of their health benefits.

There are also state and federal laws that may require us to release your health information to others. We may be required to provide information as follows:

▪ To state and federal agencies that regulate us such as the US Department of Health and Human Services the Louisiana Department of Insurance, and CMS.

▪ For public health activities. We may report information to the Food and Drug Administration for investigating or tracking of Prescription Drug and medical device issues or problems.

▪ To public health agencies if we believe there is a serious health or safety threat.
▪ To a health oversight agency for certain oversight activities (for example, audits, inspections, licensure, and disciplinary actions).
▪ To a court or administrative agency (for example, pursuant to a court order, search warrant or subpoena).
▪ For law enforcement purposes. We may give information to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness or missing person.
▪ To a government authority regarding child abuse, neglect or domestic violence.
▪ To a coroner or medical examiner to identify a deceased person, determine a cause of death, or as otherwise authorized by law. We may also share information with funeral directors as necessary to carry out their duties.
▪ For procurement, banking or transplantation of organs, eyes or tissue.
▪ To specialized government functions, such as military and veteran activities, national security and intelligence activities, and the protective services for the President and other government officials.
▪ For on the job-related injuries because of requirements of state workers’ compensation laws.

We do not share PHI for any purpose other than those listed above. If one of the above reasons does not apply, we must get your written authorization to use or disclose your health information. For example, written authorization from you would be required for the use and/or disclosure of psychotherapy notes (if applicable) and the use of PHI for marketing purposes. Written authorization is also required for the “sale” of PHI as defined under 45 CFR Section 164.501. In the event that you are unable to provide the authorization (for example, if the Member is medically unable to give consent), we will accept authorization from any person legally authorized to give consent on behalf of the Member, such as a parent or guardian, or court-appointed representative. If you give us written authorization and change your mind you may revoke your written authorization at any time.

What are your rights?
The following are your rights with respect to your PHI. If you would like to exercise any of these rights, please contact us at the address or phone numbers listed at the end of this Notice. We will require that you make your request in writing and will provide you with the appropriate forms.

**You have the right to inspect and/or obtain a copy or summary of information** that we maintain about you in your designated record set. A “designated record set” is a group of records maintained by or for us that are your enrollment, payment, claims determination, and case or medical management records or a group of records, used in whole or in part, by us to make decisions about you, such as Appeal and Grievance records. We may charge you a reasonable administrative fee for copying, postage or summary preparation depending on your specific request.

*However, you do not have the right to inspect certain types of information and we cannot provide you with copies of the following information:*
  ▪ contained in psychotherapy notes; or
  ▪ compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding.

We will do our best to respond to your request no later than thirty (30) days after we receive it. If, however, we are unable to fulfill your request within this 30 day period, we may extend the period to respond by an additional 30 days provided we have given you a timely explanation for the delay.

*Additionally, in certain other situations, we may deny your request to inspect or obtain a copy of your information. If we deny your request, we will notify you in writing and may provide you with a right to have the denial reviewed.*

**You have the right to ask us to amend information** we maintain about you in your designated record set. We will require that your request be in writing. We will respond to your request no later than 30 days after we receive it. If we are unable to act within 30 days, we may extend that time by no more
than an additional 30 days. If we need the extension, we will notify you of the delay, the reason for the delay, and the date by which we will complete action on your request.

If we make the amendment, we will notify you that it was made. In addition, we will provide the amendment to any person that we know has received your health information. We will also provide the amendment to other persons identified by you.

If we deny your request to amend, we will notify you in writing of the reason for the denial. The denial will explain your right to file a written statement of disagreement. We have a right to dispute your statement through a written rebuttal. However, you have the right to request that your written request, our written denial and your statement of disagreement be included with your information for any future disclosures.

**NOTE:** If you want to access or amend information about yourself, you should first go to your Provider (e.g., physician, pharmacy, Hospital or other caregiver) that generated the original records, which could be more complete than any we maintain.

You have the right to receive an accounting of certain disclosures of your information made by us during the six (6) years prior to your request. Please note that we are not required to provide you with an accounting of the following information:

- Any information collected prior to April 14, 2003;
- Information disclosed or used for treatment, payment, and health care operations purposes;
- Information disclosed to you or pursuant to your authorization;
- Information that is incidental to a use or disclosure otherwise permitted;
- Information disclosed for a facility's directory or to persons involved in your care or other notification purposes;
- Information disclosed for national security or intelligence purposes;
- Information disclosed to correctional institutions, law enforcement officials or health oversight agencies; or
- Information that was disclosed or used as part of a limited data set for research, public health, or health care operations purposes.

We will act on your request for an accounting within 30 days. If we need additional time to act on your request, we may take up to an additional 30 days. In connection therewith, we will provide you with a written statement of the reasons for the delay and the date by which we will provide the accounting. Your first accounting will be free, and we will continue to provide to you one free accounting upon request every twelve (12) months. However, if you request an additional accounting within 12 months of receiving your free accounting, we may charge you a fee. The fee will be reasonable and cost-based. We will inform you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

You have the right to ask us to restrict how we use or disclose your information for treatment, payment, or health care operations. You also have the right to ask us to restrict information that we have been asked to give to family members or to others who are involved in your health care or payment for your health care. If we engage in any type of fundraising activity, you have the right to opt out of receiving any such communication.

You have the right to ask to receive confidential communications of information. We may require that your request include a statement that disclosure of all or part of the information to which the request pertains could endanger you or someone else. For example, in situations involving domestic disputes or violence, you can ask us to send the information by alternative means (for example by fax) or to an alternative address. We will try to accommodate a reasonable request made by you.

Essential STD COC Rev 9/2021
What do we do with Member PHI when the Member is no longer enrolled in our Plan?
We do not destroy PHI when individuals terminate their coverage. The information is necessary and used for many purposes as described in this Notice, even after the individual leaves a plan. However, the policies and procedures that protect that information against inappropriate use and disclosure apply regardless of the status of any individual Member. In many cases, PHI is subject to legal retention requirements, and after that requirement for record maintenance, PHI is destroyed in a secure process.

Exercising your rights:
- You have a right to receive a copy of this Notice upon request at any time. We provide this Notice to our subscribers upon enrollment in a Vantage health plan. You can also view a copy of the Notice on our website at [www.VantageHealthPlan.com](http://www.VantageHealthPlan.com). Should any of our privacy practices change, we reserve the right to change the terms of this Notice and to make the new Notice effective for all protected health information that we maintain. Once revised, we will provide the new Notice to you and post it on our website.
- If you have any questions about this Notice or about how we use or share information, please write to the Vantage Privacy Officer or contact the Vantage Member Services department at the address and phone numbers listed at the end of this notice.

If you are concerned that your privacy rights may have been violated, you may file a complaint with Vantage. You also have the right to complain to the Secretary of the U.S. Department of Health and Human Services. If you have any questions about the complaint process, including the address of the Secretary of Health and Human Services, please write to our Privacy Officer at the address mentioned above or contact our Member Services department at the address and phone numbers listed at the end of this notice.

Vantage will not take any action against you for filing a complaint. This notice is effective April 14, 2003.

Contact Information for Questions or Complaints Regarding Privacy:

**Mailing Address**
Vantage Health Plan, Inc.
ATTENTION: Privacy Officer
130 DeSiard Street, Suite 300
Monroe, LA 71201
E-mail: [Privacy.Officer@vhpla.com](mailto:Privacy.Officer@vhpla.com)

**Questions**
Member Services Department
(855) 934-6847
Summary of the Louisiana Life and Health Insurance Guaranty Association Law and Notice Concerning Coverage Limitations and Exclusions

Residents of Louisiana who purchase life insurance, annuities, or health insurance should know that the insurance companies licensed in this state to write these types of insurance are required by law to be members of the Louisiana Life and Health Insurance Guaranty Association (LLHIGA). The purpose of LLHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, LLHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through LLHIGA is limited. As noted in the disclaimer below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

Disclaimer

The Louisiana Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.** Even if coverage is provided, there are significant limits and exclusions. Coverage is generally conditioned upon residence in this state. Other conditions may also preclude coverage.

Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

**LLHIGA**
P.O. Box 3337
Baton Rouge, LA 70821

**Department of Insurance**
P.O. Box 94214
Baton Rouge, LA 70804-9214

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law (the law), and is set forth at R.S. 22:2081 et seq. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change any person's rights or obligations under the law or the rights or obligations of LLHIGA.

Coverage

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a direct non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons may also be protected as well even if they live in another state unless they are afforded coverage by the guaranty association of another state, or other circumstances described under the law are applicable.

Exclusions from Coverage

A person who holds a direct non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract is not protected by LLHIGA if:
(1) He is eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.);
(2) The insurer was not authorized to do business in this state;
(3) His policy was issued by a profit or nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, an organization that issues charitable gift annuities as is defined in R.S. 22:952(A)(3), or any entity similar to any of these.

LLHIGA also does not provide coverage for:

(1) Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
(2) Any policy of reinsurance (unless an assumption certificate was issued);
(3) Interest rate or crediting rate yields, or similar factors employed in calculating changes in value, that exceed an average rate;
(4) Dividends, Premium refunds, or similar fees or allowances described under the Law;
(5) Credits given in connection with the administration of a policy by a group contract holder;
(6) Employers', associations’ or similar entities’ plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured;
(7) Unallocated annuity contracts (which give rights to group contract holders, not individuals), except unallocated annuity contracts and defined contribution government plans qualified under section 403(b) of the United States Internal Revenue Code (26 U.S.C. §403(b));
(8) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policy owner or contract owner, including but not limited to, claims described under the law;
(9) A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to “Medicare Part C coverage” or “Medicare Part D coverage” and any regulations issued pursuant to those parts;
(10) Interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner’s rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer, whichever is earlier.

**Limits on Amounts of Coverage**
The Louisiana Life and Health Insurance Guaranty Association Law also limits the amount that LLHIGA is obligated to pay out. The benefits for which LLHIGA may become liable shall in no event exceed the lesser of the following:

(1) LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not an impaired or an insolvent insurer.
(2) For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance.
(3) For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $500,000 in health insurance benefits, and LLHIGA will pay a maximum of $250,000 in present value of annuities, including net cash surrender and net cash withdrawal values.

In no event, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages, LLHIGA shall not be liable to expend more than $500,000 in the aggregate with respect to any one individual.
Nondiscrimination Notice

Vantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, religion, national origin, age, disability, sex, gender identity, sexual orientation, or any other legally protected characteristic. Vantage does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, religion, national origin, age, disability, sex, gender identity, sexual orientation, or any other legally protected characteristic.

Vantage provides free aids and services to people with disabilities to communicate effectively with us. Those services include qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, and other formats).

For people whose primary language is not English, Vantage provides free language translation services. Those services include qualified interpreters and information written in other languages. You can use Vantage’s free language translation services by calling the “Members” phone number on the back of your Member ID card. For Members who are deaf or hearing impaired, please call for teletypewriter (TTY) services at 711.

If you believe that Vantage has failed to provide these services or has discriminated in another way on the basis of race, color, religion, national origin, age, disability, sex, gender identity, sexual orientation, or any other legally protected characteristic, you can file a grievance with Vantage or the U.S. Dept. of Health and Human Services, Office for Civil Rights.

If you would like to file a complaint directly with Vantage, you can reach us in person, by mail, by fax, or by email at the addresses below:

Vantage Health Plan
Attention: Civil Rights Coordinator
130 DeSiard Street, Suite 300
Monroe, LA 71201
Phone: (318) 998-2887, TTY 711
Fax: (318) 361-2165
Email: civilrightscoordinator@vhpla.com

If you would like to file a complaint directly with the U.S. Dept. of Health and Human Services, Office for Civil Rights, you can contact them by mail, by phone, or by email at the addresses below:

U.S. Department of Health and Human Services
200 Independence Avenue SW Room 509F, HHH Building Washington, DC 20201
Phone: (800) 368-1019, (800) 537-7697 (TDD)
Online Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. If you need help filing a grievance, our Civil Rights Coordinator is available to help at civilrightscoordinator@vhpla.com or by phone at (318) 998-2887.

Vantage has adopted internal grievance procedures for providing prompt and equitable resolution of complaints alleging discrimination on the basis of race, color, religion, national origin, age, disability, sex, gender identity, sexual orientation, or any other legally protected characteristic. Any person who believes someone has been subjected to discrimination on any of these grounds, may file a grievance under Vantage’s grievance procedure. It is against the law for Vantage to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance. Depending on the type of grievance, a 60-day filing limit may apply. To learn more about Vantage’s grievance procedure, you can call or email our Civil Rights Coordinator at the addresses above or you can visit our website at www.vantagehealthplan.com/vhpnnondiscriminationgrievanceprocedure.

Vantage Health Plan is required by federal law to provide the following information.
English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 888-823-1910 (TTY 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 888-823-1910 (TTY 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 888-823-1910 (TTY 711)。我们的中文工作人员将乐意帮助您。这是一项免费服务。

Chinese Cantonese: 我們有翻譯員為您解答有關健康或藥物保險的任何疑問。如需翻譯服務，請致電 888-823-1910 (TTY 711)。我們的華語職員將提供幫助。這是一項免費服務。

French Creole: Nou genyen sèvis entèprèt grátis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 888-823-1910 (TTY 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis. }


Hindi: हमारे स्वास्थ्य या दवा के बारे में आपकी किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुबािषया सेवाएं उपलब्ध हैं, एक दुबािषया प्राप्त करने के लिए, बस हमें 888-823-1910 (TTY 711) पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपके मदद कर सकता है, यह एक मुफ्त सेवा है।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 888-823-1910 (TTY 711). Un nostro incaricato che parla Italiano fornirà l’assistenza necessaria. È un servizio gratuito.

Japanese: 当社の健康・薬品処方プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、888-823-1910 (TTY 711) にお電話ください。日本語の通訳者がご支援いたします。これは無料のサービスです。

Korean: 저희는 건강 및 약물 보험에 대한 모든 의문에 대해 무료로 해답하는 서비스를 제공합니다. 888-823-1910 (TTY 711)에 전화하면 한국어로 대화할 이들이 도와드릴 것입니다. 이는 무료 서비스입니다.


Persian: ما تضم ترجمة رایگان برای یک بی‌سایش به هر کوتاه شما ممکن است در مورد سلامت ما و یا تاریخ مواد شناسی‌ای که ۱۹۱۰-۸۲۳-۱۹۱۰ (TTY 711) باشد. برای دریافت ترجمه، فقط با ما در ۸۲۳-۱۹۱۰ (TTY 711) تماس بگیرید. کسی که فارسی صحبت می‌کند، می‌توانید به ۷۱۱ (TTY 711) بپرسید که سرویس رایگان است.

Urdu: بمارین پاس بیماری صحبت یا منشیتی کی متقاضی کو بارے میں آپ کے کسی بھی سوال جواب دینے کے لئے مفت ترجمہ خدمات پیئ۔ آپ ترجمہ حاصل کرے کی لئے، تلفن 888-823-1910 (TTY 711) اپنے 711 (آپ کال 711) میں جو کوئی ایڈو بولا یا وہ آپ کی مدد کر سکتا ہیں۔ آپ مفت سرویس پیسسی ہیں۔

Vantage Health Plan is required by federal law to provide the following information.
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