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M E D I C A R E

A D V A N T A G E



Vantage **BASIC**
(HMO-POS)

Vantage **STANDARD**
(HMO-POS)

Vantage **PREMIUM**
(HMO-POS)



Freedom to live a healthy life

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Vantage Health Plan (Vantage) is an HMO with a Medicare contract. Enrollment in Vantage depends on contract renewal. You may be eligible to enroll in a Vantage Medicare Advantage plan if you reside in our service area and are currently entitled to Medicare Part A and enrolled in Part B. This information is not a complete description of benefits. Limitations, copayments/coinsurance, and restrictions may apply to this plan. Benefits, premiums, and copayments/coinsurance amounts may change on January 1 of each year. You must continue to pay your Medicare Part B premium. You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for extra help, call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**, 24 hours a day/7 days a week. You may also call the Social Security Office at **1-800-772-1213** between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call **1-800-325-0778**. You may also call the Louisiana State Medicaid Office. Services provided by out-of-network providers may cost more than services provided by in-network providers, unless the services are related to urgent care, an emergency, or out-of-area dialysis.

For more information on Vantage Medicare Advantage Plan benefits, or for information in an alternate format or language, call Member Services at **(866) 704-0109** or TTY **711**, seven days a week from 8:00 a.m. – 8:00 p.m. CST from October 1, 2021 – March 31, 2022. For all other dates, Member Services representatives are available Monday through Friday from 8:00 a.m. – 8:00 p.m. CST.



► WHO IS VANTAGE?

Vantage Health Plan, Inc. (Vantage) is a Louisiana-based insurance company with a Medicare Advantage contract that offers HMO plans with a Point-of-Service (POS) option available to anyone entitled to Part A and enrolled in Part B of Medicare through age or disability.

Vantage was founded in 1994 by physicians who wanted to provide quality healthcare coverage through the teamwork of physicians and their patients. Vantage continues the belief that health insurance should be affordable and customer service should be local and compassionate.

With corporate offices in Monroe, Louisiana, Vantage has expanded across the state including Baton Rouge, Shreveport, Hammond, and several rural locations. Vantage's membership has grown significantly over the past 25 years, providing great services to our members and contracting with healthcare providers in Louisiana, Arkansas, and Mississippi.

Important decisions are required often throughout your lifetime, but one of the most important decisions you will make will be regarding your health coverage. Plans that may work for friends or family members may not be the best plan for you, so it can be difficult to select coverage. With Vantage's depth of knowledge and experience, you will walk away confident that you have selected the coverage that best suits your lifestyle.

Enclosed you will find information on Vantage's Medicare Advantage plans and tools you will need to enroll.

If you have any questions, need assistance while completing the enrollment form, or need help choosing a doctor, call **1-866-704-0109 or TTY 711** (for the hearing impaired). Request a one-on-one home visit and a representative will come to you. Vantage upholds the belief that everyone has the "Freedom to live a healthy life!"



► WHAT IS MEDICARE?

The Parts of Medicare

Medicare is a health insurance program offered to citizens and legal residents 65 years of age and older by the U.S. Government. This program assists over 60 million Americans in getting the healthcare

needed. Medicare is also available to those who qualify due to a disability or those with End-Stage Renal Disease (ESRD).



PART A

Hospital coverage that helps with costs for skilled nursing facilities, hospice, inpatient hospital care, and some home health care services.



PART B

Medical coverage that helps with costs for doctor services, outpatient care, some home health, and some physical and occupational therapy.



PART C

Also called Medicare Advantage, Part C plans are plans like HMO's and PPO's. They include Part A and Part B.



PART D

Outpatient prescription drug coverage that is offered by private insurers and Part C Medicare Advantage plans approved by Medicare.

► ABOUT VANTAGE MEDICARE ADVANTAGE



Depending on your eligibility, Vantage Medicare Advantage is available to anyone entitled to Part A and enrolled in Part B of Medicare through age or disability. Vantage is a Medicare Advantage Prescription Drug (MAPD) plan, meaning plans through Vantage contain Parts C and D together. You must remember

to continue paying your Medicare Part B premium even if the Medicare Advantage plan you have chosen through Vantage has a premium of **\$0**. In most cases, the Part B premium is already deducted from your Social Security check.



ANNUAL ENROLLMENT PERIOD

OCTOBER 15 - DECEMBER 7, 2021

Annual Enrollment. Sign up for Medicare between these two dates.

JANUARY 1, 2022

New coverage begins.



► ENROLLMENT PERIODS

Annual Enrollment Period (AEP)

If you already have a Medicare Advantage plan during the Annual Enrollment period, you have the ability to change from your Medicare Advantage plan to Original Medicare or to a different Medicare Advantage plan. If you do not have a Medicare Advantage plan, you may use the Annual Enrollment Period to move from Original Medicare to a Medicare Advantage plan. AEP is October 15th through December 7th each year.

Medicare Advantage Open Enrollment Period (MA OEP)

The MA OEP is January 1st through March 31st. The MA OEP provides Medicare beneficiaries with one opportunity per year to change Medicare Advantage plans or return to Original Medicare and enroll in a stand-alone prescription drug plan.

Initial Coverage Election Period (ICEP)

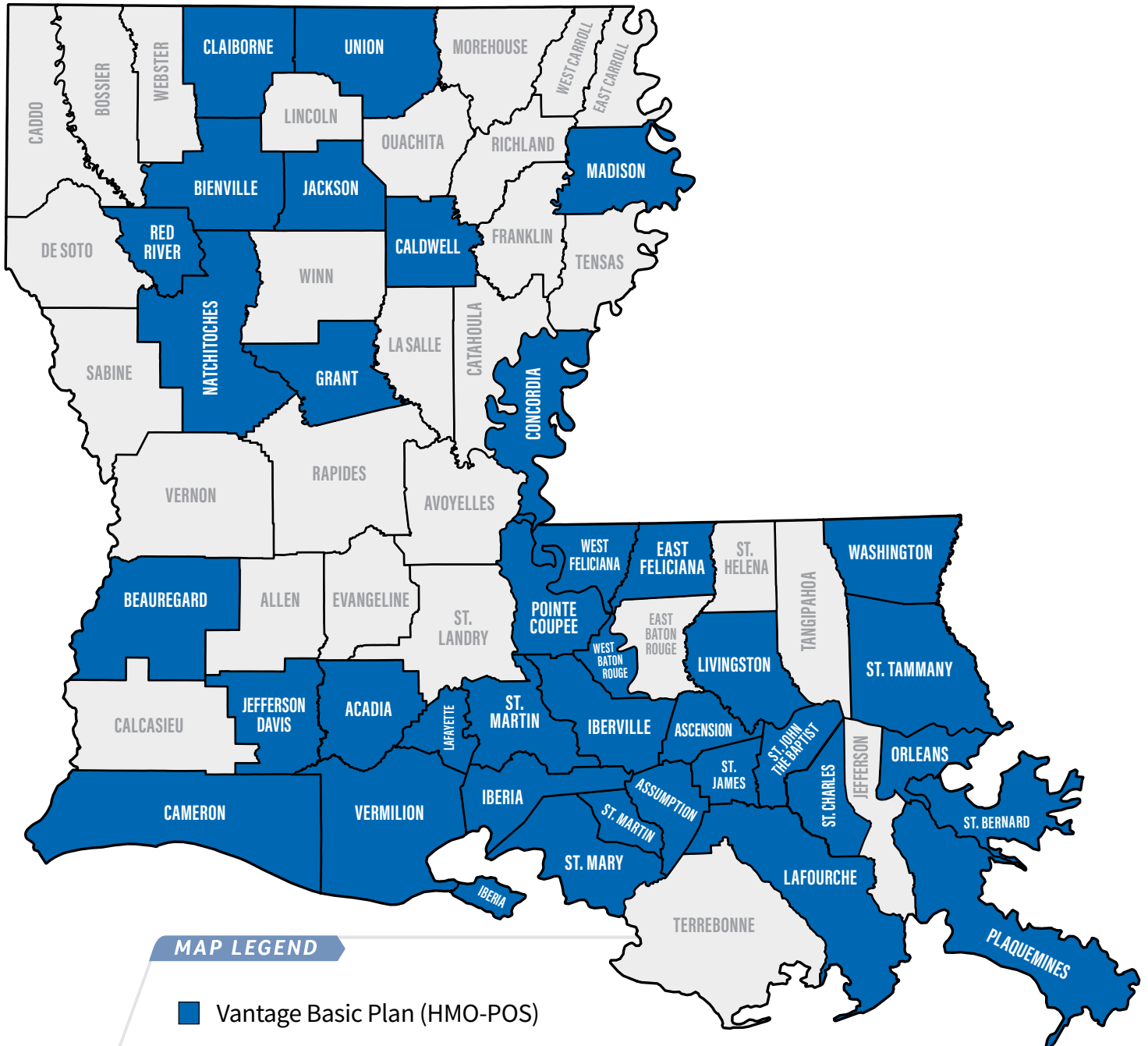
When you first become eligible for Medicare, there is a period of time when you can sign up for Medicare Part A and Part B. For example, if you are eligible for Medicare when you turn 65, your ICEP is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Special Enrollment Period (SEP)

You can make changes to your Medicare Advantage and Medicare prescription drug coverage when certain events happen in your life. This results in a “Special Enrollment Period.” Examples include moving to another area or losing employer insurance coverage. The Special Enrollment Period is in addition to the Annual Enrollment Period.

► 2022 SERVICE AREA

Vantage Medicare Advantage Coverage Map



Employer Group Plans are available in all parishes.

Freedom to live a healthy life.

Vantage Medicare Advantage Benefits include:*

- **\$0** monthly premium
- **\$0** Primary care office visit copays
- No In-network medical deductibles
- Annual wellness exam **100%** covered
- Prescription drug plan included; no separate premium
- **\$0** Tier 1 copay for preferred generic drugs through our preferred pharmacies (retail and mail order)
- Worldwide emergency coverage
- Added benefits include: Dental, Vision, Hearing, Transportation, select Over-the-Counter (OTC) items, Telehealth services, and MobileHelp® Solo System
- Silver&Fit® Fitness Program by American Specialty Health Fitness, Inc.
- Great local customer service



The search tools on our Vantage Medicare Advantage website, **www.VantageMedicare.com**, will allow you to compare plans and enroll online, find a provider or a retail pharmacy, and search for prescription drugs covered by Vantage Medicare Advantage plans.

*There are several plans to choose from and benefits vary by plan.

2022 BENEFIT COMPARISON

BENEFITS:	ORIGINAL MEDICARE <i>Deductible & Patient Responsibility based on 2021 Medicare</i>	
Flu Shots	100% covered - No deductible	
Radiologist / Anesthesiologist	20% coinsurance after \$203 deductible	
Lab / Pathology	100% covered - No deductible	
Physician Professional Fees (<i>Inpatient</i>)	20% coinsurance after \$203 deductible	
Office Visit / Primary Care Provider (<i>PCP</i>)	20% coinsurance after \$203 deductible	
Office Visit / Specialist	20% coinsurance after \$203 deductible	
Emergency Room	20% coinsurance after \$203 deductible	
Major Diagnostic Tests (<i>e.g., MRI, CT Scans</i>)	20% coinsurance after \$203 deductible	
Other Hospital Outpatient Services (<i>e.g., X-rays</i>)	20% - 25% coinsurance after \$203 deductible	
Outpatient Surgery Services	20% coinsurance after \$203 deductible	
Inpatient Hospital	<u>Days</u> 1-60 61-90 91-150	<u>Patient Responsibility</u> \$1,484 deductible \$371 per day \$742 per day
Medical Out-Of-Pocket Maximum	Not applicable	
PRESCRIPTION DRUGS (PART D) (<i>31-day supply</i>) <i>(No Separate Premium)</i> Tier 1 Preferred Generics (<i>Preferred Pharmacies</i>): Tier 1 Preferred Generics (<i>Other Pharmacies</i>): Tier 2 Generics : Tier 3 Preferred Brand : Tier 4 Non-Preferred Brand : Tier 5 Specialty : Part D Senior Savings Model : <i>(select insulins for non-low income subsidy members)</i>	NOT COVERED	

VANTAGE BASIC (HMO-POS) \$0 Monthly Premium NO IN-NETWORK MEDICAL DEDUCTIBLE	VANTAGE STANDARD (HMO-POS) \$36.40 Monthly Premium NO IN-NETWORK MEDICAL DEDUCTIBLE	VANTAGE PREMIUM (HMO-POS) \$171 Monthly Premium NO IN-NETWORK MEDICAL DEDUCTIBLE
100% covered	100% covered	100% covered
100% covered	100% covered	100% covered
100% covered	100% covered	100% covered
100% covered	100% covered	100% covered
\$0 copay/visit	\$0 copay/visit	\$0 copay/visit
\$50 copay/visit	\$45 copay/visit	\$40 copay/visit
\$90 ER copay per visit <i>Worldwide coverage</i>	\$90 ER copay per visit <i>Worldwide coverage</i>	\$90 ER copay per visit <i>Worldwide coverage</i>
\$250 copay/day	\$150 copay/day	\$125 copay/day
20% coinsurance	20% coinsurance	20% coinsurance
\$350 copay	\$250 copay	\$150 copay
\$318 copay per day for days 1-7	\$270 copay per day for days 1-7	\$250 copay per day for days 1-7
\$5,900	\$4,900	\$3,500
\$0 copay \$8 copay \$16 copay \$47 copay \$100 copay ¹ 25% coinsurance ¹ \$35 copay through the coverage gap. ¹ After \$480 Part D deductible	\$0 copay \$5 copay \$14 copay \$47 copay \$100 copay ¹ 25% coinsurance ¹ \$35 copay through the coverage gap. ¹ After \$480 Part D deductible	\$0 copay \$5 copay \$14 copay \$47 copay \$100 copay 33% coinsurance \$35 copay through the coverage gap. No Part D deductible
Tier 1 Preferred Generics are covered through the coverage gap and catastrophic stage in each plan.		

► EXTRA BENEFITS INCLUDED IN VANTAGE PLANS

Not Covered by Original Medicare!

VISION

- » **100%** coverage for an annual routine eye exam
- » **0%** coinsurance for **12** pairs of contacts (fitting included) or **one** pair of glasses per year; maximum benefit of **\$300** per year

HEARING/HEARING AIDS

- » **100%** coverage for an annual routine hearing exam
- » **BASIC AND PREMIUM PLANS:**
0% coinsurance for hearing aids (fitting/evaluation included); maximum benefit of **\$1,000** per year (both ears combined)
- » **STANDARD PLAN:**
0% coinsurance for hearing aids (fitting/evaluation included); maximum benefit of **\$1,100** per year (both ears combined)

OVER-THE-COUNTER (OTC)

- » **100** credits per quarter of select OTC items (pain relievers, vitamins, toiletries, etc.)*, available through Saint John Pharmacy (SJP). *No rollover in credits.*
- » Items can be mailed directly from SJP and delivered to your door at no cost to you.
- » Once your OTC order is made, allow 10 - 14 days for handling and shipping.
- » To place an order, members can call **1-833-FREE-OTC (1-833-373-3682)**, or go online at **www.VantageOTC.com**.

**Items and credits per item are subject to change (shipping, handling, and sales tax included).*

TELEHEALTH SERVICES

- » Includes qualifying appointments with primary care providers, specialists, podiatrists, dietitians, behavioral health providers, and occupational/physical/speech therapists.
- » **BASIC PLAN: \$0 - \$50** copay per appointment
- » **STANDARD PLAN: \$0 - \$45** copay per appointment
- » **PREMIUM PLAN: \$0 - \$40** copay per appointment

DENTAL

- » **BASIC PLAN:**
100% coverage for preventive dental services: semi-annual cleanings and oral exams and an annual x-ray; maximum benefit of **\$400** per year. **100%** coverage for comprehensive dental services; maximum benefit of **\$700** per year
- » **STANDARD PLAN:**
100% coverage for preventive dental services: semi-annual cleanings and oral exams and an annual x-ray; maximum benefit of **\$400** per year. **100%** coverage for comprehensive dental services; maximum benefit of **\$1,000** per year
- » **PREMIUM PLAN:**
100% coverage for preventive dental services: semi-annual cleanings and oral exams and an annual x-ray; maximum benefit of **\$400** per year. **100%** coverage for comprehensive dental services; maximum benefit of **\$1,600** per year

MOBILEHELP® SOLO SYSTEM

- » **STANDARD PLAN ONLY: 100%** coverage for qualifying members who must be enrolled for 30 consecutive days to be eligible for the device. Please contact plan for details.
- » Choice of waterproof wrist button or neck pendant

MobileHelp® Solo system is a personal Emergency Response System (PERS) that summons for help wherever you are.

MobileHelp® is a registered trademark of MobileHelp® Patented technology. MobileHelp® is an FDA-registered Medical Device Manufacturer.

FITNESS PROGRAM

- » **100%** coverage for Silver&Fit® program by American Specialty Health Fitness, Inc.
- » No-cost membership at 14,000+ participating fitness centers and YMCAs
- » One-on-One lifestyle coaching by phone with a Healthy Aging Coach
- » Silver&Fit's ASHConnect™ Mobile App
- » If you prefer to work out at home, you may receive:
 - » One home fitness kit per benefit year from a variety of fitness categories; and
 - » Online Healthy Aging classes

Visit **www.silverandfit.com** for more information.

The Silver&Fit program is provided by American Specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH).

TRANSPORTATION

- » **100%** coverage for twenty-four (24) one-way (12 round-trip) non-emergent trips per year for medical treatment with Vantage-approved transportation.
- » Call **1-844-657-7820** to schedule transportation. Some restrictions apply.



► VANTAGE MEMBER ONLINE PERKS

Vantage Member Portal

We make it easy to get quick access to your information and records, find a Primary Care Provider, read and download plan documents, and update contact information. With a click of the mouse, you can also review claim information and status as well as transfer and/or refill prescriptions. Visit ***members.vantagehealthplan.com***, select the “Click here to get started” link, and fill out your information.

Contact us toll-free at **1-866-704-0109 or TTY 711** (for the hearing impaired). Our local Member Services team is available to answer questions or help with registering, if needed.

Vantage Member Portal features include:

- Monthly premium invoice and payment information
- Your plan documents online – no more paper booklets!
- Your pre-authorization and claims history
- Your record of payments for medical and pharmacy services (deductible, copay, and coinsurance amounts)
- Your contact information and communication preferences
- Primary Care Provider selection
- Links to the Navitus Member Portal where you can view prescriptions, search for drug interactions and generic options, and find covered drugs



Online Provider Directory

Look up participating providers with the online Provider Directory by visiting www.VantageMedicare.com and follow the easy instructions outlined below.

Please enter your ZIP code:

Please verify your State and County/Parish:

LOUISIANA

OUACHITA

Save Selections and Find Plan

1 Find a Doctor

1 Click “Find a Doctor” blue button on the main page, under the “Save Selections and Find Plan” button after entering zip code.

Click below to search for Hospitals or Medical Providers in the Vantage Network.

Are you a member or just looking around?

I'm a Member

2 I'm Looking Around

What type of plan are you looking for?

Groups and Other Plans

3 Medicare Advantage

Metal Tier Individuals

Please enter the ZIP code where you live or work:

4 Enter ZIP Code

Search

2 A pop up box will open. Select the “I’m Looking Around” button.

3 Choose the “Medicare Advantage” button.

4 Enter the zip code again and click the Search button.

5 Search using any field to find participating providers. Last Name, Category, and/or Parish/County are the most helpful search fields.

If you need additional help finding and using the website, or to request a paper copy of the Provider Directory, call Vantage’s Member Services toll-free at **1-866-704-0109 or TTY 711** (for the hearing impaired).

5 First Name or Facility Name

First

Specialty

— Any Specialty —

City

City

ZIP Code

Zip Code

Last Name

Last

Category

— Any Category —

State

— Any State —

Parish/County

Parish/County

BASIC PLAN

SUMMARY COST SHARE SCHEDULE



EFFECTIVE JANUARY 1, 2022

PREMIUM	\$0, with no in-network deductible
MAXIMUM OUT-OF-POCKET	\$5,900
OUT-OF-NETWORK (POS) BENEFITS	\$500 Deductible; 50% Coinsurance; \$5,000 Maximum Benefit

HOSPITAL INPATIENT

Medical/Surgical (Facility)	Days 1-7: \$318 Copay/day
Professional Fees	Covered 100%
Diagnostic Tests, Procedures, X-Rays, Lab Services <i>Radiology/Pathology/Pre-admission Testing and Lab Services</i>	Covered 100%
Skilled Nursing (Facility)	Days 1-20: \$0 /day; Days 21-100: \$188 /day

OUTPATIENT

Annual Wellness (PCP or OBGYN only)	Covered 100%
Primary Care Provider (PCP) (Office Visit & Telehealth Services)	\$0 Copay
Specialist (Office Visit & Telehealth Services)	\$50 Copay
Nutritional Counseling (Office Visit & Telehealth Services)	20% Coinsurance
Chiropractic Office Visit	\$20 Copay
Physical/Occupational/Speech Therapy (Office Visit & Telehealth Services)	\$20 Copay
Lab Services/Professional Fees <i>Includes lab and pathology services, anesthesia, and outpatient surgery professional fees</i>	Covered 100%
Outpatient Surgery <i>(\$0 diagnostic colonoscopies)</i>	\$350 Copay
Major Diagnostics <i>(e.g., MRI, CT Scan, Other major outpatient diagnostic tests)</i>	\$250 Copay/day
Other Outpatient Diagnostics <i>(e.g., X-ray, Ultrasounds, Other diagnostic outpatient services)</i>	20% Coinsurance

ANCILLARY SERVICES

Hospice	Covered by Original Medicare
Home Health	Covered 100%
Immunizations, including Flu Shots	Covered 100%
Chemotherapy/Radiation	20% Coinsurance
Durable Medical Equipment/Prosthetics	20% Coinsurance

EMERGENCY CARE

Emergency Room (Facility) <i>Waived if admitted.</i>	\$90 Copay
Emergency Room Professional Fees	Covered 100%
Urgent Care	\$65 Copay/Visit
Ground Ambulance	\$250 Copay/Trip

MENTAL HEALTH CARE

Inpatient Mental Health Care	Days 1-4: \$467 Copay/day
Outpatient Mental Health Care (Office Visit & Telehealth Services)	\$40 Copay
Outpatient Substance Abuse Care (Office Visit & Telehealth Services)	\$40 Copay

PRESCRIPTION DRUG (31-DAY SUPPLY)

Tier 1 Preferred Generics: Preferred Pharmacies	\$0 Copay, no deductible ¹
Tier 1 Preferred Generics: Other Pharmacies	\$8 Copay, no deductible ¹
Tier 2 Generics	\$16 Copay, no deductible
Tier 3 Preferred Brand	\$47 Copay; no deductible
Tier 4 Non-Preferred Brand	\$100 Copay ²
Tier 5 Specialty	25% Coinsurance ²
Part D Senior Savings Model (<i>select insulins for non-low income subsidy members</i>)	\$35 Copay, no deductible, covered through the coverage gap

¹Tier 1 Preferred Generics are also covered through the coverage gap and catastrophic stage.
²after a \$480 Part D Deductible

EXTRA BENEFITS

DENTAL

- » **100%** coverage for preventive dental services: semi-annual cleanings and oral exams and an annual x-ray; max benefit of **\$400** per year
- » **100%** coverage for comprehensive dental services; max benefit of **\$700** per year

HEARING/HEARING AIDS

- » **100%** coverage for an annual routine hearing exam
- » **0%** coinsurance for hearing aids (fitting/evaluation included); max benefit of **\$1,000** per year (both ears combined)

VISION

- » **100%** coverage for annual routine eye exam
- » **0%** coinsurance for 12 pairs of contacts (fitting included) or one pair of glasses per year; max benefit of **\$300** per year

OVER-THE-COUNTER (OTC)

- » **100** credits per quarter of OTC items (pain relievers, vitamins, toiletries, etc.), available through Saint John Pharmacy, delivered at no cost to you. *No rollover in credits.*

TELEHEALTH SERVICES

- » **\$0 - \$50** copay for qualifying appointments

TRANSPORTATION

- » **100%** coverage for twenty-four (24) one-way (12 round-trip) non-emergent trips per year for medical treatment with Vantage-approved transportation

FITNESS PROGRAM

- » **100%** coverage for Silver&Fit® program by American Specialty Health Fitness, Inc.
- » No-cost membership at 14,000+ participating fitness centers and YMCAs

STANDARD PLAN

SUMMARY COST SHARE SCHEDULE



EFFECTIVE JANUARY 1, 2022

PREMIUM	\$36.40 , with no in-network deductible
MAXIMUM OUT-OF-POCKET	\$4,900
OUT-OF-NETWORK (POS) BENEFITS	\$500 Deductible; 50% Coinsurance; \$5,000 Maximum Benefit

HOSPITAL INPATIENT

Medical/Surgical (Facility)	Days 1-7: \$270 Copay/day
Professional Fees	Covered 100%
Diagnostic Tests, Procedures, X-Rays, Lab Services <i>Radiology/Pathology/Pre-admission Testing and Lab Services</i>	Covered 100%
Skilled Nursing (Facility)	Days 1-20: \$0 /day; Days 21-100: \$188 /day

OUTPATIENT

Annual Wellness (PCP or OBGYN only)	Covered 100%
Primary Care Provider (PCP) (Office Visit & Telehealth Services)	\$0 Copay
Specialist (Office Visit & Telehealth Services)	\$45 Copay
Nutritional Counseling (Office Visit & Telehealth Services)	20% Coinsurance
Chiropractic Office Visit	\$20 Copay
Physical/Occupational/Speech Therapy (Office Visit & Telehealth Services)	\$10 Copay
Lab Services/Professional Fees <i>Includes lab and pathology services, anesthesia, and outpatient surgery professional fees</i>	Covered 100%
Outpatient Surgery <i>(\$0 diagnostic colonoscopies)</i>	\$250 Copay
Major Diagnostics <i>(e.g., MRI, CT Scan, Other major outpatient diagnostic tests)</i>	\$150 Copay/day
Other Outpatient Diagnostics <i>(e.g., X-ray, Ultrasounds, Other diagnostic outpatient services)</i>	20% Coinsurance

ANCILLARY SERVICES

Hospice	Covered by Original Medicare
Home Health	Covered 100%
Immunizations, including Flu Shots	Covered 100%
Chemotherapy/Radiation	20% Coinsurance
Durable Medical Equipment/Prosthetics	20% Coinsurance

EMERGENCY CARE

Emergency Room (Facility) <i>Waived if admitted.</i>	\$90 Copay
Emergency Room Professional Fees	Covered 100%
Urgent Care	\$65 Copay/Visit
Ground Ambulance	\$250 Copay/Trip

MENTAL HEALTH CARE

Inpatient Mental Health Care	Days 1-4: \$467 Copay/day
Outpatient Mental Health Care (Office Visit & Telehealth Services)	\$30 Copay
Outpatient Substance Abuse Care (Office Visit & Telehealth Services)	\$30 Copay

PRESCRIPTION DRUG (31-DAY SUPPLY)

Tier 1 Preferred Generics: Preferred Pharmacies	\$0 Copay, no deductible ¹
Tier 1 Preferred Generics: Other Pharmacies	\$5 Copay, no deductible ¹
Tier 2 Generics	\$14 Copay, no deductible
Tier 3 Preferred Brand	\$47 Copay; no deductible
Tier 4 Non-Preferred Brand	\$100 Copay ²
Tier 5 Specialty	25% Coinsurance ²
Part D Senior Savings Model (<i>select insulins for non-low income subsidy members</i>)	\$35 Copay, no deductible, covered through the coverage gap

¹Tier 1 Preferred Generics are also covered through the coverage gap and catastrophic stage.

²after a \$480 Part D Deductible

EXTRA BENEFITS

DENTAL

- » **100%** coverage for preventive dental services: semi-annual cleanings and oral exams and an annual x-ray; max benefit of **\$400** per year
- » **100%** coverage for comprehensive dental services; max benefit of **\$1,000** per year

HEARING/HEARING AIDS

- » **100%** coverage for an annual routine hearing exam
- » **0%** coinsurance for hearing aids (fitting/evaluation included); max benefit of **\$1,100** per year (both ears combined)

VISION

- » **100%** coverage for annual routine eye exam
- » **0%** coinsurance for 12 pairs of contacts (fitting included) or one pair of glasses per year; max benefit of **\$300** per year

OVER-THE-COUNTER (OTC)

- » **100** credits per quarter of OTC items (pain relievers, vitamins, toiletries, etc.), available through Saint John Pharmacy, delivered at no cost to you. *No rollover in credits.*

MOBILEHELP® SOLO SYSTEM

- » **100%** coverage for qualifying members

TRANSPORTATION

- » **100%** coverage for twenty-four (24) one-way (12 round-trip) non-emergent trips per year for medical treatment with Vantage-approved transportation

TELEHEALTH SERVICES

- » **\$0 - \$45** copay for qualifying appointments

FITNESS PROGRAM

- » **100%** coverage for Silver&Fit® program by American Specialty Health Fitness, Inc.
- » No-cost membership at 14,000+ participating fitness centers and YMCAs

PREMIUM PLAN

SUMMARY COST SHARE SCHEDULE



EFFECTIVE JANUARY 1, 2022

PREMIUM	\$171 , with no in-network deductible
MAXIMUM OUT-OF-POCKET	\$3,500
OUT-OF-NETWORK (POS) BENEFITS	\$500 Deductible; 50% Coinsurance; \$5,000 Maximum Benefit

HOSPITAL INPATIENT

Medical/Surgical (Facility)	Days 1-7: \$250 Copay/day
Professional Fees	Covered 100%
Diagnostic Tests, Procedures, X-Rays, Lab Services <i>Radiology/Pathology/Pre-admission Testing and Lab Services</i>	Covered 100%
Skilled Nursing (Facility)	Days 1-20: \$0 /day; Days 21-100: \$188 /day

OUTPATIENT

Annual Wellness (PCP or OBGYN only)	Covered 100%
Primary Care Provider (PCP) (Office Visit & Telehealth Services)	\$0 Copay
Specialist (Office Visit & Telehealth Services)	\$40 Copay
Nutritional Counseling (Office Visit & Telehealth Services)	20% Coinsurance
Chiropractic Office Visit	\$20 Copay
Physical/Occupational/Speech Therapy (Office Visit & Telehealth Services)	\$10 Copay
Lab Services/Professional Fees <i>Includes lab and pathology services, anesthesia, and outpatient surgery professional fees</i>	Covered 100%
Outpatient Surgery <i>(\$0 diagnostic colonoscopies)</i>	\$150 Copay
Major Diagnostics <i>(e.g., MRI, CT Scan, Other major outpatient diagnostic tests)</i>	\$125 Copay/day
Other Outpatient Diagnostics <i>(e.g., X-ray, Ultrasounds, Other diagnostic outpatient services)</i>	20% Coinsurance

ANCILLARY SERVICES

Hospice	Covered by Original Medicare
Home Health	Covered 100%
Immunizations, including Flu Shots	Covered 100%
Chemotherapy/Radiation	20% Coinsurance
Durable Medical Equipment/Prosthetics	20% Coinsurance

EMERGENCY CARE

Emergency Room (Facility) <i>Waived if admitted.</i>	\$90 Copay
Emergency Room Professional Fees	Covered 100%
Urgent Care	\$65 Copay/Visit
Ground Ambulance	\$250 Copay/Trip

MENTAL HEALTH CARE

Inpatient Mental Health Care	Days 1-4: \$467 Copay/day
Outpatient Mental Health Care (Office Visit & Telehealth Services)	20% Coinsurance
Outpatient Substance Abuse Care (Office Visit & Telehealth Services)	20% Coinsurance

PRESCRIPTION DRUG (31-DAY SUPPLY)

Tier 1 Preferred Generics: Preferred Pharmacies	\$0 Copay, no deductible ¹
Tier 1 Preferred Generics: Other Pharmacies	\$5 Copay, no deductible ¹
Tier 2 Generics	\$14 Copay, no deductible
Tier 3 Preferred Brand	\$47 Copay; no deductible
Tier 4 Non-Preferred Brand	\$100 Copay; no deductible
Tier 5 Specialty	33% Coinsurance; no deductible
Part D Senior Savings Model (<i>select insulins for non-low income subsidy members</i>).	\$35 Copay, no deductible, covered through the coverage gap

¹Tier 1 Preferred Generics are also covered through the coverage gap and catastrophic stage.

EXTRA BENEFITS

DENTAL

- » **100%** coverage for preventive dental services: semi-annual cleanings and oral exams and an annual x-ray; max benefit of **\$400** per year
- » **100%** coverage for comprehensive dental services; max benefit of **\$1,600** per year

HEARING/HEARING AIDS

- » **100%** coverage for an annual routine hearing exam
- » **0%** coinsurance for hearing aids (fitting/evaluation included); max benefit of **\$1,000** per year (both ears combined)

VISION

- » **100%** coverage for annual routine eye exam
- » **0%** coinsurance for 12 pairs of contacts (fitting included) or one pair of glasses per year; max benefit of **\$300** per year

OVER-THE-COUNTER (OTC)

- » **100** credits per quarter of OTC items (pain relievers, vitamins, toiletries, etc.), available through Saint John Pharmacy, delivered at no cost to you. *No rollover in credits.*

TELEHEALTH SERVICES

- » **\$0 - \$40** copay for qualifying appointments

TRANSPORTATION

- » **100%** coverage for twenty-four (24) one-way (12 round-trip) non-emergent trips per year for medical treatment with Vantage-approved transportation

FITNESS PROGRAM

- » **100%** coverage for Silver&Fit® program by American Specialty Health Fitness, Inc.
- » No-cost membership at 14,000+ participating fitness centers and YMCAs

2022 SUMMARY OF BENEFITS

Vantage BASIC (HMO-POS)

H5576 - 020-2

Vantage STANDARD (HMO-POS)

H5576 - 017-2

Vantage PREMIUM (HMO-POS)

H5576 - 018-2

Our plans and service areas:

H5576 - 020-2 Vantage BASIC (HMO-POS) includes the following parishes: Acadia, Ascension, Assumption, Beauregard, Bienville, Caldwell, Cameron, Claiborne, Concordia, East Feliciana, Grant, Iberia, Iberville, Jackson, Jefferson Davis, Lafayette, Lafourche, Livingston, Madison, Natchitoches, Orleans, Plaquemines, Pointe Coupee, Red River, St. Bernard, St. Charles, St. James, St. John the Baptist, St. Martin, St. Mary, St. Tammany, Union, Vermilion, Washington, West Baton Rouge, West Feliciana.

H5576 - 017-2 Vantage STANDARD (HMO-POS) includes the following parishes: Acadia, Ascension, Assumption, Beauregard, Bienville, Caldwell, Cameron, Claiborne, Concordia, East Feliciana, Grant, Iberia, Iberville, Jackson, Jefferson Davis, Lafayette, Lafourche, Livingston, Madison, Natchitoches, Orleans, Plaquemines, Pointe Coupee, Red River, St. Bernard, St. Charles, St. James, St. John the Baptist, St. Martin, St. Mary, St. Tammany, Union, Vermilion, Washington, West Baton Rouge, West Feliciana.

H5576 - 018-2 Vantage PREMIUM (HMO-POS) include the following parishes: Acadia, Ascension, Assumption, Beauregard, Bienville, Caldwell, Cameron, Claiborne, Concordia, East Feliciana, Grant, Iberia, Iberville, Jackson, Jefferson Davis, Lafayette, Lafourche, Livingston, Madison, Natchitoches, Orleans, Plaquemines, Pointe Coupee, Red River, St. Bernard, St. Charles, St. James, St. John the Baptist, St. Martin, St. Mary, St. Tammany, Union, Vermilion, Washington, West Baton Rouge, West Feliciana.

This is a summary of drug and health services covered by Vantage BASIC (HMO-POS) , Vantage STANDARD (HMO-POS), and Vantage PREMIUM (HMO-POS) from January 1, 2022 - December 31, 2022.

Vantage Health Plan, Inc. is an HMO plan with a Medicare contract.

Enrollment in Vantage Health Plan, Inc. depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call Member Services and request the *Evidence of Coverage*.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare Advantage health plan, such as Vantage Health Plan.

Tips for comparing your Medicare choices:

This Summary of Benefits booklet gives you a summary of what Vantage Health Plan covers and what you pay.

- If you want to compare our plan with other Medicare Advantage health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder at www.medicare.gov/plan-compare.
- If you want to know more about the coverage and costs of Original Medicare, look in your current “**Medicare & You**” handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Contact us

Please contact our Member Services number at 1-866-704-0109 for additional information. (TTY users should call 711.) Hours are seven days a week, 8:00 a.m. – 8:00 p.m. CST from October 1, 2021 – March 31, 2022. After March 31, 2022, Member Services will operate five days a week Monday – Friday, 8:00 a.m. – 8:00 p.m. CST. You may also visit our website at www.VantageMedicare.com.

Who can join?

To join Vantage BASIC (HMO-POS), Vantage STANDARD (HMO-POS), or Vantage PREMIUM (HMO-POS), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Which doctors, hospitals, and pharmacies can I use?

Vantage BASIC (HMO-POS), Vantage STANDARD (HMO-POS), and Vantage PREMIUM (HMO-POS) have a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at www.VantageMedicare.com. Because our plan is an HMO-POS plan, you can use Point-of-Service (POS) providers that are outside our network for an additional cost. The maximum benefit for services rendered by POS providers is \$5,000.

What do we cover?

Like all Medicare Advantage health plans, we cover everything that Original Medicare covers - *and more*.

- **Our plan members get *all of the benefits covered by Original Medicare*.** For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.
- **Our plan members also get *more than what is covered by Original Medicare*.** Some of the extra benefits are outlined in this booklet.

What drugs do we cover?

We cover Part D drugs. In addition, we cover Part B drugs such as most oral chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.VantageMedicare.com.
- Or call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each prescription drug into one of five "tiers." You will need to use our formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur after you meet your deductible, if applicable: Initial Coverage, Coverage Gap, and Catastrophic Coverage. If you have questions about the different benefit stages, please contact the Plan for more information or access the *Evidence of Coverage* on our website.

	Vantage BASIC (HMO-POS) 020-2	Vantage STANDARD (HMO-POS) 017-2	Vantage PREMIUM (HMO-POS) 018-2
Monthly plan premium (includes Part C and D)	\$0 You must keep paying your Medicare Part B premium.	\$36.40 You must keep paying your Medicare Part B premium.	\$171 You must keep paying your Medicare Part B premium.
Medical Deductible	\$500 per year for point-of-service (POS) benefits	\$500 per year for point-of-service (POS) benefits	\$500 per year for point-of-service (POS) benefits
Maximum out-of-pocket amount (does not include prescription drugs)	For in-network providers: \$5,900 per year	For in-network providers: \$4,900 per year	For in-network providers: \$3,500 per year
Inpatient Hospital coverage Includes substance abuse and rehabilitation services	In-Network \$318 copay each day for days 1 to 7 and \$0 copay each day for days 8 to 90 for Medicare-covered hospital care. \$0 copay for an additional Medicare-covered 60 lifetime reserve days. <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance for each Medicare-covered hospital stay. <i>Prior Authorization is required.</i>	In-Network \$270 copay each day for days 1 to 7 and \$0 copay each day for days 8 to 90 for Medicare-covered hospital care. \$0 copay for an additional Medicare-covered 60 lifetime reserve days. <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance for each Medicare-covered hospital stay. <i>Prior Authorization is required.</i>	In-Network \$250 copay each day for days 1 to 7 and \$0 copay each day for days 8 to 90 for Medicare-covered hospital care. \$0 copay for an additional Medicare-covered 60 lifetime reserve days. <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance for each Medicare-covered hospital stay. <i>Prior Authorization is required.</i>

	Vantage BASIC (HMO-POS) 020-2	Vantage STANDARD (HMO-POS) 017-2	Vantage PREMIUM (HMO-POS) 018-2
Outpatient Hospital coverage			
Outpatient hospital services	In-Network \$0 - \$350 copay <i>Prior Authorization is required.</i>	In-Network \$0 - \$250 copay <i>Prior Authorization is required.</i>	In-Network \$0 - \$150 copay <i>Prior Authorization is required.</i>
	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
Outpatient hospital observation services	In-Network \$318 copay per day <i>Prior Authorization is required.</i>	In-Network \$270 copay per day <i>Prior Authorization is required.</i>	In-Network \$250 copay per day <i>Prior Authorization is required.</i>
	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
Ambulatory surgical center	In-Network \$0 - \$350 copay <i>Prior Authorization is required.</i>	In-Network \$0 - \$250 copay <i>Prior Authorization is required.</i>	In-Network \$0 - \$150 copay <i>Prior Authorization is required.</i>
	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
Doctor Visits			
Primary Care Provider visit	In-Network \$0 copay	In-Network \$0 copay	In-Network \$0 copay
	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>

	Vantage BASIC (HMO-POS) 020-2	Vantage STANDARD (HMO-POS) 017-2	Vantage PREMIUM (HMO-POS) 018-2
Specialist visit	In-Network \$50 copay <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network \$45 copay <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network \$40 copay <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>

	Vantage BASIC (HMO-POS) 020-2	Vantage STANDARD (HMO-POS) 017-2	Vantage PREMIUM (HMO-POS) 018-2
<p>Preventive Care Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Bone mass measurement • Breast cancer screening (mammogram) • Cervical and vaginal cancer screening • Cologuard or FOBT colorectal screenings • Colonoscopy and all other colorectal screenings • Diabetes screenings • Glaucoma screenings • Prostate cancer screenings (PSA) • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) <p>Other preventive services are available. Any additional preventive services approved by Medicare during the contract year will be covered.</p>	<p>In-Network \$0 copay</p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>	<p>In-Network \$0 copay</p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>	<p>In-Network \$0 copay</p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
<p>Emergency care Emergency coverage is worldwide, but the copay is not waived if you are admitted to a hospital outside of the United States.</p>	<p>\$90 copay Copayment is waived if you are admitted to a hospital within 72 hours.</p>	<p>\$90 copay Copayment is waived if you are admitted to a hospital within 72 hours.</p>	<p>\$90 copay Copayment is waived if you are admitted to a hospital within 72 hours.</p>

	Vantage BASIC (HMO-POS) 020-2	Vantage STANDARD (HMO-POS) 017-2	Vantage PREMIUM (HMO-POS) 018-2
Urgently Needed Services (Urgent Care)	\$65 copay	\$65 copay	\$65 copay
Diagnostic Services/Labs/Imaging			
Diagnostic tests and procedures	In-Network 0% - 20% coinsurance depending on place of service <i>Prior Authorization may be required.</i>	In-Network 0% - 20% coinsurance depending on place of service <i>Prior Authorization may be required.</i>	In-Network 0% - 20% coinsurance depending on place of service <i>Prior Authorization may be required.</i>
Diagnostic radiology services (e.g. MRI, CT Scan)	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
	In-Network \$0 copay for mammograms \$250 copay for all other diagnostic radiology services <i>Prior Authorization may be required.</i>	In-Network \$0 copay for mammograms \$150 copay for all other diagnostic radiology services <i>Prior Authorization may be required.</i>	In-Network \$0 copay for mammograms \$125 copay for all other diagnostic radiology services <i>Prior Authorization may be required.</i>
	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
Lab services	In-Network \$0 copay <i>Prior Authorization may be required.</i>	In-Network \$0 copay <i>Prior Authorization may be required.</i>	In-Network \$0 copay <i>Prior Authorization may be required.</i>
	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>

	Vantage BASIC (HMO-POS) 020-2	Vantage STANDARD (HMO-POS) 017-2	Vantage PREMIUM (HMO-POS) 018-2
Outpatient X-rays	In-Network 20% coinsurance <i>Prior Authorization may be required.</i>	In-Network 20% coinsurance <i>Prior Authorization may be required.</i>	In-Network 20% coinsurance <i>Prior Authorization may be required.</i>
Therapeutic Radiology	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
	In-Network 20% coinsurance <i>Prior Authorization may be required.</i>	In-Network 20% coinsurance <i>Prior Authorization may be required.</i>	In-Network 20% coinsurance <i>Prior Authorization may be required.</i>
	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
Hearing services			
Exam to diagnose and treat hearing and balance issues	In-Network 20% coinsurance <i>Prior Authorization is required.</i>	In-Network 20% coinsurance <i>Prior Authorization is required.</i>	In-Network 20% coinsurance <i>Prior Authorization is required.</i>
	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
Routine hearing exam	Limited to 1 visit(s) every year In-Network \$0 copay Out-of-Network \$0 copay	Limited to 1 visit(s) every year In-Network \$0 copay Out-of-Network \$0 copay	Limited to 1 visit(s) every year In-Network \$0 copay Out-of-Network \$0 copay

	Vantage BASIC (HMO-POS) 020-2	Vantage STANDARD (HMO-POS) 017-2	Vantage PREMIUM (HMO-POS) 018-2
<p>Fitting-evaluation(s) for hearing aids</p> <p>Hearing aids</p>	<p>Limited to 1 visit(s) every year In-Network \$0 copay</p> <p>Out-of-Network \$0 copay</p> <p>Up to a \$1,000 maximum benefit coverage amount for both ears combined every year for hearing aids.</p> <p>In-Network \$0 copay</p> <p>Out-of-Network \$0 copay</p>	<p>Limited to 1 visit(s) every year In-Network \$0 copay</p> <p>Out-of-Network \$0 copay</p> <p>Up to a \$1,100 maximum benefit coverage amount for both ears combined every year for hearing aids.</p> <p>In-Network \$0 copay</p> <p>Out-of-Network \$0 copay</p>	<p>Limited to 1 visit(s) every year In-Network \$0 copay</p> <p>Out-of-Network \$0 copay</p> <p>Up to a \$1,000 maximum benefit coverage amount for both ears combined every year for hearing aids.</p> <p>In-Network \$0 copay</p> <p>Out-of-Network \$0 copay</p>
<p>Dental services</p> <p>Preventive dental services</p> <p>○ Oral Exams</p>	<p>Up to a \$400 maximum benefit coverage amount for all in-network and out-of-network covered services every year.</p> <p>Limited to 1 oral exam(s) every six months In-Network \$0 copay</p> <p>Out-of-Network \$0 copay</p>	<p>Up to a \$400 maximum benefit coverage amount for all in-network and out-of-network covered services every year.</p> <p>Limited to 1 oral exam(s) every six months In-Network \$0 copay</p> <p>Out-of-Network \$0 copay</p>	<p>Up to a \$400 maximum benefit coverage amount for all in-network and out-of-network covered services every year.</p> <p>Limited to 1 oral exam(s) every six months In-Network \$0 copay</p> <p>Out-of-Network \$0 copay</p>

	Vantage BASIC (HMO-POS) 020-2	Vantage STANDARD (HMO-POS) 017-2	Vantage PREMIUM (HMO-POS) 018-2
○ Prophylaxis (Cleaning)	Limited to 1 cleaning(s) every six months In-Network \$0 copay Out-of-Network \$0 copay	Limited to 1 cleaning(s) every six months In-Network \$0 copay Out-of-Network \$0 copay	Limited to 1 cleaning(s) every six months In-Network \$0 copay Out-of-Network \$0 copay
○ Fluoride Treatment	Limited to 1 fluoride treatment(s) every six months In-Network \$0 copay Out-of-Network \$0 copay	Limited to 1 fluoride treatment(s) every six months In-Network \$0 copay Out-of-Network \$0 copay	Limited to 1 fluoride treatment(s) every six months In-Network \$0 copay Out-of-Network \$0 copay
○ Dental X-rays	Limited to 1 set(s) of horizontal bitewing x-rays every year In-Network \$0 copay Out-of-Network \$0 copay	Limited to 1 set(s) of horizontal bitewing x-rays every year In-Network \$0 copay Out-of-Network \$0 copay	Limited to 1 set(s) of horizontal bitewing x-rays every year In-Network \$0 copay Out-of-Network \$0 copay
Comprehensive dental services	Up to a \$700 maximum benefit coverage amount for all in-network and out-of-network covered services every year. In-Network \$0 copay Out-of-Network \$0 copay	Up to a \$1,000 maximum benefit coverage amount for all in-network and out-of-network covered services every year. In-Network \$0 copay Out-of-Network \$0 copay	Up to a \$1,600 maximum benefit coverage amount for all in-network and out-of-network covered services every year. In-Network \$0 copay Out-of-Network \$0 copay

	Vantage BASIC (HMO-POS) 020-2	Vantage STANDARD (HMO-POS) 017-2	Vantage PREMIUM (HMO-POS) 018-2
Vision care			
Exam to diagnose and treat diseases and conditions of the eye	In-Network \$50 copay <i>Prior Authorization is required.</i>	In-Network \$45 copay <i>Prior Authorization is required.</i>	In-Network \$40 copay <i>Prior Authorization is required.</i>
	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
○ Diabetic eye exams	In-Network \$0 copay	In-Network \$0 copay	In-Network \$0 copay
	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
Eyeglasses or contact lenses after cataract surgery	In-Network 20% coinsurance	In-Network 20% coinsurance	In-Network 20% coinsurance
	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
Glaucoma screening	In-Network \$0 copay	In-Network \$0 copay	In-Network \$0 copay
	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
Routine eye exam	Limited to 1 visit(s) every year In-Network \$0 copay	Limited to 1 visit(s) every year In-Network \$0 copay	Limited to 1 visit(s) every year In-Network \$0 copay
	Out-of-Network 50% coinsurance	Out-of-Network 50% coinsurance	Out-of-Network 50% coinsurance

	Vantage BASIC (HMO-POS) 020-2	Vantage STANDARD (HMO-POS) 017-2	Vantage PREMIUM (HMO-POS) 018-2
Supplemental eyewear	Up to a \$300 combined maximum benefit coverage amount every year.	Up to a \$300 combined maximum benefit coverage amount every year.	Up to a \$300 combined maximum benefit coverage amount every year.
○ Contact lenses	Limited to 12 pair(s) of contact lenses In-Network \$0 copay Out-of-Network \$0 copay	Limited to 12 pair(s) of contact lenses In-Network \$0 copay Out-of-Network \$0 copay	Limited to 12 pair(s) of contact lenses In-Network \$0 copay Out-of-Network \$0 copay
○ Eyeglass lenses	Limited to 1 set(s) of eyeglass lenses In-Network \$0 copay Out-of-Network \$0 copay	Limited to 1 set(s) of eyeglass lenses In-Network \$0 copay Out-of-Network \$0 copay	Limited to 1 set(s) of eyeglass lenses In-Network \$0 copay Out-of-Network \$0 copay
○ Eyeglass frames	Limited to 1 pair(s) of eyeglass frames In-Network \$0 copay Out-of-Network \$0 copay	Limited to 1 pair(s) of eyeglass frames In-Network \$0 copay Out-of-Network \$0 copay	Limited to 1 pair(s) of eyeglass frames In-Network \$0 copay Out-of-Network \$0 copay
○ Eyeglasses (lenses and frames)	Limited to 1 pair(s) of eyeglasses (lenses and frames) In-Network \$0 copay Out-of-Network \$0 copay	Limited to 1 pair(s) of eyeglasses (lenses and frames) In-Network \$0 copay Out-of-Network \$0 copay	Limited to 1 pair(s) of eyeglasses (lenses and frames) In-Network \$0 copay Out-of-Network \$0 copay

	Vantage BASIC (HMO-POS) 020-2	Vantage STANDARD (HMO-POS) 017-2	Vantage PREMIUM (HMO-POS) 018-2
○ Upgrades	In-Network \$0 copay Out-of-Network \$0 copay	In-Network \$0 copay Out-of-Network \$0 copay	In-Network \$0 copay Out-of-Network \$0 copay
Mental Health Services Inpatient stay	In-Network \$467 copay each day for days 1 to 4 and \$0 copay each day for days 5 to 90 for Medicare-covered hospital care. \$0 copay for an additional Medicare-covered 60 lifetime reserve days. <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance for each Medicare-covered hospital stay. <i>Prior Authorization is required.</i>	In-Network \$467 copay each day for days 1 to 4 and \$0 copay each day for days 5 to 90 for Medicare-covered hospital care. \$0 copay for an additional Medicare-covered 60 lifetime reserve days. <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance for each Medicare-covered hospital stay. <i>Prior Authorization is required.</i>	In-Network \$467 copay each day for days 1 to 4 and \$0 copay each day for days 5 to 90 for Medicare-covered hospital care. \$0 copay for an additional Medicare-covered 60 lifetime reserve days. <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance for each Medicare-covered hospital stay. <i>Prior Authorization is required.</i>
Outpatient group therapy visit	In-Network \$40 copay <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network \$30 copay <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network 20% coinsurance <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>

	Vantage BASIC (HMO-POS) 020-2	Vantage STANDARD (HMO-POS) 017-2	Vantage PREMIUM (HMO-POS) 018-2
Outpatient individual therapy visit	In-Network \$40 copay <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network \$30 copay <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network 20% coinsurance <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
Skilled nursing facility (SNF) care Our plan covers up to 100 days in a Skilled Nursing Facility. Three-day prior hospital stay is required.	In-Network \$0 copay each day for days 1 to 20 and \$188 copay each day for days 21 to 100 for Medicare-covered skilled nursing facility care. <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance for each Medicare-covered skilled nursing facility stay. <i>Prior Authorization is required.</i>	In-Network \$0 copay each day for days 1 to 20 and \$188 copay each day for days 21 to 100 for Medicare-covered skilled nursing facility care. <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance for each Medicare-covered skilled nursing facility stay. <i>Prior Authorization is required.</i>	In-Network \$0 copay each day for days 1 to 20 and \$188 copay each day for days 21 to 100 for Medicare-covered skilled nursing facility care. <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance for each Medicare-covered skilled nursing facility stay. <i>Prior Authorization is required.</i>
Physical Therapy Cost share applies to each Medicare-covered therapy visit. Separate cost share will apply for each type of therapy services rendered on the same day.	In-Network \$20 copay per visit <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network \$10 copay per visit <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network \$10 copay per visit <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>

	Vantage BASIC (HMO-POS) 020-2	Vantage STANDARD (HMO-POS) 017-2	Vantage PREMIUM (HMO-POS) 018-2
Ambulance services			
Ground Ambulance Copay applies to each one-way trip.	In-Network \$250 copay <i>Prior Authorization may be required.</i>	In-Network \$250 copay <i>Prior Authorization may be required.</i>	In-Network \$250 copay <i>Prior Authorization may be required.</i>
Air Ambulance	Out-of-Network 50% coinsurance <i>Prior Authorization may be required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization may be required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization may be required.</i>
	In-Network 20% coinsurance <i>Prior Authorization is required.</i>	In-Network 20% coinsurance <i>Prior Authorization is required.</i>	In-Network 20% coinsurance <i>Prior Authorization is required.</i>
	Out-of-Network 20% - 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 20% - 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 20% - 50% coinsurance <i>Prior Authorization is required.</i>
Transportation	In-Network \$0 copay Routine transportation for up to 24 trips every year. A trip is considered one-way transportation by van or medical transport to a plan-approved health-related location. <i>Prior Authorization is required.</i>	In-Network \$0 copay Routine transportation for up to 24 trips every year. A trip is considered one-way transportation by van or medical transport to a plan-approved health-related location. <i>Prior Authorization is required.</i>	In-Network \$0 copay Routine transportation for up to 24 trips every year. A trip is considered one-way transportation by van or medical transport to a plan-approved health-related location. <i>Prior Authorization is required.</i>
	Out-of-Network <u>Not covered</u>	Out-of-Network <u>Not covered</u>	Out-of-Network <u>Not covered</u>

	Vantage BASIC (HMO-POS) 020-2	Vantage STANDARD (HMO-POS) 017-2	Vantage PREMIUM (HMO-POS) 018-2
Medicare Part B prescription drugs			
Chemotherapy/Radiation drugs	In-Network 20% coinsurance <i>Prior Authorization is required.</i>	In-Network 20% coinsurance <i>Prior Authorization is required.</i>	In-Network 20% coinsurance <i>Prior Authorization is required.</i>
	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
Other Part B drugs	In-Network 20% coinsurance <i>Prior Authorization is required.</i>	In-Network 20% coinsurance <i>Prior Authorization is required.</i>	In-Network 20% coinsurance <i>Prior Authorization is required.</i>
	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>

Prescription Drug Coverage	Vantage BASIC (HMO-POS) 020-2	Vantage STANDARD (HMO-POS) 017-2	Vantage PREMIUM (HMO-POS) 018-2			
Stage 1: Annual Prescription Deductible						
Deductible	\$480 prescription drug deductible; applies to drugs in Tiers 4 and 5		\$0 prescription drug deductible			
Stage 2: Initial Coverage						
After you meet your deductible (if applicable), you pay the following until your total yearly drug costs reach \$4,430. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.						
Vantage participates in the Part D Senior Savings Model which covers select insulins for members without low income subsidy for a \$35 copay (31-day supply) and a \$105 copay (100-day supply).						
Preferred Retail and Saint John Pharmacy* Mail-Order Cost-Sharing						
	31-Day	100-Day	31-Day	100-Day	31-Day	100-Day
Tier 1 (Preferred Generics)	\$0	\$0	\$0	\$0	\$0	\$0
Tier 2 (Generics)	\$16	\$48	\$14	\$42	\$14	\$42
Tier 3 (Preferred Brand)	\$47	\$141	\$47	\$141	\$47	\$141
Tier 4 (Non-Preferred Brand)	\$100	\$300	\$100	\$300	\$100	\$300
Tier 5 (Specialty)	25%	N/A	25%	N/A	33%	N/A
*Members can have prescription drugs shipped to their home through the Saint John Pharmacy network mail order delivery program. Once the order is received by Saint John Pharmacy, members should expect to receive their pharmacy order in 5-7 business days. If the requested pharmacy order is not received within the estimated time frame, please contact Vantage Health Plan at (866) 704-0109.						
Standard Retail and Mail-Order Cost-Sharing						
Tier 1 (Preferred Generics)	\$8	\$24	\$5	\$15	\$5	\$15
Tier 2 (Generics)	\$16	\$48	\$14	\$42	\$14	\$42
Tier 3 (Preferred Brand)	\$47	\$141	\$47	\$141	\$47	\$141
Tier 4 (Non-Preferred Brand)	\$100	\$300	\$100	\$300	\$100	\$300
Tier 5 (Specialty)	25%	N/A	25%	N/A	33%	N/A
If an in-network pharmacy is not available, you may get drugs from an out-of-network pharmacy. Your prescription cost may be more at an out-of-network pharmacy than at an in-network pharmacy. If you reside in a long-term care facility, you pay the same as at a preferred retail pharmacy.						

Stage 3: Coverage Gap

Most Medicare drug plans have a coverage gap (also called the “donut hole”). The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,430.

After you enter the coverage gap, you pay

Preferred retail pharmacy and Saint John Pharmacy:

- \$0 copay for a 31-day or 100-day supply of Tier 1 Preferred Generic drugs

All other retail pharmacies:

- Tier 1 copay for a 31-day supply of Tier 1 Preferred Generic drugs; or
- 25% of the plan’s costs (plus a portion of the dispensing fee), **whichever is lower.**

For all other covered generics and for all covered brand name drugs, you pay 25% of the plan’s cost (plus a portion of the dispensing fee).

Select insulins for members without low income subsidy are covered through the coverage gap under the Part D Senior Savings Model for a \$35 copay (31-day supply) and a \$105 copay (100-day supply).

You stay in this stage until your year-to-date “out-of-pocket costs” (your payments) reach a total of \$7,050. Not everyone will enter the coverage gap.

Stage 4: Catastrophic Coverage

After your yearly out-of-pocket drug costs reach \$7,050, you continue to pay:

Tier 1 Preferred Generic Drugs:

- Preferred cost sharing: \$0 copay, or
- Standard cost sharing: \$3.95 copay

For all other drugs, you pay the greater of:

- 5% coinsurance, or
- \$3.95 copay for generic drugs (including brand drugs treated as generic) and a \$9.85 copay for all other drugs.

Other Covered Benefits

	Vantage BASIC (HMO-POS) 020-2	Vantage STANDARD (HMO-POS) 017-2	Vantage PREMIUM (HMO-POS) 018-2
Cardiac (Heart) Rehabilitation Services	In-Network \$50 copay per visit <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network \$50 copay per visit <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network \$50 copay per visit <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
Chiropractic office visit	In-Network \$20 copay <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network \$20 copay <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network \$20 copay <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
Diabetic monitoring supplies	In-Network 0% - 20% coinsurance <i>Prior Authorization may be required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network 0% - 20% coinsurance <i>Prior Authorization may be required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network 0% - 20% coinsurance <i>Prior Authorization may be required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
Diabetes Self-Management Training	In-Network 20% coinsurance <i>Prior Authorization may be required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network 20% coinsurance <i>Prior Authorization may be required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network 20% coinsurance <i>Prior Authorization may be required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>

	Vantage BASIC (HMO-POS) 020-2	Vantage STANDARD (HMO-POS) 017-2	Vantage PREMIUM (HMO-POS) 018-2
Diabetic therapeutic shoes or inserts	In-Network 20% coinsurance <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network 20% coinsurance <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network 20% coinsurance <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
Durable medical equipment (DME) and related supplies	In-Network 20% coinsurance <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network 20% coinsurance <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network 20% coinsurance <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
Podiatry services (foot care)	In-Network \$50 copay <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network \$45 copay <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network \$40 copay <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
Home health agency care	In-Network \$0 copay <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network \$0 copay <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network \$0 copay <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>

	Vantage BASIC (HMO-POS) 020-2	Vantage STANDARD (HMO-POS) 017-2	Vantage PREMIUM (HMO-POS) 018-2
Hospice Services must be provided by a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Contact the plan for more details.	\$0 copay	\$0 copay	\$0 copay
Outpatient rehabilitation services Services provided by an occupational therapist. Cost share applies to each Medicare-covered therapy visit. Separate cost share will apply for each type of therapy services rendered on the same day.	In-Network \$20 copay per visit <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network \$10 copay per visit <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network \$10 copay per visit <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
Outpatient substance abuse services	In-Network \$40 copay <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network \$30 copay <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network 20% coinsurance <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
Prosthetic devices and related supplies	In-Network 20% coinsurance <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network 20% coinsurance <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network 20% coinsurance <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>

	Vantage BASIC (HMO-POS) 020-2	Vantage STANDARD (HMO-POS) 017-2	Vantage PREMIUM (HMO-POS) 018-2
Renal Dialysis Services	In-Network 20% coinsurance <i>Prior Authorization is required.</i> Out-of-Network 20% coinsurance <i>Prior Authorization is required.</i>	In-Network 20% coinsurance <i>Prior Authorization is required.</i> Out-of-Network 20% coinsurance <i>Prior Authorization is required.</i>	In-Network 20% coinsurance <i>Prior Authorization is required.</i> Out-of-Network 20% coinsurance <i>Prior Authorization is required.</i>
Speech and Language Therapy Cost share applies to each Medicare-covered therapy visit. Separate cost share will apply for each type of therapy services rendered on the same day.	In-Network \$20 copay per visit <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network \$10 copay per visit <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network \$10 copay per visit <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
Worldwide emergency coverage	\$90 copay	\$90 copay	\$90 copay

Extra Benefits

	Vantage BASIC (HMO-POS) 020-2	Vantage STANDARD (HMO-POS) 017-2	Vantage PREMIUM (HMO-POS) 018-2
24-Hour Nurse Line	Vantage offers a 24-hour, 7 days a week Nurse Line so you can speak to a Registered Nurse at any time regarding any medical question you may have. Get professional advice around the clock! Call 1-844-657-7829.		
Fitness program	Vantage Health Plan offers a fitness benefit for Medicare members by providing access to hundreds of fitness locations throughout the state of Louisiana and thousands more nationwide.		
Over-the-counter benefit	You are eligible for 100 credits every three months to be used toward the purchase of over-the-counter (OTC) health and wellness products.		
Personal emergency response system (PERS)	<u>Not</u> covered	\$0 copay	<u>Not</u> covered
Additional Telehealth	Includes qualifying appointments with primary care providers, physician specialists, podiatrists, other healthcare professionals, dietitians, behavioral health providers, and occupational/physical/speech therapists.		

PRE-ENROLLMENT CHECKLIST



Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Member Services representative at 1-866-704-0109 (TTY users should call 711). Member Services will operate seven (7) days a week from 8:00 a.m. - 8:00 p.m. CST from October 1, 2021 - March 31, 2022. After March 31, 2022, Member Services will operate five (5) days a week, Monday - Friday, 8:00 a.m. - 8:00 p.m. CST.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit www.VantageMedicare.com or call 1-866-704-0109 (TTY users should call 711) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2023.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

► HOW TO ENROLL

Vantage makes it easy and it only takes a few minutes!
Call us to enroll over the phone.

(866) 704-0109

TTY 711 *(for the hearing impaired)*

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Other ways to enroll:



REQUEST A HOME VISIT

To request a one-on-one home visit, call **(866) 704-0109, TTY 711**, and one of our representatives will stop by so you can enroll from the comfort of your own home. Your safety is our #1 priority. Masks are required and social distancing guidelines will be followed.



VISIT THE VANTAGE WEBSITE

Visit us at **www.VantageMedicare.com** to enroll online or for more information.



STOP BY OUR OFFICE

Locations are listed on the back cover. No appointment necessary.

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Medicare beneficiaries may also enroll in a Vantage Medicare Advantage plan through the CMS Online Enrollment Center located at **www.Medicare.gov**.



2022 MEDICARE ADVANTAGE ENROLLMENT ELECTION FORM



Vantage Medicare Advantage

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit *Medicare.gov* to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Vantage Health Plan
130 DeSiard St, Ste 300
Monroe, LA 71201
Medicare Enrollment Fax: (318) 807-1115

Once we process your request to join, we will contact you.

How do I get help with this form?

Call Vantage Health Plan at (866) 704-0109. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227).

TTY users can call 1-877-486-2048.

En español: Llame a Vantage Health Plan al (866) 704-0109/TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

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Section 1 – All fields in this section are required (unless marked optional)

Select the plan you want to join:

_____ **Vantage Basic (HMO-POS) \$0.00 per month.** Available to residents of the following parishes:

020-001 Allen, Avoyelles, Bossier, Caddo, Calcasieu, Catahoula, De Soto, East Baton Rouge, East Carroll, Evangeline, Franklin, Jefferson, LaSalle, Lincoln, Morehouse, Ouachita, Rapides, Richland, Sabine, St Helena, St Landry, Tangipahoa, Tensas, Terrebonne, Vernon, Webster, West Carroll and Winn.

020-002 Acadia, Ascension, Assumption, Beauregard, Bienville, Caldwell, Cameron, Claiborne, Concordia, East Feliciana, Grant, Iberia, Iberville, Jackson, Jefferson Davis, Lafayette, Lafourche, Livingston, Madison, Natchitoches, Orleans, Plaquemines, Pointe Coupee, Red River, St Bernard, St Charles, St James, St John Baptist, St Martin, St Mary, St Tammany, Union, Vermillion, Washington, West Baton Rouge and West Feliciana.

_____ **Vantage Standard (HMO-POS) \$36.40 per month.** Available to residents of the following parishes:

017-001 Allen, Avoyelles, Bossier, Caddo, Calcasieu, Catahoula, De Soto, East Baton Rouge, East Carroll, Evangeline, Franklin, Jefferson, LaSalle, Lincoln, Morehouse, Ouachita, Rapides, Richland, Sabine, St Helena, St Landry, Tangipahoa, Tensas, Terrebonne, Vernon, Webster, West Carroll and Winn.

017-002 Acadia, Ascension, Assumption, Beauregard, Bienville, Caldwell, Cameron, Claiborne, Concordia, East Feliciana, Grant, Iberia, Iberville, Jackson, Jefferson Davis, Lafayette, Lafourche, Livingston, Madison, Natchitoches, Orleans, Plaquemines, Pointe Coupee, Red River, St Bernard, St Charles, St James, St John Baptist, St Martin, St Mary, St Tammany, Union, Vermillion, Washington, West Baton Rouge and West Feliciana.

_____ **Vantage Premium (HMO-POS) \$171.00 per month.** Available to residents of the following parishes:

018-001 Allen, Avoyelles, Bossier, Caddo, Calcasieu, Catahoula, De Soto, East Baton Rouge, East Carroll, Evangeline, Franklin, Jefferson, LaSalle, Lincoln, Morehouse, Ouachita, Rapides, Richland, Sabine, St Helena, St Landry, Tangipahoa, Tensas, Terrebonne, Vernon, Webster, West Carroll and Winn.

018-002 Acadia, Ascension, Assumption, Beauregard, Bienville, Caldwell, Cameron, Claiborne, Concordia, East Feliciana, Grant, Iberia, Iberville, Jackson, Jefferson Davis, Lafayette, Lafourche, Livingston, Madison, Natchitoches, Orleans, Plaquemines, Pointe Coupee, Red River, St Bernard, St Charles, St James, St John Baptist, St Martin, St Mary, St Tammany, Union, Vermillion, Washington, West Baton Rouge and West Feliciana.

_____ **Vantage 100 (HMO-POS) \$222.00 per month**

022-000 Available to all residents in the state of Louisiana.

Your information:

First name: _____ Last name: _____ Middle Initial (Optional): _____

Birth Date: (MM/DD/YYYY)

Sex:

☐ M ☐ F

Cell Phone Number:

(____)____-____

Home Phone Number:

(____)____-____
(Optional)

____/____/____
Month Day Year

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Section 1 (continued)

Permanent Residence Street Address (*Do not enter a P.O. Box*):

City:	County/Parish (<i>Optional</i>):	State:	ZIP Code:
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Mailing Address, *if different from your Permanent Address (P.O. Box allowed)*:

Address: _____ City: _____ State: _____ ZIP Code: _____

Emergency Contact (*Optional*): _____
Phone Number: _____ Relationship to you: _____

Your Medicare information:

Medicare Number: _____ - _____ - _____

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Vantage Medicare Advantage?

☐ Yes ☐ No

Name of other coverage: _____ Member number for this coverage: _____ Group number for this coverage: _____

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Vantage Medicare Advantage.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Vantage Medicare Advantage will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement on page 5).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Vantage Medicare Advantage coverage begins, I must get all of my medical and prescription drug benefits from Vantage Medicare Advantage. Benefits and services provided by Vantage Medicare Advantage and contained in my Vantage Medicare Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Vantage Medicare Advantage will pay for benefits or services that are not covered.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
 - 1) This person is authorized under State law to complete this enrollment, and
 - 2) Documentation of this authority is available upon request by Medicare.

Signature: _____	Today's Date: _____
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If you are the authorized representative, sign above and fill out these fields:

Name: _____ Address: _____
Phone Number: _____ Relationship to Enrollee: _____ DOB: _____

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Attestation of Eligibility (Required if enrolling outside of Annual Enrollment Period)

Typically, you may enroll in a Medicare Advantage plan *only* during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you.

By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP). *Only available for dates 1/1–3/31 or within the first 3 months after entitlement.*
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.
- ☐ I recently was released from incarceration. I was released on (insert date) _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help, paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I recently left a PACE program on (insert date) _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- ☐ I am leaving employer or union coverage on (insert date) _____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost my special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.
- ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you are not sure, please contact Vantage Medicare Advantage at (866) 704-0109. TTY users should call 711 to see if you are eligible to enroll. Member Services is available seven days a week, 8:00 a.m. – 8:00 p.m. CST, from October 1, 2021 through March 31, 2022. For all other dates, Member Services is available Monday through Friday, 8:00 a.m. – 8:00 p.m. CST.

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Section 2 – All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select if you want us to send you information in a language other than English. ☐ Spanish ☐ Other: _____

Select one if you want us to send you information in an accessible format.

☐ Large Print ☐ Audio CD

Please contact Vantage Medicare Advantage at (866) 704-0109 if you need information in an accessible format other than what is listed above. TTY users should call 711. Member Services is available seven days a week, 8:00 a.m. – 8:00 p.m. CST, from October 1, 2021 through March 31, 2022. For all other dates, Member Services is available Monday through Friday, 8:00 a.m. – 8:00 p.m. CST.

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

List your Primary Care Provider (PCP):

I want to get the following materials via email. ☐ Annual Notice of Changes ☐ Evidence of Coverage

☐ Provider Directory ☐ Pharmacy Directory ☐ Formulary

E-mail address: _____

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT), credit/debit card each month, or by prepaying quarterly or annually. **You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). **DO NOT** pay Vantage Medicare Advantage the Part D-IRMAA.

If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:

☐ Receive a bill (*choose one*): ☐ Monthly ☐ Quarterly (prepay only) ☐ Annually (prepay only)

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a **VOIDED** check or provide the following:

Account holder name: _____

Account type: ☐ Checking ☐ Savings

Bank routing number: _____

Bank account number: _____

☐ Credit/Debit Card. Please provide the following information:

Type of Card: ☐ Visa ☐ Mastercard ☐ Discover Name as it appears on card: _____

Account number: _____ - _____ - _____ - _____ CVV: _____ Expiration Date: _____ / _____

Month Year

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security or RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

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RETURN COMPLETED FORM TO VANTAGE:

Member Services Fax: (318) 807-1113 Medicare Enrollment Fax: (318) 807-1115
 Exchange Enrollment Fax: (318) 361-2171 Commercial Enrollment Fax: (318) 807-1040

AUTHORIZED PERSONAL REPRESENTATIVE (APR) FORM



This form allows a member to designate an Authorized Personal Representative (APR), such as a spouse, parent, Power of Attorney, or broker/agent. Vantage Health Plan (Vantage) may share protected health information (“PHI”) with a member’s APR. PHI may include viewing payment, claims or authorization history, or filing or responding to appeals. A member’s APR may also act on the member’s behalf and make changes to the member’s account, such as changing primary care provider, demographic or contact information, or making payments on an account. **Mark the options in Section C below for what information your APR may view or change.**

Instructions: Please complete all sections of this APR Form and return to Vantage.

Section A - Member Information (* - required fields): List Vantage Member whose information is to be shared.

*Name:	*Date of Birth:	
*Phone Number:	*Health Plan ID, MBI <i>or</i> SSN:	
*Address:		
*City:	*State:	*Zip:

Section B - Person or Organization to Receive Information (* - required fields): List the specific person or entity that can receive, access or change the Member’s information.

Effective Date:	Termination Date:
*Person/Entity Name:	*Date of Birth:
*Phone Number:	*Health Plan ID, MBI <i>or</i> SSN:
*Address:	
*City:	*State: *Zip:
Relationship to Member:	<input type="checkbox"/> Attorney <input type="checkbox"/> Family member <input type="checkbox"/> Agent/Broker <input type="checkbox"/> Facility <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Guardian <input type="checkbox"/> Employee of Agent/Broker <input type="checkbox"/> Other

Section C - Access Details: Mark the options below to allow your APR to access and/or change each type of information. Options left unmarked below will not be available to your APR.

My representative can (mark all that apply):

- | | |
|--|---|
| <input type="checkbox"/> View my PHI/Medical information | <input type="checkbox"/> View or change my primary care provider |
| <input type="checkbox"/> File or respond on my behalf regarding an appeal or grievance | <input type="checkbox"/> View or change my demographic or contact information |
| <input type="checkbox"/> View information on my infectious diseases | <input type="checkbox"/> View my family relationships |
| <input type="checkbox"/> View information on my mental health | <input type="checkbox"/> View my Power of Attorney |
| <input type="checkbox"/> View information on my chemical or substance dependency | <input type="checkbox"/> View my payment history |

Section D - Member Signature (required): I understand by signing this form, I have read and understand that Vantage has permission to release my PHI to and accept changes or actions made on my behalf by this person or entity as well. If no effective date is listed in Section B, the effective date for these permissions is indicated below. I understand that I must contact Vantage to change or terminate this appointment.

Signature: _____ Date: _____

Section E - Acceptance of Appointment (required): I, _____, hereby accept the above appointment. I certify that I am not disqualified from acting as the Member’s authorized Personal Representative.

Signature: _____ Date: _____

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SCOPE OF SALES APPOINTMENT CONFIRMATION FORM



The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative).

By signing this form, you agree to a meeting with a sales agent to discuss Vantage Medicare Advantage Health Maintenance Organization (HMO-POS) and/or Vantage Medicare Advantage Dual Plus (HMO-POS D-SNP) plans. These plans are Medicare Advantage plans that provide all Original Medicare Part A and B health coverage and cover Part D prescription drug coverage.

Signing this form does NOT obligate you to enroll in a plan, will NOT impact your current or future Medicare enrollment status, and will NOT automatically enroll you in the Medicare plans discussed.

Please indicate which plan(s) are to be discussed during this sales meeting:

- | | |
|--|--|
| <input type="checkbox"/> Vantage Basic (HMO-POS) | <input type="checkbox"/> Vantage Premium (HMO-POS) |
| <input type="checkbox"/> Vantage Standard (HMO-POS) | <input type="checkbox"/> Vantage 100 (HMO-POS) |
| <input type="checkbox"/> Vantage Dual Plus (HMO-POS D-SNP) | |

Beneficiary or Authorized Representative Signature and Initial Date of Contact:

Signature

Date of Contact

If you are the authorized representative, please sign above and print below:

Representative's Name: _____

Your Relationship to the Beneficiary: _____

Please mail or fax this form to:

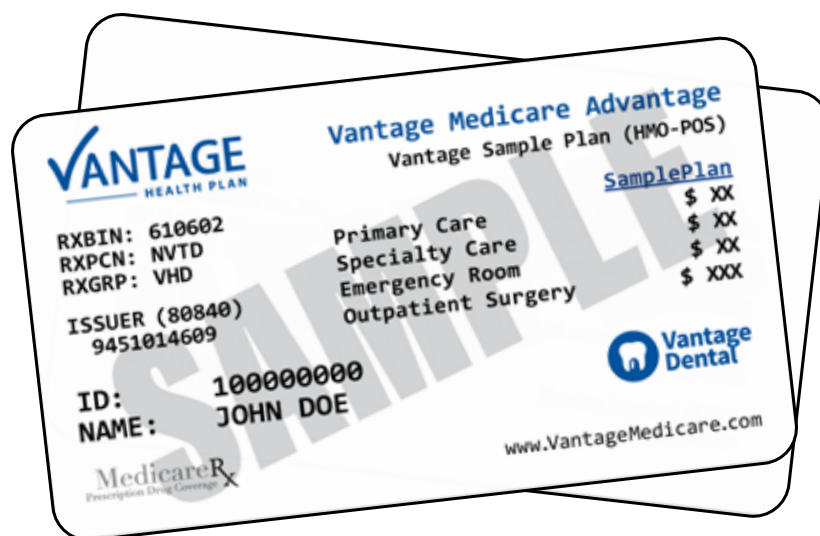
Vantage Medicare Advantage
Attn: Medicare Enrollment Department
130 DeSiard Street, Suite 300, Monroe, LA 71201
Fax: (318) 807-1115

To be completed by Agent:

Beneficiary Name:	Beneficiary Phone Number:
Agent Name:	Agent Phone Number:
Agent's Signature:	Date of Appointment:

Vantage Health Plan (Vantage) is a health plan with a Medicare Contract. Enrollment in Vantage depends on contract renewal.

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► WHAT TO EXPECT

What Happens After Initial Enrollment

After you have completed and submitted your Vantage Medicare Advantage enrollment application to Vantage, your application is sent to the Centers for Medicare and Medicaid Services (CMS) for approval.

Approximately 15 days after CMS confirms your enrollment, you will receive a Welcome Call from our Member Services Department to answer questions or address any concerns you may have.

Your Vantage Medicare Advantage ID card will be mailed to you prior to your effective enrollment date. When you receive your ID card, place it in your purse or wallet immediately.

Remember, you must show your new Vantage Medicare Advantage ID card for all healthcare and pharmacy services.

► NEED MORE INFORMATION?

CONTACT INFORMATION

Phone Numbers:

Toll-Free **1-866-704-0109**

TTY 711 for the hearing impaired

Website: **www.VantageMedicare.com**

HOURS OF OPERATION

October 1, 2021 - March 31, 2022:

Seven (7) Days a Week 8:00 a.m. – 8:00 p.m.

All other dates:

Monday - Friday 8:00 a.m. – 8:00 p.m.



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

NONDISCRIMINATION NOTICE

Vantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, 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, 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 hard of hearing, 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, 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, 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/vhpnondiscriminationgrievanceprocedure.



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

LANGUAGE ASSISTANCE

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

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-823-1910 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 888-823-1910 (ATS: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 888-823-1910 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 888-823-1910 (TTY 711)。

مُؤَرَّب لَصِنَا. نَجْمَلَاب لَكَا رِفَاوَتْ قَوَّوْغَلَّا قَدْعَاسْمَا تَامَدَخ نَا، قَوَّوْغَلَّا رَكَاذَا تَدَحْنُ تَنَكَا اِذَا: قَطَوَحْم فَتَاه مَر (888-823-1910 مَكَلَبَاو مَصَلَا: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 888-823-1910 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 888-823-1910 (TTY: 711) 번으로 전화해 주십시오.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 888-823-1910 (TTY: 711).

ໂປດຊາບ: ຖ້າວາ ທານເວາພາສາ ລາວ, ການບວການຊ່ວຍເຫຼືອດານພາສາ, ໂດຍບຸເສຍຄ່າ, ແມ່ນມາພອມໃຫ້ທານ. ໂທ 888-823-1910 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。888-823-1910 (TTY: 711) まで、お電話にてご連絡ください。

نَیْزِک لاک - نِیْه بَايَسْد رِیْم تَفْم تَامَدَخ یِک دَدَم یِک نَايَز وَک پَا وَ، نَیْه رِیْطَلُوب وَدِرَا پَا رَگَا: رَايَرِیْخ (TTY: 711) 888-823-1910

સચન: જો તમે ગજરાતી બોલતા છો, તો નન:શલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 888-823-1910 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 888-823-1910 (TTY: 711)

مَهَارِف امش يارب ناگوار تروصب يزابز تلاهست، ديزک يم وگنگنگ ي سراف نابز هب رگا: هجوت اب دشاب يم (TTY: 711) 888-823-1910 تيریگب سام.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 888-823-1910 (телетайп: 711).

หมายเหตุ: ถาคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาไดฟรี โทร 888-823-1910 (TTY: 711).



Freedom to live a healthy life

LOCATIONS

MONROE

122 St. John Street
Monroe, LA 71201

SHREVEPORT

855 Pierremont Rd., Ste. 109
Shreveport, LA 71106

BATON ROUGE

13348 Coursey Blvd., Ste. A
Baton Rouge, LA 70816

HAMMOND

219 West Thomas Street
Hammond, LA 70401

OTHER LOCATIONS:

VantageHealthPlan.com/locations

HOURS OF OPERATION

OCTOBER 1, 2021 - MARCH 31, 2022

Seven (7) Days a Week,
8:00 a.m. - 8:00 p.m.

ALL OTHER DATES:

Monday - Friday,
8:00 a.m. - 8:00 p.m.

CONTACT INFO

PHONE:

(866) 704-0109
TTY 711 *(for the hearing impaired)*

WEBSITE:

www.VantageMedicare.com