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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 **GIVEBACK**
(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. For more information on Vantage Medicare Advantage Plan benefits, call Member Services at (866) 704-0109 or TTY 711, available from 8:00 a.m.–8:00 p.m. CST seven days a week between October 1 - March 31 and Monday - Friday between April 1 - September 30.

Freedom to live a healthy life



VANTAGE
HEALTH PLAN



You have many options when considering your Medicare coverage. Plans that work for friends or family members may not be the best plan for you. Vantage gives you the freedom to live a healthy life by providing benefits you need, providers you rely on, and local service you trust.

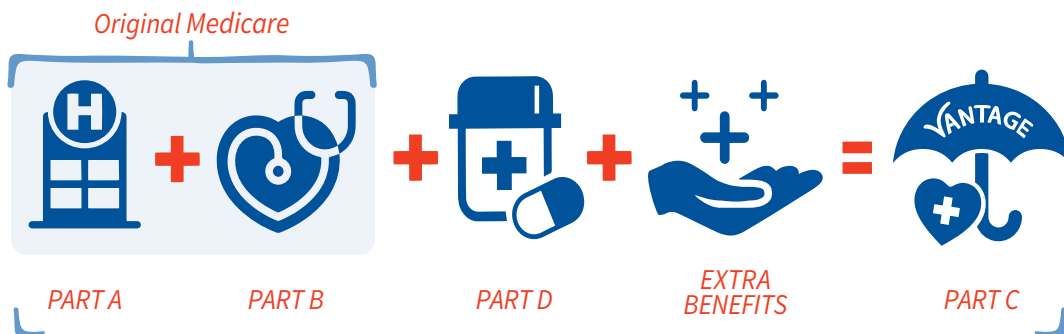
We know healthcare can seem complicated sometimes. If you need help completing forms, finding a doctor, or getting a question answered, call **1-866-704-0109 or TTY 711** (for the hearing impaired). Request a one-on-one home visit and a representative will come to you.

THE VANTAGE ADVANTAGE

Medicare is a health insurance program administered by the federal government that has four parts. Part A covers hospital stays and inpatient services while Part B covers doctor visits and outpatient services. Part D covers prescription drugs through private insurers as a standalone plan or as part of a Medicare Advantage plan.

Part C, Medicare Advantage, combines Part A and Part B coverage with Part D prescription drug coverage and additional benefits such as vision, hearing, and dental, all in one plan.

Medicare Advantage is offered by private companies like Vantage Health Plan. In 1994, Vantage was founded by a group of doctors wanting to provide high quality coverage while teaming up with physicians and patients to ensure well-coordinated healthcare.



REMEMBER!


You will use your Vantage card at your provider's office or pharmacy instead of your red, white, and blue Medicare card.


WHAT WE OFFER

- ▶ **\$0** Monthly premium
- ▶ **\$0** In-Network medical deductibles
- ▶ **\$0** Primary care office visit copay
- ▶ **\$0** Lab copay
- ▶ **\$0** Copay for professional fees in a hospital setting
- ▶ Low to no copay for many prescription drugs
- ▶ Annual wellness exam **100%** covered
- ▶ Local customer service


Extra benefits included in Vantage Medicare Advantage plans not offered by Original Medicare:


 Vision exam + eyewear

 Fitness program


 Over-the-counter (OTC) items

 Personal emergency response system

 Hearing exam + hearing aids

 Telehealth services

 Dental

 Wellness and health care planning

 Transportation



The search tools found at [VantageMedicare.com](https://www.vantagemedicare.com) allow you to compare plans, enroll online, find a provider, look for a pharmacy, and search for covered prescription drugs.

Not all benefits are available in every plan.










BENEFIT COMPARISON CHART

Benefits:	<i>ORIGINAL MEDICARE</i> <i>(based on 2022 Medicare)</i>	VANTAGE BASIC <i>(HMO-POS)</i>								
Monthly Premium	Varies	\$0								
Max Out-Of-Pocket Limit <i>(Does Not Include Part D)</i>	No maximum	\$5,900								
Part B Annual Deductible	\$233	\$0								
Primary Care Provider (PCP)	20%	\$0								
Specialist	20%	\$35								
Preventive Care/Flu Shots	\$0	\$0								
Professional Fees in a Hospital Setting	20%	\$0								
Lab Services	\$0	\$0								
Inpatient Hospital Care	<table border="0"> <tr> <td><u>Days</u></td> <td><u>Patient Responsibility</u></td> </tr> <tr> <td>1-60</td> <td>\$1,556 deductible</td> </tr> <tr> <td>61-90</td> <td>\$389 per day</td> </tr> <tr> <td>91-150</td> <td>\$778 per day</td> </tr> </table>	<u>Days</u>	<u>Patient Responsibility</u>	1-60	\$1,556 deductible	61-90	\$389 per day	91-150	\$778 per day	\$318 per day <i>(Days 1-7)</i> <hr/> \$0 <i>(Days 8-90)</i>
<u>Days</u>	<u>Patient Responsibility</u>									
1-60	\$1,556 deductible									
61-90	\$389 per day									
91-150	\$778 per day									
Outpatient Surgery	20%	\$350								
Emergency Care	20%	\$90								
Major Outpatient Diagnostic <i>(Copay Per Visit)</i>	20%	\$200								



VANTAGE STANDARD <i>(HMO-POS)</i>	VANTAGE GIVEBACK <i>(HMO-POS)</i>
\$31.90	\$0
\$4,900	\$5,900
\$0	\$0
\$0	\$0
\$35	\$35
\$0	\$0
\$0	\$0
\$0	\$0
\$270 <i>per day</i> <i>(Days 1-7)</i>	\$318 <i>per day</i> <i>(Days 1-7)</i>
\$0 <i>(Days 8-90)</i>	\$0 <i>(Days 8-90)</i>
\$250	\$350
\$90	\$90
\$100	\$200

ADDITIONAL BENEFITS CHART

BENEFITS:		VANTAGE BASIC
FLEX BENEFITS	 EYEWEAR <i>(1 pair of glasses or 12 pairs of contacts, includes contact fitting)</i>	\$0 copay; Max benefit \$300/yr
	 OVER-THE-COUNTER ITEMS <i>Per Quarter, No Rollover</i>	\$100
	 HEARING EXAM <i>Annual Hearing Exam</i>	100% covered
	 HEARING AIDS <i>(Both ears combined, includes evaluation/fitting)</i>	\$0 copay; Max benefit \$1,000/yr
	 VISION EXAM <i>Annual Vision Exam</i>	100% covered
	 PREVENTIVE DENTAL	\$0 copay; Max benefit \$400/yr
	 COMPREHENSIVE DENTAL	\$0 copay; Max benefit \$1,000/yr
	 TRANSPORTATION	24 one-way non-emergent rides
	 FITNESS PROGRAM	100% covered
	 PERSONAL EMERGENCY RESPONSE SYSTEM	N/A
 PART B PREMIUM GIVEBACK	N/A	
 TELEHEALTH SERVICES	Telehealth services are limited to	

NOT OFFERED BY ORIGINAL MEDICARE



VANTAGE STANDARD	VANTAGE GIVEBACK
\$0 copay; Max benefit \$300/yr	\$0 copay; Max benefit \$300/yr
\$100	N/A
100% covered	100% covered
\$0 copay; Max benefit \$1,100/yr	\$0 copay; Max benefit \$1,000/yr
100% covered	100% covered
\$0 copay; Max benefit \$400/yr	\$0 copay; Max benefit \$400/yr
\$0 copay; Max benefit \$1,550/yr	\$0 copay; Max benefit \$850/yr
24 one-way non-emergent rides	N/A
100% covered	100% covered
100% covered	N/A
N/A	\$50

certain provider types. Cost share varies depending on provider type.

PRESCRIPTION COVERAGE

Note: Original Medicare does not cover Part D Prescription Drugs.

	VANTAGE BASIC	VANTAGE STANDARD	VANTAGE GIVEBACK
TIER 1 Preferred Generics: Preferred Pharmacies	\$0	\$0	\$0
TIER 1 Preferred Generics: Other Pharmacies	\$8	\$5	\$10
TIER 2 Generics	\$16	\$14	\$20
TIER 3 Preferred Brand	\$47	\$47	\$47 ¹
TIER 4 Brand	\$100 ¹	\$100 ¹	\$100 ¹
TIER 5 Specialty	25% ¹	25% ¹	25% ¹
SELECT INSULINS	\$35	\$35	\$35
PART D DEDUCTIBLE	\$505	\$505	\$505

¹ Part D deductible applies.

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

Vantage Health Plan's pharmacy network includes limited lower-cost, preferred pharmacies in Arkansas. **There are an extremely limited number of preferred cost share pharmacies in Arkansas.** The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call 866-704-0109 (TTY 711) or consult the online pharmacy directory at www.VantageHealthPlan.com/rx. Note: Vantage Health Plan, which is a health insurance company, has ownership control of Saint John Pharmacy. Other pharmacies are available in your network.

PREFERRED PHARMACIES

Using Preferred Pharmacies Saves Money!



DESIARD PHARMACY NETWORK

The DeSiard Pharmacy Network (DPN) is Vantage's preferred network of independent pharmacies where you can fill covered Tier 1 preferred generics for a **\$0 copay**. Many DPN pharmacies offer mail order services or OTC items that can be purchased with your Flex card. Visit VantageHealthPlan.com/dpn to view a complete list of DPN pharmacies.

DPN DIABETIC SUPPLIES PROGRAM

\$0 copay for **GLUCOCARD Shine®** blood glucose strips. With a valid prescription, you can receive up to a 100-day supply of strips along with a free **GLUCOCARD Shine®** Meter that comes with ten complementary strips, ten lancets, and a lancing device. *Limited to one meter per member per year. (Cost share applies to the Glucocard strips and meters at non-DPN pharmacies.)*

Other pharmacies are available in your network.

ADDITIONAL BENEFITS OVERVIEW

FLEX CARD

Vantage provides members with a pre-paid Mastercard debit card (Flex card). Eyewear and over-the-counter allowances which may be covered by your plan are loaded onto your Flex card. Use your Flex card at participating nationwide chain retailers such as WalMart, Walgreens, Dollar General, Albertson's, Kroger, and CVS, as well as many local independent merchants. View balances, search for retail locations, and view and shop for mail order over-the-counter items in the Vantage Member Portal.



EYEWEAR

Use your Flex card annual eyewear allowance to purchase glasses or contacts from participating eyewear providers and retailers. Eyewear Flex funds left over at the end of the year expire and do not carry over to the next year.

OVER-THE-COUNTER (OTC) ITEMS

Use your Flex card quarterly allowance toward a wide range of health-related products available at physical store locations or through our mail order options. OTC Flex funds left over at the end of the quarter expire and do not carry over to the next quarter.

NOT OFFERED BY ORIGINAL MEDICARE

VISION EXAM

An eye exam can tell so much about your overall health; that's why your annual routine eye exam is 100% covered!

HEARING EXAM + HEARING AIDS

Hearing is especially critical to overall health, safety, and happiness so your annual routine hearing exam is 100% covered! Hearing aids are also covered up to the maximum benefit amount of your plan.

DENTAL

Smile bigger knowing you are covered for preventive dental services, including cleanings, oral exams, and x-rays! Comprehensive dental services are also covered up to the maximum benefit amount of your plan.

TRANSPORTATION

Seeing your provider on a regular basis is important, and how you will get there should never be a concern! Our plan covers non-emergent rides for medical treatment using Vantage-approved transportation. Call **1-844-657-7820** to schedule transportation. Some restrictions apply.

Not all benefits are available in every plan.

ADDITIONAL BENEFITS OVERVIEW *cont.*



FITNESS PROGRAM

Enjoy the freedom of a flexible fitness program. Exercise at your gym, join classes from home, and access personalized resources to support your healthy aging journey.



PERSONAL EMERGENCY RESPONSE SYSTEM

Your personal emergency response system gives you peace of mind knowing that emergency help is just a button press away. Qualifying members can choose between a waterproof wrist button or a neck pendant, both GPS-enabled.



TELEHEALTH SERVICES

Qualifying telehealth appointments with your doctor, specialist, podiatrist, nutritionist, behavioral health provider, and occupational/physical/speech therapist are covered.



WELLNESS AND HEALTH CARE PLANNING

Prevention, coordination, and communication drive your health outcomes. Vantage's Wellness and Health Care Planning initiatives like the annual wellness coupon and visit, health risk assessment and case management programs encourage members to be proactive in their healthcare.

Not all benefits are available in every plan.

GIVEBACK PLAN EXPLAINED

Do you really get money back?

WHAT IS THE MEDICARE PART B GIVEBACK BENEFIT?

The Medicare Part B Giveback is a type of Medicare Advantage plan that gives back a portion of the Part B premium that is deducted from your monthly Social Security check. The Vantage Giveback plan pays up to **\$50** of your Part B premium each month. As a result, your monthly Social Security check will increase by this amount. Once enrolled, you do nothing to receive this benefit, we will take care of that for you.



TO BE ELIGIBLE, YOU MUST:

Be enrolled in Original Medicare (Parts A & B) and the Vantage Giveback plan.

Pay your own Part B premium, either directly to Medicare or as a deduction from your Social Security check.

HOW DO I RECEIVE THE MEDICARE GIVEBACK BENEFIT?

You will not receive checks directly from Vantage. You will receive your reduction in one of the following ways:

1. If you pay your Part B premium through Social Security, the Part B Giveback will be credited monthly to your Social Security check.
2. If you don't pay your Part B premium through Social Security, you'll pay a reduced monthly amount directly to Medicare.

WHEN SHOULD I EXPECT TO SEE AN INCREASE?

Processing can take several months after enrolling, so you may not see the increase right away. Any missed increases will be added to your next Social Security check.

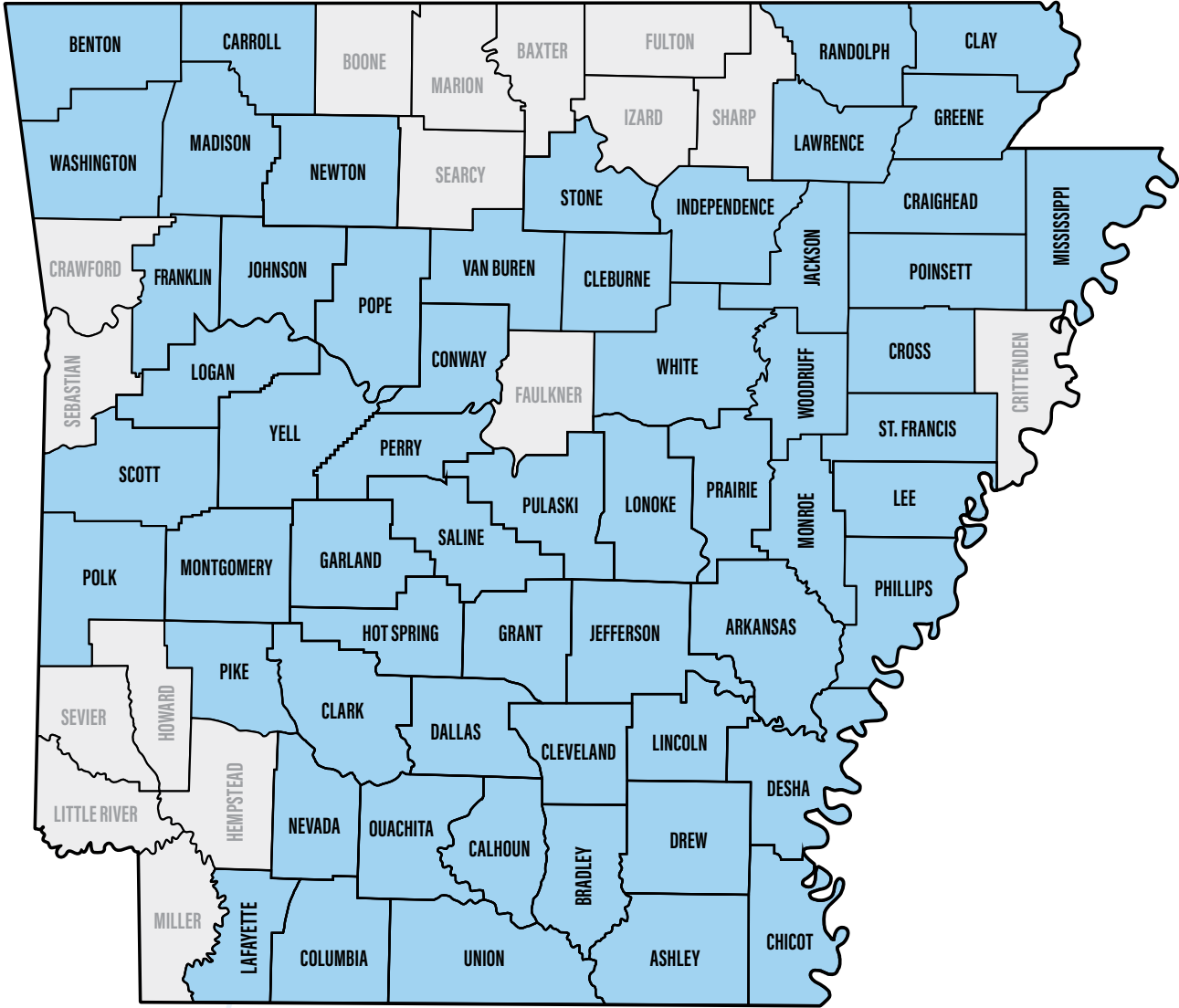
If you disenroll from this plan, your giveback benefit will end. Processing disenrollment can also take several months, and any premium reductions you received after disenrolling will be deducted from your Social Security check.

Freedom to live a healthy life



SERVICE AREA

Vantage Medicare Advantage Coverage Map



MAP LEGEND

- Vantage Medicare Advantage Plans available:
Vantage Basic Plan (HMO-POS)
Vantage Standard Plan (HMO-POS)
Vantage Giveback Plan (HMO-POS)

Employer Group Plans are available in all counties.

TERMS TO KNOW

AMBULATORY SURGICAL CENTER

An entity that furnishes outpatient surgical services to patients not requiring hospitalization and when you are not expected to stay longer than 24 hours.

COINSURANCE

An amount you may be required to pay for services or prescription drugs. Coinsurance is a percentage.

COPAYMENT (COPAY)

An amount you may be required to pay for a medical service or supply like a doctor's visit, hospital outpatient visit, or prescription drugs. A copayment is a set amount instead of a percentage.

COST-SHARING

An amount that a member has to pay when services or drugs are received. Examples are deductible, copayment, and coinsurance.

DEDUCTIBLE

The amount you must spend on drugs or services before your plan pays for healthcare benefits.

DURABLE MEDICAL EQUIPMENT (DME)

Certain medical equipment that your doctor requires you to use for medical reasons. Examples include crutches, diabetic supplies, oxygen equipment, walkers, wheelchairs, hospital beds and more.

FORMULARY

A list of prescription drugs covered by the plan that includes both brand names and generic names.

NETWORK PROVIDER

A provider who accepts your health plan and has a contract with us to provide health care services to you at a pre-negotiated rate.

OUT-OF-NETWORK PROVIDER

A provider who does not have a contract with us to provide health care services to you at a pre-negotiated rate.

PREMIUM

The periodic payment (usually monthly) to Medicare, an insurance company, or a health care plan for coverage they are providing.

PREVENTIVE CARE

Care that helps detect or prevent serious diseases and medical problems before they become major.

PROVIDER

A doctor, hospital, health care professional, health care facility, or pharmacy.

SKILLED NURSING FACILITY

Facility where skilled nursing care and rehabilitation services are provided on a continuous daily basis.

URGENTLY NEEDED SERVICES

Services provided to treat a non-emergent unforeseen medical illness or injury requiring immediate medical care.



SUMMARY OF BENEFITS

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2023 Summary of Benefits

Vantage BASIC (HMO-POS)

H2722 - 002

Vantage STANDARD (HMO-POS)

H2722 - 004

Our plans and service areas:

H2722 - 002 Vantage BASIC (HMO-POS) includes the following counties: Arkansas, Ashley, Benton, Bradley, Calhoun, Carroll, Chicot, Clark, Clay, Cleburne, Cleveland, Columbia, Conway, Craighead, Cross, Dallas, Desha, Drew, Franklin, Garland, Grant, Greene, Hot Spring, Independence, Jackson, Jefferson, Johnson, Lafayette, Lawrence, Lee, Lincoln, Logan, Lonoke, Madison, Mississippi, Monroe, Montgomery, Nevada, Newton, Ouachita, Perry, Phillips, Pike, Poinsett, Polk, Pope, Prairie, Pulaski, Randolph, Saline, Scott, St. Francis, Stone, Union, Van Buren, Washington, White, Woodruff, Yell.

H2722 - 004 Vantage STANDARD (HMO-POS) includes the following counties: Arkansas, Ashley, Benton, Bradley, Calhoun, Carroll, Chicot, Clark, Clay, Cleburne, Cleveland, Columbia, Conway, Craighead, Cross, Dallas, Desha, Drew, Franklin, Garland, Grant, Greene, Hot Spring, Independence, Jackson, Jefferson, Johnson, Lafayette, Lawrence, Lee, Lincoln, Logan, Lonoke, Madison, Mississippi, Monroe, Montgomery, Nevada, Newton, Ouachita, Perry, Phillips, Pike, Poinsett, Polk, Pope, Prairie, Pulaski, Randolph, Saline, Scott, St. Francis, Stone, Union, Van Buren, Washington, White, Woodruff, Yell.

This is a summary of drug and health services covered by Vantage BASIC (HMO-POS) and Vantage STANDARD (HMO-POS) from January 1, 2023 - December 31, 2023.

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

Enrollment in Vantage Health Plan Of Arkansas, 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, 2022 – March 31, 2023. After March 31, 2023, 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) or Vantage STANDARD (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) and Vantage STANDARD (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) 002	Vantage STANDARD (HMO-POS) 004
Monthly plan premium <i>(includes Part C and D)</i>	\$0 You must keep paying your Medicare Part B premium.	\$31.90 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
Maximum out-of-pocket amount <i>(does not include Part D prescription drugs)</i>	For in-network providers: \$5,900 per year	For in-network providers: \$4,900 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>

	Vantage BASIC (HMO-POS) 002	Vantage STANDARD (HMO-POS) 004
<p>Outpatient Hospital coverage Outpatient hospital services</p> <p>Outpatient hospital observation services</p>	<p>In-Network \$0 copay for diagnostic colonoscopies \$350 copay for all other outpatient hospital services <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p> <p>In-Network \$318 copay per day <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>	<p>In-Network \$0 copay for diagnostic colonoscopies \$250 copay for all other outpatient hospital services <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p> <p>In-Network \$270 copay per day <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
<p>Ambulatory Surgical Center (ASC)</p>	<p>In-Network \$0 copay for diagnostic colonoscopies \$350 copay for all other outpatient surgeries <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>	<p>In-Network \$0 copay for diagnostic colonoscopies \$250 copay for all other outpatient surgeries <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
<p>Doctor Visits Primary Care Provider visit</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>

	Vantage BASIC (HMO-POS) 002	Vantage STANDARD (HMO-POS) 004
Specialist visit	<p>In-Network \$35 copay <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>	<p>In-Network \$35 copay <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>

	Vantage BASIC (HMO-POS) 002	Vantage STANDARD (HMO-POS) 004
<p>Preventive Care Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Annual wellness visit • 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>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 Copay is waived if you are admitted to a hospital within 72 hours.</p>	<p>\$90 copay Copay is waived if you are admitted to a hospital within 72 hours.</p>

	Vantage BASIC (HMO-POS) 002	Vantage STANDARD (HMO-POS) 004
Urgently Needed Services (Urgent Care)	\$60 copay inside of the United States	\$60 copay inside of the United States
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>
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>
	In-Network \$0 copay for mammograms \$200 copay for all other diagnostic radiology services <i>Prior Authorization may be required.</i>	In-Network \$0 copay for mammograms \$100 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>
Lab services	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>

	Vantage BASIC (HMO-POS) 002	Vantage STANDARD (HMO-POS) 004
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>
Therapeutic Radiology	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>
	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>
	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	Limited to 1 visit(s) every year In-Network \$0 copay
	Out-of-Network \$0 copay	Out-of-Network \$0 copay
Fitting-evaluation(s) for hearing aids	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 \$0 copay	Out-of-Network \$0 copay

	Vantage BASIC (HMO-POS) 002	Vantage STANDARD (HMO-POS) 004
Hearing aids	<p>\$0 copay 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>\$0 copay 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>
Dental services		
Preventive dental services	Up to a \$400 maximum benefit coverage amount for all in-network and out-of-network covered services every year.	Up to a \$400 maximum benefit coverage amount for all in-network and out-of-network covered services every year.
Oral Exams	<p>Limited to 1 oral exam(s) every six months</p> <p>In-Network \$0 copay</p> <p>Out-of-Network \$0 copay</p>	<p>Limited to 1 oral exam(s) every six months</p> <p>In-Network \$0 copay</p> <p>Out-of-Network \$0 copay</p>
Prophylaxis (Cleaning)	<p>Limited to 1 cleaning(s) every six months</p> <p>In-Network \$0 copay</p> <p>Out-of-Network \$0 copay</p>	<p>Limited to 1 cleaning(s) every six months</p> <p>In-Network \$0 copay</p> <p>Out-of-Network \$0 copay</p>
Fluoride Treatment	<p>Limited to 1 fluoride treatment(s) every six months</p> <p>In-Network \$0 copay</p> <p>Out-of-Network \$0 copay</p>	<p>Limited to 1 fluoride treatment(s) every six months</p> <p>In-Network \$0 copay</p> <p>Out-of-Network \$0 copay</p>

	Vantage BASIC (HMO-POS) 002	Vantage STANDARD (HMO-POS) 004
Dental X-rays	Limited to 1 bitewing x-ray per year. 1 full mouth x-ray every 3 years. These services share visit frequency of 1. In-Network \$0 copay	Limited to 1 bitewing x-ray per year. 1 full mouth x-ray every 3 years. These services share visit frequency of 1. In-Network \$0 copay
Comprehensive dental services	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% coinsurance	Out-of-Network \$0 copay Up to a \$1,550 maximum benefit coverage amount for all in-network and out-of-network covered services every year. In-Network 0% coinsurance
Limited Medicare-covered Dental Services	Out-of-Network \$0 copay In-Network 20% coinsurance for each Medicare-covered service. <i>Prior Authorization is required.</i>	Out-of-Network \$0 copay In-Network 20% coinsurance for each Medicare-covered service. <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>
Vision care Exam to diagnose and treat diseases and conditions of the eye	In-Network \$35 copay Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network \$35 copay Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>

	Vantage BASIC (HMO-POS) 002	Vantage STANDARD (HMO-POS) 004
Diabetic eye exams	In-Network \$0 copay Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network \$0 copay Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
Eyeglasses or contact lenses after cataract surgery	In-Network 20% coinsurance Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network 20% coinsurance Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>
Glaucoma screening	In-Network \$0 copay Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>	In-Network \$0 copay 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 Out-of-Network 50% coinsurance	Limited to 1 visit(s) every year In-Network \$0 copay Out-of-Network 50% coinsurance
Supplemental eyewear Contact lenses Eyeglass lenses Eyeglass frames Eyeglasses (lenses and frames) Upgrades	\$0 copay up to a \$300 combined maximum benefit coverage amount loaded to your Flex card every year. Retailer restrictions may apply.	\$0 copay up to a \$300 combined maximum benefit coverage amount loaded to your Flex card every year. Retailer restrictions may apply.

	Vantage BASIC (HMO-POS) 002	Vantage STANDARD (HMO-POS) 004
Mental Health Services		
Inpatient stay	<p>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></p> <p>Out-of-Network 50% coinsurance for each Medicare-covered hospital stay. <i>Prior Authorization is required.</i></p>	<p>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></p> <p>Out-of-Network 50% coinsurance for each Medicare-covered hospital stay. <i>Prior Authorization is required.</i></p>
Outpatient group therapy visit	<p>In-Network \$40 copay <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>	<p>In-Network \$30 copay <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
Outpatient individual therapy visit	<p>In-Network \$40 copay <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>	<p>In-Network \$30 copay <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>

	Vantage BASIC (HMO-POS) 002	Vantage STANDARD (HMO-POS) 004
<p>Skilled nursing facility (SNF) care Our plan covers up to 100 days in a Skilled Nursing Facility. Three-day prior hospital stay is required.</p>	<p>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></p> <p>Out-of-Network 50% coinsurance for each Medicare-covered skilled nursing facility stay. <i>Prior Authorization is required.</i></p>	<p>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></p> <p>Out-of-Network 50% coinsurance for each Medicare-covered skilled nursing facility stay. <i>Prior Authorization is required.</i></p>
<p>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.</p>	<p>In-Network \$20 copay per visit <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>	<p>In-Network \$10 copay per visit <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
<p>Ambulance services Ground Ambulance Copay applies to each one-way trip.</p>	<p>In-Network \$250 copay <i>Prior Authorization may be required.</i></p> <p>Out-of-Network \$250 copay for emergent ambulance 50% coinsurance for non-emergent ambulance <i>Prior Authorization may be required.</i></p>	<p>In-Network \$250 copay <i>Prior Authorization may be required.</i></p> <p>Out-of-Network \$250 copay for emergent ambulance 50% coinsurance for non-emergent ambulance <i>Prior Authorization may be required.</i></p>

	Vantage BASIC (HMO-POS) 002	Vantage STANDARD (HMO-POS) 004
Air Ambulance	<p>In-Network 20% coinsurance <i>Prior Authorization is required.</i></p> <p>Out-of-Network 20% coinsurance for emergent ambulance 50% coinsurance for non-emergent ambulance <i>Prior Authorization is required.</i></p>	<p>In-Network 20% coinsurance <i>Prior Authorization is required.</i></p> <p>Out-of-Network 20% coinsurance for emergent ambulance 50% coinsurance for non-emergent ambulance <i>Prior Authorization is required.</i></p>
Transportation	<p>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></p> <p>Out-of-Network <u>Not covered</u></p>	<p>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></p> <p>Out-of-Network <u>Not covered</u></p>
<p>Medicare Part B prescription drugs</p> <p>Chemotherapy/Radiation drugs</p>	<p>In-Network 20% coinsurance <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>	<p>In-Network 20% coinsurance <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>

	Vantage BASIC (HMO-POS) 002	Vantage STANDARD (HMO-POS) 004
Other Part B drugs	<p>In-Network 20% coinsurance <i>Prior Authorization may be required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>	<p>In-Network 20% coinsurance <i>Prior Authorization may be required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>

Prescription Drug Coverage	Vantage BASIC (HMO-POS)		Vantage STANDARD (HMO-POS)	
Stage 1: Annual Prescription Deductible				
Deductible	\$505 prescription drug deductible applies to drugs in Tier 4 and Tier 5 Select insulins do not apply to your Annual Prescription Drug Deductible.			
Stage 2: Initial Coverage (after you meet your deductible, if applicable)				
<p>After you meet your deductible (if applicable), you pay the following until your total yearly drug costs reach \$4,660. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p> <p>Vantage participates in the Part D Senior Savings Model which covers select insulins for all members for a \$35 copay (31-day supply) and a \$105 copay (100-day supply).</p>				
Preferred Retail and Saint John Pharmacy* Mail-Order Cost-Sharing				
	31-Day	100-Day	31-Day	100-Day
Tier 1 (Preferred Generics)	\$0 copay	\$0 copay	\$0 copay	\$0 copay
Tier 2 (Generics)	\$16 copay	\$48 copay	\$14 copay	\$42 copay
Tier 3 (Preferred Brand)	\$47 copay \$35 copay for select insulins	\$141 copay \$105 copay for select insulins	\$47 copay \$35 copay for select insulins	\$141 copay \$105 copay for select insulins
Tier 4 (Non-Preferred Brand)	\$100 copay \$35 copay for select insulins	\$300 copay \$105 copay for select insulins	\$100 copay \$35 copay for select insulins	\$300 copay \$105 copay for select insulins
Tier 5 (Specialty Tier)	25% coinsurance \$35 copay for select insulins	Not Offered	25% coinsurance \$35 copay for select insulins	Not Offered
<p>*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 1-866-704-0109.</p>				

Prescription Drug Coverage	Vantage BASIC (HMO-POS)		Vantage STANDARD (HMO-POS)	
	31-Day	100-Day	31-Day	100-Day
Standard Retail and Mail-Order Cost-Sharing				
Tier 1 (Preferred Generics)	\$8 copay	\$24 copay	\$5 copay	\$15 copay
Tier 2 (Generics)	\$16 copay	\$48 copay	\$14 copay	\$42 copay
Tier 3 (Preferred Brand)	\$47 copay \$35 copay for select insulins	\$141 copay \$105 copay for select insulins	\$47 copay \$35 copay for select insulins	\$141 copay \$105 copay for select insulins
Tier 4 (Non-Preferred Brand)	\$100 copay \$35 copay for select insulins	\$300 copay \$105 copay for select insulins	\$100 copay \$35 copay for select insulins	\$300 copay \$105 copay for select insulins
Tier 5 (Specialty Tier)	25% coinsurance \$35 copay for select insulins	Not Offered	25% coinsurance \$35 copay for select insulins	Not Offered
<p>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. You pay retail pharmacy prices while staying in a long term facility.</p>				

Prescription Drug Coverage	Vantage BASIC (HMO-POS)	Vantage STANDARD (HMO-POS)
Stage 3: Coverage Gap		
<p>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 \$4,660.</p> <p>For covered generic drugs, you pay</p> <ul style="list-style-type: none"> • \$0 copay for a 31-day or 100-day supply of Tier 1 Preferred Generic drugs from a preferred retail pharmacy or from Saint John Pharmacy. • Tier 1 copay for a 31-day supply of Tier 1 Preferred Generic drugs from all other retail pharmacies, or • 25% of the plan’s costs, whichever is lower. <p>For all other covered generics and brand name drugs, you pay 25% of the plan’s cost (plus a portion of the dispensing fee).</p> <p>Select insulins for all members are covered through the coverage gap under the Part D Senior Savings Model for a \$35 copay (31-day supply) and a \$105 copay (31-day supply).</p> <p>You stay in this stage until your year-to-date “out-of-pocket costs” (your payments) reach a total of \$7,400.</p>		
Stage 4: Catastrophic Coverage		
<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$7,400, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% coinsurance, or • \$4.15 copay for generic drugs (including brand drugs treated as generic) and a \$10.35 copay for all other drugs. <p>For Tier 1 Preferred Generic Drugs, you continue to pay your Tier 1 copay in this stage.</p>		

Cost-sharing may differ based on point-of-service (mail-order, retail, Long Term Care (LTC)), home infusion, whether the pharmacy is in our preferred or standard network, or whether the prescription is a short-term (31-day supply) or long-term (100-day supply).

Other Covered Benefits

	Vantage BASIC (HMO-POS) 002	Vantage STANDARD (HMO-POS) 004
Cardiac (Heart) Rehabilitation Services	<p>In-Network \$40 copay per session for cardiac rehabilitation services \$60 copay per session for intensive cardiac rehabilitation services <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>	<p>In-Network \$40 copay per session for cardiac rehabilitation services \$60 copay per session for intensive cardiac rehabilitation services <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
Chiropractic services	<p>In-Network \$20 copay <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>	<p>In-Network \$20 copay <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
Diabetic monitoring supplies	<p>Arkray at Preferred Pharmacies: 0% coinsurance <i>Prior Authorization may be required.</i></p> <p>All other brands/pharmacies: 20% coinsurance <i>Prior Authorization may be required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>	<p>Arkray at Preferred Pharmacies: 0% coinsurance <i>Prior Authorization may be required.</i></p> <p>All other brands/pharmacies: 20% coinsurance <i>Prior Authorization may be required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>

	Vantage BASIC (HMO-POS) 002	Vantage STANDARD (HMO-POS) 004
Diabetes Self-Management Training	<p>In-Network 20% coinsurance <i>Prior Authorization may be required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>	<p>In-Network 20% coinsurance <i>Prior Authorization may be required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
Diabetic therapeutic shoes or inserts	<p>In-Network 20% coinsurance <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>	<p>In-Network 20% coinsurance <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
Durable medical equipment (DME) and related supplies	<p>In-Network 20% coinsurance <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>	<p>In-Network 20% coinsurance <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
Podiatry services (foot care)	<p>In-Network \$35 copay <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>	<p>In-Network \$35 copay <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>

	Vantage BASIC (HMO-POS) 002	Vantage STANDARD (HMO-POS) 004
Home health agency care	<p>In-Network \$0 copay <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>	<p>In-Network \$0 copay <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
<p>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 us for more details.</p>	\$0 copay	\$0 copay
<p>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.</p>	<p>In-Network \$20 copay per visit <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>	<p>In-Network \$10 copay per visit <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
Outpatient substance abuse services	<p>In-Network \$40 copay <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>	<p>In-Network \$30 copay <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>

	Vantage BASIC (HMO-POS) 002	Vantage STANDARD (HMO-POS) 004
Prosthetic devices and related supplies	<p>In-Network 20% coinsurance <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>	<p>In-Network 20% coinsurance <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
Renal Dialysis Services	<p>In-Network 20% coinsurance <i>Prior Authorization is required.</i></p> <p>Out-of-Network 20% coinsurance <i>Prior Authorization is required.</i></p>	<p>In-Network 20% coinsurance <i>Prior Authorization is required.</i></p> <p>Out-of-Network 20% coinsurance <i>Prior Authorization is required.</i></p>
<p>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.</p>	<p>In-Network \$20 copay per visit <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>	<p>In-Network \$10 copay per visit <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
Worldwide emergency coverage	\$90 copay	\$90 copay

Extra Benefits

	Vantage BASIC (HMO-POS) 002	Vantage STANDARD (HMO-POS) 004
Health and wellness education programs	Vantage Health Plan offers a fitness benefit for Medicare members by providing access to hundreds of fitness locations throughout the state of Arkansas and thousands more nationwide.	
Over-the-counter benefit	You are eligible for a \$100 maximum benefit coverage amount loaded to your Flex card 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
Additional Telehealth	Includes qualifying appointments with primary care providers, physician specialists, podiatrists, other healthcare professionals, dieticians, behavioral health providers, and occupational/physical/speech therapists.	

2023 Summary of Benefits

Vantage Giveback (HMO-POS)

H2722 - 005

H2722 - 005 Vantage Giveback (HMO-POS) includes the following parishes: Arkansas, Ashley, Benton, Bradley, Calhoun, Carroll, Chicot, Clark, Clay, Cleburne, Cleveland, Columbia, Conway, Craighead, Cross, Dallas, Desha, Drew, Franklin, Garland, Grant, Greene, Hot Spring, Independence, Jackson, Jefferson, Johnson, Lafayette, Lawrence, Lee, Lincoln, Logan, Lonoke, Madison, Mississippi, Monroe, Montgomery, Nevada, Newton, Ouachita, Perry, Phillips, Pike, Poinsett, Polk, Pope, Prairie, Pulaski, Randolph, Saline, Scott, St. Francis, Stone, Union, Van Buren, Washington, White, Woodruff, Yell.

This is a summary of drug and health services covered by Vantage Giveback (HMO-POS) from January 1, 2023 - December 31, 2023.

Vantage Health Plan Of Arkansas, Inc. is an HMO plan with a Medicare contract. Enrollment in Vantage Health Plan Of Arkansas, 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, 2022 – March 31, 2023. After March 31, 2023, 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 Giveback (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 Giveback (HMO-POS) has 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 Giveback (HMO-POS) 005
Monthly plan premium <i>(includes Part C and D)</i>	\$0 You must keep paying your Medicare Part B premium.
Part B Premium Reduction	This plan offers a \$50 give back every month in your Social Security check.
Medical Deductible	\$500 per year for point-of-service (POS) benefits
Maximum out-of-pocket amount <i>(does not include Part D prescription drugs)</i>	For in-network providers: \$5,900 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>
Outpatient Hospital coverage Outpatient hospital services Outpatient hospital observation services	In-Network \$0 copay for diagnostic colonoscopies \$350 copay for all other outpatient hospital services <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i> In-Network \$318 copay per day <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>

	<p>Vantage Giveback (HMO-POS) 005</p>
<p>Ambulatory Surgical Center (ASC)</p>	<p>In-Network \$0 copay for diagnostic colonoscopies \$350 copay for all other outpatient surgeries <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
<p>Doctor Visits</p> <p>Primary Care Provider visit</p> <p>Specialist visit</p>	<p>In-Network \$0 copay</p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p> <p>In-Network \$35 copay <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>

	Vantage Giveback (HMO-POS) 005
<p>Preventive Care Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Annual wellness visit • 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>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 Copay is waived if you are admitted to a hospital within 72 hours.</p>

	<p>Vantage Giveback (HMO-POS) 005</p>
<p>Urgently Needed Services (Urgent Care)</p>	<p>\$60 copay inside of the United States</p>
<p>Diagnostic Services/Labs/Imaging</p>	
<p>Diagnostic tests and procedures</p>	<p>In-Network 0% - 20% coinsurance depending on place of service <i>Prior Authorization may be required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
<p>Diagnostic radiology services (e.g. MRI, CT Scan)</p>	<p>In-Network \$0 copay for mammograms \$200 copay for all other diagnostic radiology services <i>Prior Authorization may be required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
<p>Lab services</p>	<p>In-Network \$0 copay <i>Prior Authorization may be required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
<p>Outpatient X-rays</p>	<p>In-Network 20% coinsurance <i>Prior Authorization may be required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
<p>Therapeutic Radiology</p>	<p>In-Network 20% coinsurance <i>Prior Authorization may be required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>

	<p>Vantage Giveback (HMO-POS) 005</p>
<p>Hearing services</p> <p>Exam to diagnose and treat hearing and balance issues</p> <p>Routine hearing exam</p> <p>Fitting-evaluation(s) for hearing aids</p> <p>Hearing aids</p>	<p>In-Network 20% coinsurance <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p> <p>Limited to 1 visit(s) every year</p> <p>In-Network \$0 copay</p> <p>Out-of-Network \$0 copay</p> <p>Limited to 1 visit(s) every year</p> <p>In-Network \$0 copay</p> <p>Out-of-Network \$0 copay</p> <p>\$0 copay 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</p> <p>In-Network \$0 copay</p> <p>Out-of-Network \$0 copay</p>

	Vantage Giveback (HMO-POS) 005
Prophylaxis (Cleaning)	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
Dental X-rays	Limited to 1 bitewing x-ray per year. 1 full mouth x-ray every 3 years. These services share visit frequency of 1. In-Network \$0 copay Out-of-Network \$0 copay
Comprehensive dental services	Up to a \$850 maximum benefit coverage amount for all in-network and out-of-network covered services every year. In-Network 0% coinsurance Out-of-Network \$0 copay
Limited Medicare-covered Dental Services	In-Network 20% coinsurance for each Medicare-covered service. <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>

	Vantage Giveback (HMO-POS) 005
Vision care	
Exam to diagnose and treat diseases and conditions of the eye	<p>In-Network \$35 copay</p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
Diabetic eye exams	<p>In-Network \$0 copay</p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
Eyeglasses or contact lenses after cataract surgery	<p>In-Network 20% coinsurance</p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
Glaucoma screening	<p>In-Network \$0 copay</p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
Routine eye exam	<p>Limited to 1 visit(s) every year</p> <p>In-Network \$0 copay</p> <p>Out-of-Network 50% coinsurance</p>
Supplemental eyewear	<p>\$0 copay up to a \$300 combined maximum benefit coverage amount loaded to your Flex card every year. Retailer restrictions may apply.</p>
Contact lenses	
Eyeglass lenses	
Eyeglass frames	
Eyeglasses (lenses and frames)	
Upgrades	

	<p>Vantage Giveback (HMO-POS) 005</p>
<p>Mental Health Services</p> <p>Inpatient stay</p> <p>Outpatient group therapy visit</p> <p>Outpatient individual therapy visit</p>	<p>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></p> <p>Out-of-Network 50% coinsurance for each Medicare-covered hospital stay. <i>Prior Authorization is required.</i></p> <p>In-Network \$40 copay <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p> <p>In-Network \$40 copay <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
<p>Skilled nursing facility (SNF) care Our plan covers up to 100 days in a Skilled Nursing Facility. Three-day prior hospital stay is required.</p>	<p>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></p> <p>Out-of-Network 50% coinsurance for each Medicare-covered skilled nursing facility stay. <i>Prior Authorization is required.</i></p>

	Vantage Giveback (HMO-POS) 005
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>
Ambulance services Ground Ambulance Copay applies to each one-way trip. Air Ambulance	In-Network \$250 copay <i>Prior Authorization may be required.</i> Out-of-Network \$250 copay for emergent ambulance 50% coinsurance for non-emergent ambulance <i>Prior Authorization may be required.</i> In-Network 20% coinsurance <i>Prior Authorization is required.</i> Out-of-Network 20% coinsurance for emergent ambulance 50% coinsurance for non-emergent ambulance <i>Prior Authorization is required.</i>
Transportation	In-Network <u>Not covered</u> Out-of-Network <u>Not covered</u>
Medicare Part B prescription drugs Chemotherapy/Radiation drugs	In-Network 20% coinsurance <i>Prior Authorization is required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>

	Vantage Giveback (HMO-POS) 005
Other Part B drugs	In-Network 20% coinsurance <i>Prior Authorization may be required.</i> Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i>

Prescription Drug Coverage	Vantage Giveback (HMO-POS)	
Stage 1: Annual Prescription Deductible		
Deductible	\$505 prescription drug deductible applies to drugs in Tier 3, Tier 4, and Tier 5 Select insulins do not apply to your Annual Prescription Drug Deductible.	
Stage 2: Initial Coverage (after you meet your deductible, if applicable)		
<p>After you meet your deductible (if applicable), you pay the following until your total yearly drug costs reach \$4,660. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p> <p>Vantage participates in the Part D Senior Savings Model which covers select insulins for all members for a \$35 copay (31-day supply) and a \$105 copay (100-day supply).</p>		
Preferred Retail and Saint John Pharmacy* Mail-Order Cost-Sharing		
	31-Day	100-Day
Tier 1 (Preferred Generics)	\$0 copay	\$0 copay
Tier 2 (Generics)	\$20 copay	\$60 copay
Tier 3 (Preferred Brand)	\$47 copay \$35 copay for select insulins	\$141 copay \$105 copay for select insulins
Tier 4 (Non-Preferred Brand)	\$100 copay \$35 copay for select insulins	\$300 copay \$105 copay for select insulins
Tier 5 (Specialty Tier)	25% coinsurance \$35 copay for select insulins	Not Offered
<p>*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 1-866-704-0109.</p>		

Prescription Drug Coverage	Vantage Giveback (HMO-POS)	
Standard Retail and Mail-Order Cost-Sharing		
	31-Day	100-Day
Tier 1 (Preferred Generics)	\$10 copay	\$30 copay
Tier 2 (Generics)	\$20 copay	\$60 copay
Tier 3 (Preferred Brand)	\$47 copay \$35 copay for select insulins	\$141 copay \$105 copay for select insulins
Tier 4 (Non-Preferred Brand)	\$100 copay \$35 copay for select insulins	\$300 copay \$105 copay for select insulins
Tier 5 (Specialty Tier)	25% coinsurance \$35 copay for select insulins	Not Offered
<p>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. You pay retail pharmacy prices while staying in a long term facility.</p>		

Prescription Drug Coverage	Vantage Giveback (HMO-POS)
Stage 3: Coverage Gap	
<p>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 \$4,660.</p> <p>For covered generic drugs, you pay</p> <ul style="list-style-type: none"> • \$0 copay for a 31-day or 100-day supply of Tier 1 Preferred Generic drugs from a preferred retail pharmacy or from Saint John Pharmacy. • Tier 1 copay for a 31-day supply of Tier 1 Preferred Generic drugs from all other retail pharmacies, or • 25% of the plan’s costs, whichever is lower. <p>For all other covered generics and brand name drugs, you pay 25% of the plan’s cost (plus a portion of the dispensing fee).</p> <p>Select insulins for all members are covered through the coverage gap under the Part D Senior Savings Model for a \$35 copay (31-day supply) and a \$105 copay (31-day supply).</p> <p>You stay in this stage until your year-to-date “out-of-pocket costs” (your payments) reach a total of \$7,400.</p>	
Stage 4: Catastrophic Coverage	
<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$7,400, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% coinsurance, or • \$4.15 copay for generic drugs (including brand drugs treated as generic) and a \$10.35 copay for all other drugs. 	

Cost-sharing may differ based on point-of-service (mail-order, retail, Long Term Care (LTC)), home infusion, whether the pharmacy is in our preferred or standard network, or whether the prescription is a short-term (31-day supply) or long-term (100-day supply).

Other Covered Benefits

	Vantage Giveback (HMO-POS) 005
Cardiac (Heart) Rehabilitation Services	<p>In-Network \$40 copay per session for cardiac rehabilitation services \$60 copay per session for intensive cardiac rehabilitation services <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
Chiropractic services	<p>In-Network \$20 copay <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
Diabetic monitoring supplies	<p>Arkray at Preferred Pharmacies: 0% coinsurance <i>Prior Authorization may be required.</i></p> <p>All other brands/pharmacies: 20% coinsurance <i>Prior Authorization may be required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
Diabetes Self-Management Training	<p>In-Network 20% coinsurance <i>Prior Authorization may be required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>

	Vantage Giveback (HMO-POS) 005
Diabetic therapeutic shoes or inserts	<p>In-Network 20% coinsurance <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
Durable medical equipment (DME) and related supplies	<p>In-Network 20% coinsurance <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
Podiatry services (foot care)	<p>In-Network \$35 copay <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
Home health agency care	<p>In-Network \$0 copay <i>Prior Authorization is required.</i></p> <p>Out-of-Network 50% coinsurance <i>Prior Authorization is required.</i></p>
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 us for more details.	\$0 copay

	Vantage Giveback (HMO-POS) 005
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>
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>
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>
Renal Dialysis Services	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>
Worldwide emergency coverage	\$90 copay

Extra Benefits

	Vantage Giveback (HMO-POS) 005
Health and wellness education programs	Vantage Health Plan offers a fitness benefit for Medicare members by providing access to hundreds of fitness locations throughout the state of Arkansas and thousands more nationwide.
Additional Telehealth	Includes qualifying appointments with primary care providers, physician specialists, podiatrists, other healthcare professionals, dietitians, behavioral health providers, and occupational/physical/speech therapists.

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ENROLLMENT INFORMATION

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ENROLLMENT PERIODS

There are different enrollment periods for Medicare beneficiaries. Most people are automatically enrolled in Medicare Part A when they turn 65. Once you enroll in Part B, you can select a Medicare Advantage plan. The chart below explains enrollment periods, their time frames, and the requirements for enrolling during that time.

PERIOD NAME	TIME FRAME	ABOUT ENROLLMENT PERIOD
INITIAL ENROLLMENT PERIOD (IEP)	3 months before to 3 months after becoming eligible for Medicare	Limited to those turning 65 or who qualify as disabled and are eligible for Medicare for the first time.
ANNUAL ENROLLMENT PERIOD (AEP)	October 15 - December 7	Move from Original Medicare to a Medicare Advantage plan and vice versa, or join a different Medicare plan.
OPEN ENROLLMENT PERIOD (OEP)	January 1 - March 31	If enrolled in a Medicare Advantage plan, you can switch to another Medicare Advantage plan, return to Original Medicare, or change Part D coverage.
SPECIAL ENROLLMENT PERIOD (SEP)	YEAR ROUND	Available during special circumstances like moving to a new area or losing employer coverage.

HOW TO ENROLL

Vantage makes enrolling easy, and it only takes a few minutes!

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



ENROLL OVER THE PHONE

Give us a call and a friendly Vantage representative will be happy to help you enroll over the phone. Call **866-704-0109 (TTY 711)**, 8 a.m. to 8 p.m. seven days a week from October 1 - March 31 and five days a week for all other dates.



REQUEST A HOME VISIT

If you prefer, one of our dedicated representatives can come to you and review your options with you or help you enroll from the comfort of your own home. To request a one-on-one home visit, call **866-704-0109 (TTY 711)**.



VISIT THE VANTAGE WEBSITE

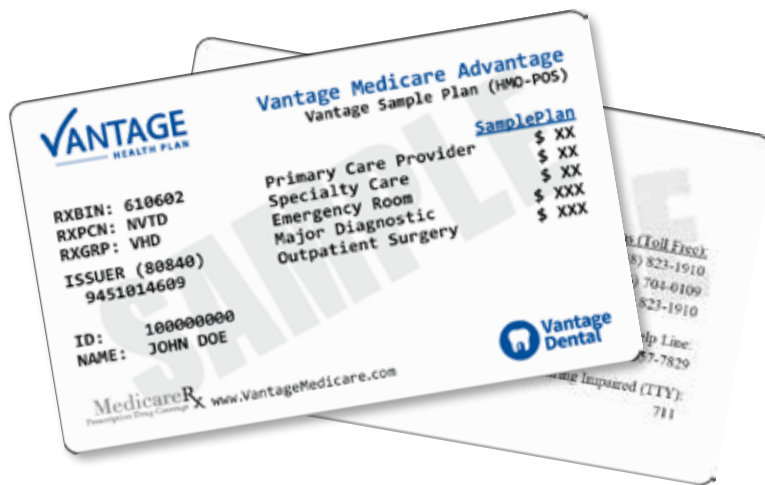
Visit our website at www.VantageMedicare.com to enroll online or for additional information.



ATTEND A SNACK & LEARN MEETING

Be our guest at any one of our Snack & Learn events in your area. You can call **866-704-0109 (TTY 711)** to find a meeting near you.

You can also enroll in a Vantage Medicare Advantage plan through the CMS Online Enrollment Center at www.Medicare.gov.



WHAT TO EXPECT AFTER ENROLLING

After you have completed and submitted your enrollment application to Vantage, it 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, show your new Vantage Medicare Advantage ID card for healthcare and pharmacy services.

(866) 704-0109 | TTY 711

HOURS OF OPERATION:

8:00 A.M. – 8:00 P.M.

Oct 1 - March 31:
SEVEN DAYS A WEEK

All other dates:
MONDAY - FRIDAY

www.VantageMedicare.com



FORMS

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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).

Understanding the Benefits

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. 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.
- Review the formulary to make sure your drugs are covered.

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, 2024.
- Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, 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 copay for services received by non-contracted providers.



2023 Medicare Advantage Enrollment Election Form



Vantage Medicare Advantage

Who can use this form?

People with Medicare who want to join a Medicare Advantage 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](https://www.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.

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 0938-1378. 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.

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 377
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.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g. social security checks) may be considered your permanent residence address.

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

Select the plan you want to join:

- _____ **Vantage Basic (HMO-POS)** **002-000** **\$0.00 per month**
- _____ **Vantage Standard (HMO-POS)** **004-000** **\$31.90 per month**
- _____ **Vantage Giveback (HMO-POS)** **005-000** **\$0.00 per month**

Available to residents of the following counties: Arkansas, Ashley, Benton, Bradley, Calhoun, Carroll, Chicot, Clark, Clay, Cleburne, Cleveland, Columbia, Conway, Craighead, Cross, Dallas, Desha, Drew, Franklin, Garland, Grant, Greene, Hot Spring, Independence, Jackson, Jefferson, Johnson, Lafayette, Lawrence, Lee, Lincoln, Logan, Lonoke, Madison, Mississippi, Monroe, Montgomery, Nevada, Newton, Ouachita, Perry, Philips, Pike, Poinsett, Polk, Pope, Prairie, Pulaski, Randolph, Saline, Scott, St. Francis, Stone, Union, Van Buren, Washington, White, Woodruff, and Yell.

Your information:

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

Birth Date: (MM/DD/YYYY)

___ / ___ / _____

Sex:

Male Female

Phone Number:

(____)____-_____

Emergency Contact (Optional): _____

Phone Number: _____ Relationship to you: _____

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

City: _____ County/Parish (Optional): _____ State: _____ ZIP Code: _____

Mailing Address, if different from your Permanent Address (P.O. Box allowed):

City: _____ State: _____ ZIP Code: _____

Name of staff member/agent/broker (if assisted in enrollment): _____

Broker Name: _____ Broker NPN: _____

Company Name: _____

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:

Section 1 (continued)

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 6). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA or Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans.)
- 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.
- 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 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: _____

If you are the authorized representative, sign above and fill out these fields:

Name: _____

Address: _____

Phone Number: _____ Relationship to Enrollee: _____

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, 2022 through March 31, 2023. For all other dates, Member Services is available Monday through Friday, 8:00 a.m. – 8:00 p.m. CST.

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.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- | | |
|---|--|
| <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin | <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a |
| <input type="checkbox"/> Yes, Puerto Rican | <input type="checkbox"/> Yes, Cuban |
| <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin | |
| <input type="checkbox"/> I choose not to answer. | |

What's your race? Select all that apply.

- | | | |
|---|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Black or African American |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Filipino | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Korean | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Other Asian | <input type="checkbox"/> Other Pacific Islander | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Vietnamese | <input type="checkbox"/> White | |
| <input type="checkbox"/> I choose not to answer | | |

Select one 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, 2022 through March 31, 2023. 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), clinic, or health center:

I want to get the following materials via email. Select one or more.

- Annual Notice of Changes Evidence of Coverage
- Provider Directory Pharmacy Directory Formulary

E-mail address: _____

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AUTHORIZED PERSONAL REPRESENTATIVE (APR) FORM



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

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: (Medicare APRs will term automatically after 365 days)
*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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Arkansas 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:

- Vantage Basic (HMO-POS)
- Vantage Standard (HMO-POS)
- Vantage Giveback (HMO-POS)
- 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 377, 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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NONDISCRIMINATION NOTICE

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

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

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

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

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

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

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

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

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

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

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

MULTI-LANGUAGE INSERT
MULTI-LANGUAGE INTERPRETER SERVICES

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

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

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

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 888-823-1910 (TTY 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 888-823-1910 (TTY 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 888-823-1910 (TTY 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 888-823-1910 (TTY 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 888-823-1910 (TTY 711) 번으로 문의해 주십시오. 한국어를 하는 담당자도 도와드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 888-823-1910 (TTY 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 888-823-1910 (TTY 711). سيقوم شخص ما بتحدث العربية بمساعدتك. هذه خدمة مجانية.

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

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

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 888-823-1910 (TTY 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

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

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 888-823-1910 (TTY 711). Ta usługa jest bezpłatna.

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

Choctaw: Chishnoat yvmmakosh chi apelaachih, hachishnovt ponaklo pilah Vantage Health Plan achih, chi ishtimpakvt chi nokfokah annopa chim annopoli keyo tvli holissoh ishahlih. Yvmma-kosh annopoli tosholi, makachi telefon 888-823-1910 (TTY 711).

Laotian: ພວກເຮົາມີບໍລິການແປພາສາພາສາລາວເພື່ອຕອບຄໍາຖາມໃດໆທີ່ທ່ານອາດມີກ່ຽວກັບແຜນສຸຂະພາບຫຼືຢາຂອງພວກເຮົາ. ເພື່ອຮັບຜູ້ແປພາສາ, ພາຍໃຈທ່ານສູນພວກເຮົາທີ່ 888-823-1910 (TTY 711). ຄົນທີ່ເວົ້າພາສາລາວສາມາດຊ່ວຍທ່ານໄດ້. ບໍ່ແມ່ນການບໍລິການພາສາ.

Persian: ما خدمات مترجم رایگان برای پاسخ به هر گونه سوال شما ممکن است در مورد سلامت ما و یا طرح مواد مخدر داشته 1910-823-888 تماس بگیرید. کسی که فارسی صحبت می کند می تواند به (TTY 711) باشد. برای دریافت مترجم، فقط با ما در 1910-823-888. شما کمک کند. این یک سرویس رایگان است.

Urdu: ہمارے پاس ہماری صحت یا منشیات کے منصوبے کے بارے میں آپ کے کسی بھی سوال کا جواب دینے کے لئے مفت ترجمان خدمات ہیں۔ ایک ترجمان حاصل کرنے کے لئے، صرف ہمیں 888-823-1910 (ٹی وائی 711) پر کال کریں۔ جو کوئی اردو بولتا ہے وہ آپ کی مدد کر سکتا ہے۔ یہ ایک مفت سروس ہے۔



Freedom to live a healthy life

LOCATIONS

**CORPORATE
HEADQUARTERS**
130 DeSiard Street
Suite 300
Monroe, LA 71201

**CUSTOMER SERVICE
AND SALES**
122 St. John Street
Monroe, LA 71201

HOURS OF OPERATION

OCTOBER 1, 2022 - MARCH 31, 2023
Seven Days a Week, 8 a.m. - 8 p.m.

ALL OTHER DATES:
Monday - Friday, 8 a.m. - 8 p.m.

CONTACT INFO

PHONE:
(866) 704-0109 (TTY 711)

www.VantageMedicare.com