The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.vantagehealthplan.com or call 1-888-823-1910. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.vantagehealthplan.com or call 1-888-823-1910 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 for In-Network medical covered services	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Out-of-Network preventive care is not subject to the Out-of-Network deductible.	This plan covers some items and services even if you haven't yet met the out-of-network deductible amount, but a coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your out-of-network deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Out-of-Network Medical Deductible: $1,500 (1 member); $3,000 (2 members); $4,500 (3 or more members)	Generally, you must pay all of the costs from out-of-network providers up to the deductible amount before this plan begins to pay.
What is the out-of-pocket limit for this plan?	In-Network Medical: $2,000 (1 member); $3,000 (2 members); $4,000 (3 or more members)	The out-of-pocket limit is the amount you could pay in a year for most in-network medical covered services.
What is not included in the out-of-pocket limit?	Premiums, Out-of-Network, balance-billing charges, some coinsurance, healthcare this plan doesn't cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. Visit www.VantageHealthPlan.com and click "Find a Provider" or call 1-888-823-1910 for a list of network providers.	You pay the least if you use a provider in Affinity Health Network (AHN). You pay more if you use a provider in the Vantage Standard Network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work).
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

* For more information about limitations and exceptions, see the plan or policy document at www.vantagehealthplan.com.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 AHN or $20 copay	50% coinsurance	None
	Specialist visit	$35 AHN or $45 copay	50% coinsurance	None
	Preventive care/screening/ immunization	100% coverage	50% coinsurance	As required by law.
If you have a test	Diagnostic test (x-ray, blood work)	100% coverage	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$0 AHN or $50 copay/test	50% coinsurance	Pre-auth required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.vhpla.com	Generic drugs (Tiers I and II)	$5 or $20 copay per prescription (retail/mail order)	Not covered	1 copay for 30 day supply; 2 copays for 31-60 day supply; 3 copays for 61-90 day supply
	Preferred brand drugs (Tier III)	$50 copay per prescription (retail/mail order)	Not covered	1 copay for 30 day supply; 2 copays for 31-60 day supply; 3 copays for 61-90 day supply
	Non-preferred brand drugs (Tier IV)	$80 copay per prescription (retail/mail order)	Not covered	1 copay for 30 day supply; 2 copays for 31-60 day supply; 3 copays for 61-90 day supply
	Specialty drugs (Tier V)	$150 copay per prescription (retail only)	Not covered	1 copay for 30 day supply (retail); mail order not applicable.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 AHN or $100 copay	50% coinsurance	Pre-auth required.
	Physician/surgeon fees	100% coverage	50% coinsurance	Pre-auth required.
If you need immediate medical attention	Emergency room care	$200 copay	$200 copay	Worldwide emergency coverage.
	Emergency medical ground transportation	$50 copay	$50 copay	Emergency criteria required. See Cost Share Schedule.
	Urgent care	$50 copay/visit	50% coinsurance	Pre-auth required on follow-up visits only.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay per day for days 1-3	50% coinsurance	Pre-auth required. $300 max per stay.
	Physician/surgeon fees	100% coverage	50% coinsurance	Pre-auth required.

* For more information about limitations and exceptions, see the plan or policy document at www.vantagehealthplan.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit	50% coinsurance	Pre-auth required.
	Inpatient services	$100 copay per day for days 1-3	50% coinsurance	Pre-auth required. $300 max per stay.
If you are pregnant	Office visits	$20 copay	50% coinsurance	Copay on initial visit only.
	Childbirth/delivery professional services	No additional copay	50% coinsurance	Covered as part of the inpatient delivery stay.
	Childbirth/delivery facility services	$100 copay per day for days 1-3	50% coinsurance	Pre-auth required. $300 max per stay.
If you need help recovering or have other special health needs	Home health care	100% coverage	Not covered	Pre-auth required.
	Rehabilitation services	$10 or $20 copay per visit	50% coinsurance	Pre-auth required. 20 visit limit.
	Habilitation services	$10 or $20 copay per visit	50% coinsurance	Pre-auth required. 20 visit limit.
	Skilled nursing care	$100 copay per day for days 1-3	50% coinsurance	Pre-auth required. 60 day limit.
	Durable medical equipment	20% coinsurance	50% coinsurance	Pre-auth required. $5,000 threshold applies. See Cost Share Schedule.
	Hospice services	100% coverage	Not covered	Pre-auth required.
If your child needs dental or eye care	Children's eye exam	$35 AHN or $45 copay/visit	50% coinsurance	Limit 1 visit annually.
	Children's glasses	50% coinsurance	50% coinsurance	Limit may apply.
	Children's dental check-up	100% coverage	50% coinsurance	Limit 2 visits annually.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Hearing aids (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Dental care
- Glasses (Adult)
- Hearing aids (Children)
- Routine eye care (Adult)
- Weight loss programs

* For more information about limitations and exceptions, see the plan or policy document at www.vantagehealthplan.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Vantage at (888) 823-1910. For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. If coverage is insured, contact the U.S. Department of Health and Human Services at 1-877-267-2323 x. 61565 or www.cciio.cms.gov.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-888-823-1910.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-823-1910.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-823-1910.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-823-1910.

——————————To see examples of how this plan might cover costs for a sample medical situation, see the next section.——————————

* For more information about limitations and exceptions, see the plan or policy document at www.vantagehealthplan.com.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$30
Hospital (facility) copayment	$750
Other coinsurance	100%

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

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$780
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$840

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

The plan's overall deductible	$0
Specialist copayment	$340
Hospital (facility) copayment	$0
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$340
Coinsurance	$350
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$745

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

The plan's overall deductible	$0
Specialist copayment	$50
Hospital (facility) copayment	$600
Other coinsurance	20%

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

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$650
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$650

The plan would be responsible for the other costs of these EXAMPLE covered services.