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 1-844-536-7104. 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 1-844-536-7104 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	The overall medical deductible: For In-Network Providers: $400 (1 member), $800 (2 members), $1,200 (3 or more members); for Out-of-Network Providers: $2,000 (1 member), $4,000 (2 members), $6,000 (3 or more members)	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Many In-Network Medical Services, including physician office services, are not subject to the deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at *https://www.healthcare.gov/coverage/preventive-care-benefits/*.
Are there other deductibles for specific services?	No.	You do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For In-Network Providers: $3,500 (1 member); $6,000 (2 members); $8,500 (3 or more members). For Out-of-Network Providers: No Out-of-Pocket Maximum limits	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments and coinsurance on certain services, premiums, balance-billing charges, cost sharing for out-of-network, and health care this plan does not 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 1-844-536-7104 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's 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). Check with your provider before you get services.
Do you need a referral to see a specialist?	No, if you use a provider in the plan's network.	You can see the In-Network 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 these charts 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 copay or $25 copay. Deductible does not apply.	50% coinsurance	AHN refers to Affinity Health Network Providers with lower cost sharing.
	Specialist visit	$35 AHN copay or $50 copay. Deductible does not apply.	50% coinsurance	None
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	50% coinsurance. Deductible does not apply.	You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible may apply.	50% coinsurance	Not all diagnostic tests are subject to the deductible.
	Imaging (CT/PET scans, MRIs)	$25 AHN copay/test or $50 copay/test. Deductible does not apply.	50% coinsurance	Pre-authorization required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.vhpla.com	Tier I & II Prescription Drugs	$10 Tier I copay or $40 Tier II copay per prescription (retail/mail order)	Not covered	1 copay for 30 day supply; 2 copays for 31-60 day supply; 3 copays for 61-100 day supply
	Tier III Prescription Drugs	$65 copay per prescription (retail/mail order)	Not covered	1 copay for 30 day supply; 2 copays for 31-60 day supply; 3 copays for 61-100 day supply
	Tier IV Prescription Drugs	$100 copay per prescription (retail/mail order)	Not covered	1 copay for 30 day supply; 2 copays for 31-60 day supply; 3 copays for 61-100 day supply
	Tier V Prescription Drugs	$150 copay per prescription (retail only)	Not covered	1 copay for 30 day supply. Mail order not available.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 AHN copay or $100 copay. Deductible does not apply.	50% coinsurance	Pre-authorization required.
	Physician/surgeon fees	No charge	50% coinsurance	Pre-authorization required.
If you need immediate medical attention	Emergency room care	$200 copay. Deductible does not apply.	$200 copay. Deductible does not apply.	Worldwide emergency coverage. Physician services are subject to deductible.
	Emergency medical ground transportation	$50 copay. Deductible does not apply.	$50 copay. Deductible does not apply.	Emergency criteria required.
	Urgent care	$50 copay/visit. Deductible does not apply.	50% coinsurance	Pre-authorization required on follow-up visits.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay/day. Deductible does not apply.	50% coinsurance	Pre-authorization required. $300 copay max.
	Physician/surgeon fees	No charge. Deductible applies.	50% coinsurance	Pre-authorization required. Physician services are subject to deductible.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 AHN copay/visit or $25 copay/visit. Deductible does not apply.	50% coinsurance	None
	Inpatient services	$100 copay/day. Deductible does not apply.	50% coinsurance	Pre-auth required. $300 copay max. Physician services are subject to deductible.
If you are pregnant	Office visits	$10 AHN copay or $25 copay. Deductible does not apply.	50% coinsurance	Copay on initial visit only.
	Childbirth/delivery professional services	No charge. Deductible applies.	50% coinsurance	Pre-authorization required. Physician services are subject to deductible.
	Childbirth/delivery facility services	$100 copay/day. Deductible does not apply.	50% coinsurance	Pre-authorization required. $300 copay max. Physician services are subject to deductible.

* 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 help recovering or have other special health needs	Home health care	No charge	Not covered	Pre-authorization required.
	Rehabilitation services	$10 AHN copay/visit or $25 copay/visit. Deductible does not apply.	50% coinsurance	Pre-authorization required. 20 visit limit.
	Habilitation services	$10 AHN copay/visit or $25 copay/visit. Deductible does not apply.	50% coinsurance	Pre-authorization required. 20 visit limit.
	Skilled nursing care	$100 copay/day. Deductible does not apply.	50% coinsurance	Pre-authorization required. 60 day limit. $300 copay max. Physician services are subject to deductible.
	Durable medical equipment	20% coinsurance	50% coinsurance	Pre-authorization required. 20% Coinsurance up to $5,000 of the Vantage Allowable then 100% covered after first $5,000 of the Vantage Allowable.
	Hospice services	No charge	Not covered	Pre-authorization required.
If your child needs dental or eye care	Children's eye exam	$35 AHN copay or $50 copay. Deductible does not apply.	50% coinsurance	Limit 1 visit per benefit period.
	Children's glasses	50% coinsurance. Deductible does not apply.	50% coinsurance. Deductible does not apply.	Limit may apply. $100 max benefit.
	Children's dental check-up	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Limit 2 visits per calendar year.

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

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
- Hearing aids (Children)
- Routine eye care (Adult)
- Weight loss programs (Vantage Wellness Program only)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or *www.dol.gov/ebsa/healthreform* or Louisiana Department of Insurance, Office of Consumer Services, P.O. Box 94214, Baton Rouge, LA 70804-9214 or call 1-800-259-5300. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit *www.HealthCare.gov* 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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or *www.dol.gov/ebsa/healthreform* or Louisiana Department of Insurance, Office of Consumer Services, P.O. Box 94214, Baton Rouge, LA 70804-9214 or call 1-800-259-5300.

Does this plan provide Minimum Essential Coverage? **Yes**
If you do not have Minimum Essential Coverage for a month, you will 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 does not 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	$400
Specialist (OB/GYN) copayment	$25
Hospital (facility) copayment	$300
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist (OB/GYN) 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	$400
Copayments	$125
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$585**

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

The plan's overall deductible	$400
Primary Care Physician copayment	$25
Hospital (facility) copayment	$300
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

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

The plan's overall deductible	$400
Specialist copayment	$50
Emergency room copayment	$200
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$475
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$925**

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