
 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](http://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](http://www.vantagehealthplan.com) or call 1-844-536-7104 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	The overall medical <a href="#">deductible</a> : 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 <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Many In-Network Medical Services, including physician office services, are not subject to the <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You do not have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	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 <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Copayments</a> and <a href="#">coinsurance</a> on certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, <a href="#">cost sharing</a> for out-of-network, and health care this <a href="#">plan</a> does not cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. Visit <a href="http://www.VantageHealthPlan.com">www.VantageHealthPlan.com</a> and click "Find a Provider" or call 1-844-536-7104 for a list of network providers.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No, if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> .	You can see the In-Network <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

\* For more information about limitations and exceptions, see the plan or policy document at [www.vantagehealthplan.com](http://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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 AHN <a href="#">copay</a> or \$40 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	AHN refers to Affinity Health Network Providers with lower <a href="#">cost sharing</a> .
	<a href="#">Specialist</a> visit	\$45 AHN <a href="#">copay</a> or \$65 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> . <a href="#">Deductible</a> does not apply.	You may have to pay for services that are not preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	<a href="#">Deductible</a> may apply.	50% <a href="#">coinsurance</a>	None.
	Imaging (CT/PET scans, MRIs)	\$25 AHN <a href="#">copay</a> /test or \$50 <a href="#">copay</a> /test. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.vhpla.com</a>	Tier I & II Prescription Drugs	\$15 Tier I <a href="#">copay</a> or \$40 Tier II <a href="#">copay</a> per prescription (retail/mail order)	Not covered	1 <a href="#">copay</a> for 30 day supply; 2 <a href="#">copays</a> for 31-60 day supply; 3 <a href="#">copays</a> for 61-100 day supply
	Tier III Prescription Drugs	\$75 <a href="#">copay</a> per prescription (retail/mail order)	Not covered	1 <a href="#">copay</a> for 30 day supply; 2 <a href="#">copays</a> for 31-60 day supply; 3 <a href="#">copays</a> for 61-100 day supply
	Tier IV Prescription Drugs	\$100 <a href="#">copay</a> per prescription (retail/mail order)	Not covered	1 <a href="#">copay</a> for 30 day supply; 2 <a href="#">copays</a> for 31-60 day supply; 3 <a href="#">copays</a> for 61-100 day supply
	Tier V Prescription Drugs	\$150 <a href="#">copay</a> per prescription (retail only)	Not covered	1 <a href="#">copay</a> 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)	\$100 AHN <a href="#">copay</a> or \$250 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
	Physician/surgeon fees	No charge	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required.
If you need immediate medical attention	Emergency room care	\$200 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply.	\$200 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply.	Worldwide emergency coverage. Physician services are subject to <a href="#">deductible</a> .
	Emergency medical ground transportation	\$50 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply.	\$50 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply.	Emergency criteria required.
	Urgent care	\$65 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required on follow-up visits.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <a href="#">copay</a> /day. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required. \$750 <a href="#">copay</a> max.
	Physician/surgeon fees	No charge.	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required. Physician services are subject to <a href="#">deductible</a> .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 AHN <a href="#">copay</a> /visit or \$40 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	None
	Inpatient services	\$250 <a href="#">copay</a> /day. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	Pre-auth required. \$750 <a href="#">copay</a> max. Physician services are subject to <a href="#">deductible</a> .
If you are pregnant	Office visits	\$20 AHN <a href="#">copay</a> or \$40 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	<a href="#">Copay</a> on initial visit only. Cost sharing does not apply for preventative services. Depending on the type of services, a <a href="#">deductible</a> , <a href="#">copay</a> , or <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge. <a href="#">Deductible</a> applies.	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required. Physician services are subject to <a href="#">deductible</a> .
	Childbirth/delivery facility services	\$250 <a href="#">copay</a> /day. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required. \$750 <a href="#">copay</a> max. Physician services are subject to <a href="#">deductible</a> .

\* For more information about limitations and exceptions, see the plan or policy document at [www.vantagehealthplan.com](http://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	<a href="#">Home health care</a>	No charge	Not covered	<a href="#">Pre-authorization</a> required.
	<a href="#">Rehabilitation services</a>	\$20 AHN <a href="#">copay</a> /visit or \$40 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required. 20 visit limit.
	<a href="#">Habilitation services</a>	\$20 AHN <a href="#">copay</a> /visit or \$40 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required. 20 visit limit.
	<a href="#">Skilled nursing care</a>	\$250 <a href="#">copay</a> /day. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required. 60 day limit. \$750 <a href="#">copay</a> max. Physician services are subject to <a href="#">deductible</a> .
	<a href="#">Durable medical equipment</a>	20% coinsurance	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required. 20% Coinsurance up to \$5,000 of the Vantage Allowable then 100% covered after first \$5,000 of the Vantage Allowable.
	<a href="#">Hospice services</a>	No charge	Not covered	<a href="#">Pre-authorization</a> required.
If your child needs dental or eye care	Children's eye exam	\$45 AHN <a href="#">copay</a> or \$65 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	Limit 1 visit per benefit period.
	Children's glasses	50% <a href="#">coinsurance</a> . <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> . <a href="#">Deductible</a> does not apply.	Limit may apply. \$100 max benefit.
	Children's dental check-up	No charge. <a href="#">Deductible</a> does not apply.	No charge. <a href="#">Deductible</a> 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](http://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
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

**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
- Routine foot care
- 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](http://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](http://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](http://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**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**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 (TTY 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-823-1910 (TTY 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-823-1910 (TTY 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-823-1910 (TTY 711).

\* For more information about limitations and exceptions, see the plan or policy document at [www.vantagehealthplan.com](http://www.vantagehealthplan.com).

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

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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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$400	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$400	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$400
■ <a href="#">Specialist (OB/GYN) copayment</a>	\$40	■ <a href="#">Primary Care Physician copayment</a>	\$40	■ <a href="#">Specialist copayment</a>	\$65
■ <a href="#">Hospital (facility) copayment</a>	\$250	■ <a href="#">Hospital (facility) copayment</a>	\$250	■ <a href="#">Emergency room copayment</a>	\$200
■ <a href="#">Other coinsurance</a>	20%	■ <a href="#">Other coinsurance</a>	20%	■ <a href="#">Other coinsurance</a>	20%
<p><b>This EXAMPLE event includes services like:</b>                      Specialist (OB/GYN) office visits (<i>prenatal care</i>)                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services                      Diagnostic tests (<i>ultrasounds and blood work</i>)                      Specialist visit (<i>anesthesia</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>                      Primary care physician office visits (<i>including disease education</i>)                      Diagnostic tests (<i>blood work</i>)                      Prescription drugs                      Durable medical equipment (<i>glucose meter</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>                      Emergency room care (<i>including medical supplies</i>)                      Diagnostic test (<i>x-ray</i>)                      Durable medical equipment (<i>crutches</i>)                      Rehabilitation services (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$400	Deductibles	\$0	Deductibles	\$400
Copayments	\$125	Copayments	\$1,200	Copayments	\$475
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$50
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$585</b>	<b>The total Joe would pay is</b>	<b>\$1,220</b>	<b>The total Mia would pay is</b>	<b>\$925</b>