

# Vantage Health Plan

A

**HEALTH MAINTENANCE ORGANIZATION**

**OPERATED BY**

**Vantage Health Plan, Inc.  
130 DeSiard Street, Suite 300  
Monroe, LA 71201  
(318) 361-2125 or (855) 934-6847  
[www.VantageHealthPlan.com](http://www.VantageHealthPlan.com)**

This Certificate of Coverage (“Certificate”) sets forth in detail your rights and obligations as a Member enrolled in Vantage Health Plan, Inc. (“Vantage”).

It is important that you **READ YOUR CERTIFICATE CAREFULLY** and familiarize yourself with its terms and conditions. For reference purposes, a table of contents has been included on the inside of this Certificate.

If you receive services from an Out-of-Network Provider, the charges may be significantly more than Participating Provider fees and/or the Vantage Allowable. You may be balance-billed for the cost of services exceeding the Vantage Allowable. It is the Member’s responsibility to verify a Provider’s participation status prior to receiving services and to find out what the Vantage Allowable is for a Covered Service provided by an Out-of-Network Provider.

Health care services may be provided to the Member at a Participating health care facility by facility-based Physicians who are not Tier I or Tier II Providers in this Plan. You may be responsible for payment of all or part of the fees for those Out-of-Network services, in addition to applicable amounts due for Co-insurance, Co-payments, Deductibles, and non-Covered Services. Specific information about In-Network and Out-of-Network facility-based Physicians can be found at our website, <https://www.VantageHealthPlan.com/Provider/ParNonParSearch> or by calling Member Services.

If you need additional information, please contact Vantage Health Plan, Inc., 130 DeSiard St., Ste. 300, Monroe, LA 71201 or by calling (318) 361-2125 or toll-free at (855) 934-6847. For language assistance services, please contact Vantage’s Member Services department. For the hearing impaired, please call TTY (866) 524-5144. Vantage offers some language translation, sign language and teletypewriter (TTY) services to Members.



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This table of contents is designed only to help you locate answers to your questions more quickly. The table of contents does not cover every topic in this Certificate and may not list all the page numbers where references to the topics listed can be found. This table of contents does not change your benefit coverage or specifications.

## WELCOME TO VANTAGE HEALTH PLAN!

You are now a Member of Vantage Health Plan, a Health Maintenance Organization (HMO). As a Louisiana HMO, Vantage is an active participant in helping you receive quality, comprehensive medical care at a reasonable cost.

Your Member packet contains important information that should answer most of your questions about your benefits, as well as your rights and responsibilities as a Member. Because the coverage under this Plan differs from traditional health insurance, it is important that you understand your benefits and the procedures required to receive the coverage available to you.



**Please read carefully when you see this symbol. This symbol will help you identify important information and help you use this Plan. This symbol is only to assist you and does not lessen the importance or make null and void any other Plan requirements.**

### **THIS PLAN PACKET INCLUDES THE FOLLOWING DOCUMENTS:**

#### **MEMBER CERTIFICATE OF COVERAGE**

This Member Certificate of Coverage is based on the Master Group Contract between your Employer and Vantage. Please read this Certificate and any riders carefully. This Certificate and any riders selected by your Employer explain what is covered and what is not covered by Vantage. Any service not listed as a Covered Service is not covered.

#### **COST SHARE SCHEDULE**

This schedule (enclosed with this Certificate) details Co-insurance, Co-payments, and Deductible amounts or percentages that are your financial responsibility and are based on the type of Covered Service and the Provider network. All Deductible and Co-insurance amounts are based on the Vantage Allowable or actual payments made after any discounts and/or reductions. Charges above the Vantage Allowable for Covered Services provided by Out-of-Network Providers do not apply to the In-Network Deductible or to the Initial Tier I Medical or PPACA In-Network Out-of-Pocket Maximums.

**Your Plan offers lower Cost Shares for certain Covered Services if such services are performed by Affinity Health Network (AHN) Providers. See Cost Share Schedule included in this packet.**

#### **OPTIONAL BENEFITS**

If your Employer has selected any optional benefits that extend your coverage in any way from our basic Plan, an explanation of those riders will be attached to this Certificate.

#### **IDENTIFICATION CARDS**





The Vantage identification card (Member ID Card) is to be shown each time you or your covered Dependents receive services at a Physician's office, Hospital, other Provider or pharmacy. Not showing your Member ID Card could result in bills being sent to you instead of to Vantage. Your Member ID Cards for the upcoming Benefit Period will be mailed to you prior to your Effective Date of coverage.

Your Member ID Card includes the Affinity Health Network logo. **This means your Cost Share will be lower when you receive certain Covered Services from Affinity Health Network (AHN) Providers.** Services with reduced Cost Share are shown on your Member ID Card and/or the Cost Share Schedule. The AHN Providers are listed on the Affinity Health Network pages in the first section of the Provider Directory or on our website, [www.VantageHealthPlan.com](http://www.VantageHealthPlan.com).

A sample image of the Member ID Card is shown on the following page.

# SAMPLE MEMBER ID CARD

## FRONT OF ID CARD

		<b>GROUP FREEDOM</b>	
		Deductible (IN)	\$ XXXX
		In-Network	Tier 1    AHN
RXBIN: 610602	Medical Home-PCP	\$ XX	\$ XX
RXPCN: NVT	Specialty Care	\$ XX	\$ XX
RXGRP: VTGC	Emergency Room	\$ XX	\$ XXX
	Outpatient Surgery	\$ XXX	\$ XXX
	Outpatient Hospital	\$ XXX	\$ XXX
	Major Diagnostic	\$ XXX	\$ XXX
ID:			
10000000000	JOHN DOE		
10000000001	JANE DOE		
			

## BACK OF ID CARD

<p><u>Submit Claims to:</u>                  Vantage Health Plan, Inc.                  130 Desiard Street, Suite 300                  Monroe, LA 71201</p>	<p><u>For Questions (Toll-Free):</u>                  Providers: (888) 823-1910                  Members: (855) 934-6847                  Pharmacy: (888) 823-1910</p>
 www.VantageHealthPlan.com	

Prescription Drug information for your pharmacist is located in the top left corner on the front of your Member ID Card.

Each Member’s unique Member ID number is located on the front of the Member ID Card next to the Member’s name. Additional Member listings may also be located on the back of the Member ID Card for policies with many Dependents.

The “Deductible” information is your individual In-Network Deductible amount. Frequently referenced Co-payment amounts are also noted on the front of your Member ID Card.

The Affinity Health Network (AHN) logo means your Co-payments will be lower when you receive certain Covered Services from AHN Providers. Services with reduced Co-payments are shown in the AHN column on your Member ID Card. Please see your Cost Share Schedule for a complete list of Cost Shares. AHN Providers are listed on the Affinity Health Network pages in the first section of the Provider Directory and on our website, [www.VantageHealthPlan.com](http://www.VantageHealthPlan.com).

Depending on where you live, your Member ID Card may have the following network logo:



The Verity Healthnet National network is only available as a primary Provider network for Vantage Members who live in the following parishes: Acadia, Ascension, Assumption, East Baton Rouge, East Feliciana, Evangeline, Iberia, Iberville, Lafayette, Lafourche, Livingston, Pointe Coupee, St. Helena, St. James, St. Landry, St. Martin, St. Mary, Terrebonne, Vermilion, West Baton Rouge and West Feliciana parishes. Access is determined from the Member’s primary address in Vantage’s records.

The PHCS logo on the back of your Member ID Card means that you may receive Eligible Charges from Tier II Providers. Tier II Providers’s cost may be higher than other similar Participating Providers. Members who choose to see these Providers will have to pay an additional Co-insurance (Tier II Co-insurance), in addition to the In-Network Deductible, Co-insurance and Co-payments as shown in the Cost Share Schedule (Tier I Cost Share). Tier II Providers cannot balance-bill the Member.

**READ THE INFORMATION IN THIS PACKET NOW, AND KEEP IT FOR FUTURE REFERENCE.**



**If you do not receive all of this information or if the information is incorrect, please contact Vantage Member Services at (318) 361-2125 or toll-free at (855) 934-6847 immediately.**

## SECTION I: VANTAGE PATIENT-CENTERED MEDICAL HOME

The Patient-Centered Medical Home (PCMH) is an approach to providing cost effective and comprehensive primary health care for children, youth and adults. The PCMH creates partnerships between individual patients and their personal Physicians, and when appropriate, the patient's family.

### **Medical Home Primary Care Physician (MH-PCP)**

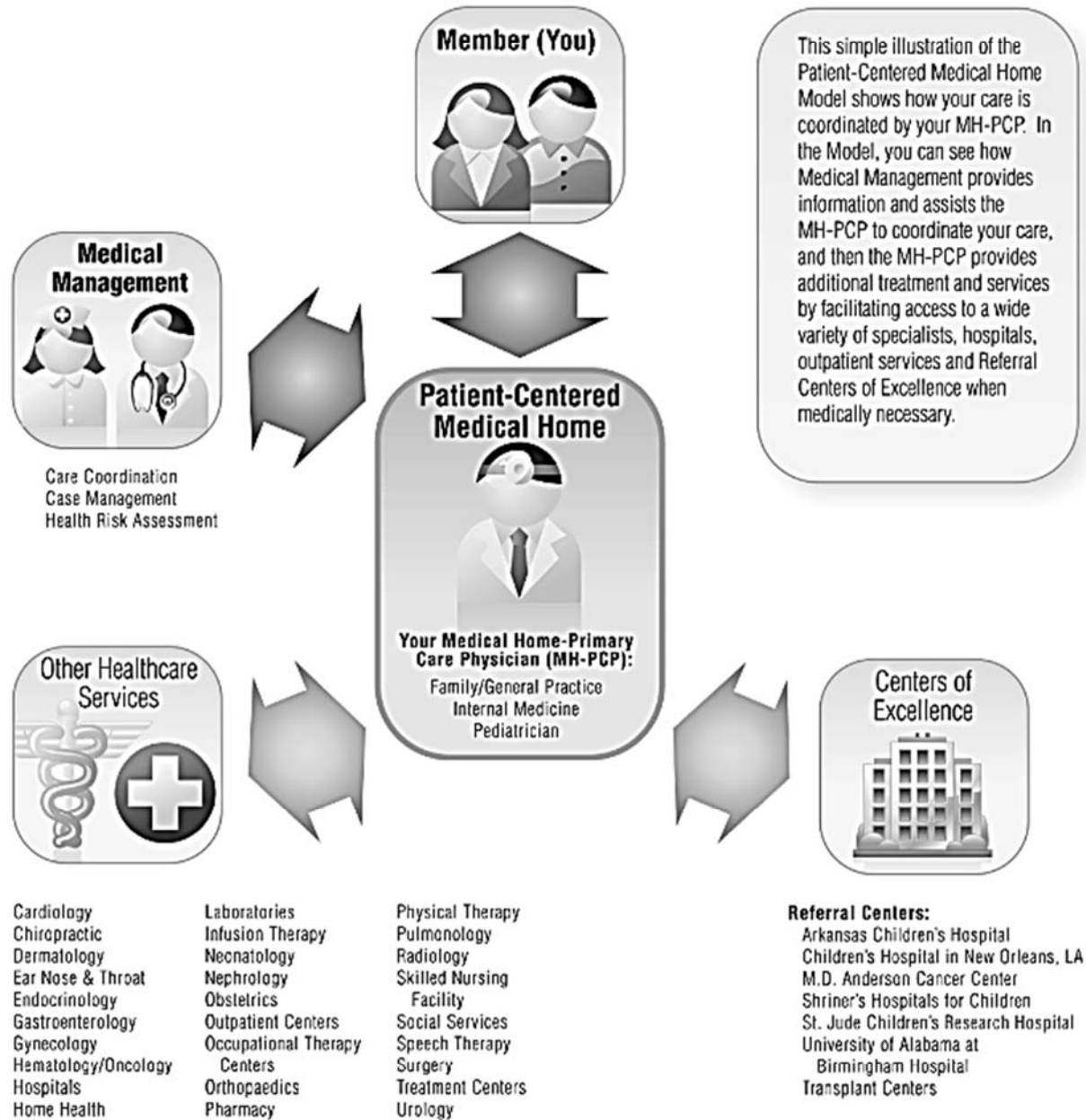
Each Vantage Member has an ongoing relationship with a personal Physician trained to provide first contact and assist you in obtaining access to ongoing and comprehensive health care. The Medical Home Primary Care Physician (MH-PCP) is your personal Physician and will work with you to coordinate all of your health care. Your MH-PCP leads a team of clinical health care professionals who collectively take responsibility for your immediate and ongoing health care needs. PCMH health care professionals may also include other clinical professionals, such as nurses, social workers, dietitians and nutritionists. Your MH-PCP will also be responsible for arranging appropriate care with other qualified health care professionals, Specialty Care Providers or facilities, such as radiologists, laboratories, surgeons, and Hospitals.

**Vantage requires the designation of a MH-PCP by all Plan Members. A MH-PCP will be assigned to coordinate your health care if you do not make a designation when you enroll. You may change your designated or assigned MH-PCP at any time by contacting Vantage. You have the right to designate any Tier I In-Network MH-PCP who is available to accept you and/or your family Members as patients. For children, you may designate a Tier I In-Network pediatrician as the MH-PCP. Each family Member may have a different MH-PCP. To select a MH-PCP or to receive a list of Tier I In-Network Providers, visit us online at <https://portal.vantagehealthplan.com/> or contact Vantage at (318) 361-2125 or toll-free at (855) 934-6847.**

When your MH-PCP arranges for you to see a Specialty Care Provider or have a diagnostic test, the reports from that visit or test are automatically sent to your MH-PCP. If you see a Specialty Care Provider or have a diagnostic test that is not arranged by your MH-PCP, then you will need to ask that your reports be sent to your MH-PCP. Always make sure your MH-PCP is aware of all of your medical treatments and your other Health Care Providers. Referrals to In-Network Specialty Care Providers and OB/GYN's are not required in this Plan.

A simple illustration of the Vantage Patient-Centered Medical Home Model on the following page shows how each Vantage Member's care is coordinated by the MH-PCP. In the model, you can see that Vantage Medical Management provides information and assists the MH-PCP to coordinate care, and then the MH-PCP provides additional treatment and services by facilitating access to a wide variety of Specialty Care Providers, Hospitals, outpatient services and referral centers of excellence whenever it is necessary.

# PATIENT-CENTERED MEDICAL HOME MODEL



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## SECTION II: HOW TO USE THIS PLAN

As a Patient-Centered Medical Home HMO, Vantage provides more of the comprehensive health services you need to get well and stay well. However, there are a few basic rules you must keep in mind to make sure you are receiving the full benefits of the coverage available.

### **Vantage Member Identification Card**

When you join the Plan, you are sent Vantage Member identification cards (Member ID Card). A sample Member ID Card is located in this Certificate of Coverage.

Your Member ID Card should be kept with you at all times. Each time services are rendered, you should present your Member ID Card. For details about the Cost Share for which you are responsible, please refer to Section IV of this Certificate of Coverage, your Cost Share Schedule, or the front of your Member ID Card or visit us online at <https://portal.vantagehealthplan.com/>. You may also contact the Member Services department at (318) 361-2125 or toll-free at (855) 934-6847.

Your Member ID Card is for identification purposes only. Any person receiving benefits or services to which they are not entitled will be financially responsible for any charges.

If you need extra Member ID Cards or lose your Member ID Card, please visit us online at <https://portal.vantagehealthplan.com/> or call the Member Services department. We will be happy to order you another set.

### **Network Design**

The In-Network benefits described in this Certificate of Coverage refer to Tier I Providers. Most In-Network Providers are Tier I Providers. Tier I Providers include the Affinity Health Network (AHN) Providers in addition to the Plan's standard network of Providers. Members seeing Tier I Providers pay the Co-insurance, Co-payments, and In-Network Deductible as shown in the Tier I In-Network column in Section IV of this Certificate of Coverage, the Cost Share Schedule, and/or the Member ID Card. Tier I Providers cannot balance-bill the Member.



**AHN Providers are Tier I In-Network Providers with lower Cost Share for certain specified Covered Services and mail order Prescription Drugs. This means your Cost Share will be lower when you receive those Covered Services from AHN Providers. Services with reduced Cost Share are shown on your Member ID Card and/or your Cost Share Schedule. AHN Providers are listed on the Affinity Health Network pages in the first section of the Provider Directory and on our website, [www.VantageHealthPlan.com](http://www.VantageHealthPlan.com).**

Vantage may contract with certain Providers or Provider networks even though their cost may be higher than similar Tier I Providers. These Providers are listed in the Vantage Provider Directory as Tier II Providers. Because of the higher cost of the Tier II Providers, Members who choose to use these Providers will pay an additional Co-insurance percentage as listed in the Cost Share Schedule.

A Provider's status (Affinity Health Network Provider, Tier I, Tier II, In-Network Provider, and Out-of-Network Provider) is subject to change at any time.

Your share of the payment for health care services may be based on the agreement between your Plan and your Provider. Under certain circumstances, this agreement may allow an Out-of-Network Provider to bill you for amounts up to the Out-of-Network Provider's regular billed charges. However, In-Network Providers are bound by an agreed-upon fee schedule and may not bill Members for amounts in excess of the fee schedule for Covered Services.

## **Medical Management**

Vantage assists the MH-PCP by providing additional health information and coordination data related to your health history, such as Prescription Drug coverage and medical treatments provided. Vantage collects and organizes all of the available health information for each Member. The goal of the Vantage Medical Management department is to support the MH-PCP in compiling a complete and accurate health profile of each Member and to facilitate access to whatever health care services are required to improve each Member's health status in consultation with the MH-PCP. Remember, the MH-PCP is your personal Medical Home Primary Care Physician.

### **A. Pre-Authorization**

Pre-Authorization means written authorization from Vantage before receiving certain health services. It can mean the difference between a claim being paid or denied. Pre-Authorizations help Vantage to control and monitor those health services that are most costly. Providers of services requiring a Pre-Authorization are required to assist in obtaining the Pre-Authorization, but the Member remains ultimately responsible. Pre-Authorizations are subject to eligibility of the Member at the time services are rendered.

The same Covered Services which require Pre-Authorization for Tier I Providers also require Pre-Authorization for Tier II Providers. This Certificate of Coverage lists the services that need a Pre-Authorization in Section IV. NOTE: This list of services requiring Pre-Authorization is subject to change. You may call Member Services at (318) 361-2125 or toll-free at (855) 934-6847 for a current list of services that require Pre-Authorization.

Referrals to In-Network Specialty Care Providers and OB/GYN's are not required in this Plan.

### **B. Vantage Medical Utilization Review Program**

Vantage has worked to develop programs that can reasonably contain costs while maintaining the quality of care. One such program is Utilization Review.

#### **What Is Utilization Review?**

Utilization Review is a process to ensure that you, your Physician, and your health Plan work together to provide quality health care that avoids unnecessary hospitalization, inconvenience, and cost. It is an added benefit to assist in making decisions about your medical care.

#### **How Does Utilization Review Work?**

When your Physician recommends that you be hospitalized, you or the Physician must call Vantage and outline the planned treatment. As you know, a Hospital is not always the most appropriate place to receive treatment and is generally more expensive. By reviewing requests for hospitalization, the Vantage Medical Management staff makes sure that a Hospital stay is Medically Necessary and appropriate for inpatient care. Many diagnostic and surgical procedures are routinely performed in an outpatient setting, which can be easier for you and less costly. Vantage will also coordinate the plan of care with your MH-PCP to ensure the services being recommended are consistent with your health history.



If elective hospitalization is planned or you know ahead of time that a Hospital stay is needed, you or your Physician must call Vantage **before** your admission. If you, your spouse, or Dependent is admitted on an emergency basis, you or your Physician must contact Vantage **within 24 hours** (or the next working day if on a weekend or holiday) of the admission.

#### **What is the Procedure for Utilization Review?**

A single phone call sets the process in motion.

When the call is made, a Vantage Medical Management nurse will request certain basic information about the patient (you, your spouse or Dependent), and the reasons for the proposed admission. Vantage uses established, Physician-approved, medical and surgical criteria to determine the Medical Necessity of all Hospital admissions.



A nurse reviewer can review and approve a request, and that is what happens in the vast majority of cases. If the Medical Management nurse has questions about the necessity of the admission, they will consult with the Vantage Medical Director (a medical doctor) who will review the medical data. The Vantage Medical Director or a nurse may also inquire further about the treatment plan by contacting the Physician recommending the admission/treatment as well as contacting your MH-PCP.

In some instances it may be determined that your care can be more appropriately provided in an outpatient setting. If so, the Medical Director will recommend alternatives to hospitalization. Your Plan provides coverage for Medically Necessary outpatient or home care services, often with lower cost to you. These options may be discussed with your Physician and MH-PCP.

If your Hospital admission is authorized, an authorization number is given to you or your Physician and the Hospital. Your continued Hospital stay is reviewed by the Medical Management nurse to determine if further inpatient care is necessary beyond the initial days certified. This will also assure appropriate discharge planning, so follow-up or home care needs can be addressed.

Vantage does not compensate Medical Management nurses, Medical Directors, UR/QM Committee Members, and/or any other professionals who are involved in Utilization Review decisions for denials, does not offer incentives to encourage denials, and does not encourage decisions that result in underutilization. Vantage ensures independence and impartiality in making referral decisions and attests that involvement will not influence compensation, hiring, termination, promotion or any other similar matters for the Medical Management nurses, Medical Directors, UR/QM Committee Members, and/or any other professionals who are involved in Utilization Review decisions in the Utilization Review process based upon the likelihood or perceived likelihood that the Medical Management nurses, Medical Directors, UR/QM Committee Members, and/or any other professionals who are involved in Utilization Review decisions will support or tend to support the denial of benefits.

### **Is the Vantage Decision Final?**

If you or your Physician disagrees with a Vantage denial, you may request an Appeal. In this situation, another Participating Physician will review the medical information. If you still disagree with the outcome, a further Appeal process is outlined in this Certificate of Coverage.



### **What Is My Responsibility?**

Your role is to share this information with your spouse or Dependent if they are covered under your health care Plan and **to show your Member ID Card to your Physician when a Hospital admission is being discussed**. This alerts your Physician to call Vantage if a Hospital admission is Planned. Following this process is essential to ensure that a Hospital stay is covered.

### **How Do I Benefit From Utilization Review?**

If you are paying any portion of the premiums on your health Plan, Utilization Review will help control rate increases that could result from unnecessary Hospital stays. If Vantage requires you to pay a part of the cost of treatment, Utilization Review assures that you will be treated in the most cost-effective way while maintaining quality health care. Your preadmission review program is a “win-win” benefit that promotes quality health care and reduces cost.

### **In Summary**

Ask your Physician to call the Vantage Medical Management department to begin the Pre-Authorization process. Pre-Authorization is required for all planned, non-Emergency admissions. Emergency hospitalization must be certified the next working day after admission or when reasonably possible.

Maternity admission must be authorized the next working day after admission. Pre-Authorization is required before admission for maternity care involving a scheduled Cesarean section.

**Monroe (318) 361-2125**  
**If outside the local calling area, toll-free 1-(855)-934-6847**  
**Monday-Friday 8 a.m. - 5 p.m.**

### C. **How to Obtain Emergency Care and After Office Hours Care**

As a Member, it is up to you to use your Vantage coverage wisely. Vantage is not an insurance program that reimburses you for whatever health care services you may desire. Your MH-PCP will work with you to assure that you receive the medical care you need in an appropriate, cost-effective manner.

Call your MH-PCP immediately when you require medical attention, even if you are traveling outside the Vantage Service Area. Your MH-PCP can advise you of the best course of action based on his/her knowledge of your medical history and your present symptoms.

However, when a Member's medical condition of recent onset and severity, including severe pain, would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in the serious jeopardy of one's health or the health of an unborn child, serious impairment to bodily function or serious dysfunction of any bodily organ or part, the **Member should call 911 and seek Emergency Medical Services**. Emergencies do not require Pre-Authorization.

Emergency hospitalization must be authorized by Vantage on the next working day after admission or when reasonably possible. Pre-Authorization is required for all planned, non-Emergency admissions.

Members may visit an after-hours clinic or other facility primarily engaged in treating patients whose conditions require medical attention after normal office hours for non-Emergency Medical Services.

### D. **How to Obtain Coverage outside of the Vantage Service Area**

Our Plan does offer Out-of-Network coverage for certain Covered Services. Members traveling or living outside of the state of Louisiana should contact the Vantage Medical Management department at (318) 361-2125 or toll-free at (855) 934-6847 prior to receiving non-Emergency Covered Services from Out-of-Network Providers. All non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization.

### E. **Member Rights and Responsibilities**

As a Member of Vantage Health Plan, you have the following rights and responsibilities:

- ▶ A right to receive information about Vantage, its services, its Health Care Providers and your rights and responsibilities as a Member.
- ▶ A right to be treated with fairness, respect and recognition of your dignity and right to privacy.
- ▶ A right to participate with Health Care Providers in making decisions about your health care.
- ▶ A right to candid discussion of appropriate or Medically Necessary treatment options for your conditions, regardless of cost or benefit coverage.
- ▶ A right to voice grievances or file Appeals about Vantage, coverage decisions, its Health Care Providers, or the care provided.
- ▶ A right to make recommendations regarding Vantage's Member rights and responsibilities policy.
- ▶ A right to receive timely access to your Covered Services and Drugs.
- ▶ A right to privacy and the protection of your personal health information, in accordance with state and federal law.
- ▶ A responsibility to supply information (to the extent possible) that Vantage and its Health Care Providers need in order to provide care.
- ▶ A responsibility to follow treatment plans and instructions for care that you have agreed to with your Health Care Provider.
- ▶ A responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

## **IMPORTANT RULES TO HELP YOU USE THIS PLAN:**

**ALWAYS** carry your Member ID Card and present it **before** receiving health services.

**ALWAYS** pay any Co-payments **at the time** you receive services.

**ALWAYS** remember, your Cost Share for certain Covered Services provided by the Affinity Health Network may be lower. You may check the website or call Member Services for the most updated list of Affinity Health Network Providers.

**ALWAYS** remember, there is an **additional Tier II Co-insurance payment** required by Members who receive services from Tier II Providers. See Cost Share Schedule.

**ALWAYS** remember, Covered Services provided by Out-of-Network Providers will be covered at a reduced benefit and you may be balance-billed for substantial amounts. Claims for Out-of-Network Providers must be received by Vantage Health Plan within one year from the date of service.

**ALWAYS** obtain Pre-Authorization (written authorization **before** services are received) from the Vantage Medical Management department for those services that require Pre-Authorization. Services requiring Pre-Authorization are identified, where applicable, in *Section IV: Schedule of Covered Services & Benefits*. All Out-of-Network Covered Services except Emergency Medical Services require Pre-Authorization.

NOTE: This list of services requiring Pre-Authorization is subject to change. You may call Member Services at (318) 361-2125 or toll-free at (855) 934-6847 for a current list of services that require Pre-Authorization.

**This Plan offers Out-of-Network coverage. When you seek treatment from an Out-of-Network Provider, the charges may be significantly more than the Vantage Allowable. You may be balance-billed for substantial amounts. You may contact Vantage's Member Services department at (318) 361-2125 or toll-free at (855) 934-6847 to find out what the estimated Vantage Allowable is for any given Covered Service. Charges above the Vantage Allowable incurred by a Member for Covered Services provided by Out-of-Network Providers do not apply toward any Deductible or to the In-Network Out-of-Pocket Maximums.**

**Pre-Authorization is required for all planned, non-emergency admissions.**

**Emergency hospitalization must be certified the next working day after admission or when reasonably possible.**

**Maternity admission must be authorized the next working day after admission. Pre-Authorization is required before admission for maternity care involving a scheduled Cesarean section.**

**The Vantage Member Services department is available to assist you in using this Plan. Call (318) 361-2125 or toll-free at (855) 934-6847, Monday-Friday, 8:00 a.m. - 8:00 p.m. For language assistance services, please contact Vantage's Member Services department. For the hearing impaired, please call TTY (866) 524-5144. Vantage offers some language translation, sign language and teletypewriter (TTY) services to Members.**

## SECTION III: DEFINITIONS

Accident means bodily injury caused by a sudden and unforeseen event, definite as to time and place.

Accidental Bodily Injury means injury by an accident of external, sudden and unforeseen means.

Actively at Work means the active expenditure of time and energy by a covered Employee in the service of the Employer. Such work must be performed (1) at the Employee's usual place of employment, or as required by the Employer; and (2) for the Employer on a regular weekly schedule as set forth in the Group Enrollment Agreement under "minimum hours at work per week." A person on a scheduled vacation from work is considered Actively at Work if the person is expected to return to active work following the vacation time.

Adverse Determination means any of the following:

- (a) A determination by Vantage that, based upon the information provided, a request for a benefit under the health insurance issuer's health benefit Plan upon application of any utilization review technique does not meet Vantage's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.
- (b) The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by Vantage of a Member's eligibility to participate in the health insurance issuer's health benefit Plan.
- (c) Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit under a health benefit Plan.
- (d) A Rescission of coverage determination.

Affiliated Employer means those employers subsidiary to or affiliated with the contract holder. The Affiliated Employers, if any, are shown in the Group Enrollment Agreement.

Affinity Health Network (AHN) means Tier I In-Network Providers with lower Cost Share for certain specified Covered Services and mail order Prescription Drugs. All AHN Cost Shares are shown on the Cost Share Schedule and certain AHN Cost Shares are shown on the Member ID Card.

Appeal means the type of complaint a Member files with Vantage to request that Vantage reconsider and change a decision related to Covered Services, (including a denial of, reduction in, or termination of a Covered Service or a failure to make a payment in whole or in part for a Covered Service) or a Rescission of coverage under this Plan.

Authorized Representative means any of the following:

- (a) A person to whom a Member has given express written consent to represent the Member. It may also include the Member's treating Health Care Provider if the Member appoints the Health Care Provider as his Authorized Representative and the Health Care Provider waives in writing any right to payment from the Member other than any applicable Cost Share amount. In the event that the service is determined not to be Medically Necessary, and the Member or his Authorized Representatives, except for the Member's treating Health Care Provider, thereafter requests the services, nothing shall prohibit the Health Care Provider from charging usual and customary charges for all non-Medically Necessary services provided.
- (b) A person authorized by law to provide substituted consent for a Member.
- (c) An immediate family Member of the Member or the Member's treating Health Care Provider when the Member is unable to provide consent.
- (d) In the case of an urgent care request, a Health Care Provider with knowledge of the Member's medical condition.

*Benefit Level* means the level at which a Member's Cost Share is paid. Each level (Tier I In-Network, Tier II In-Network, and Out-of-Network) has a different Cost Share for the Member indicated in the Cost Share Schedule.

*Benefit Period* means the plan year or contract period for which benefits are covered for the Group Health Plan.

*Chronic Condition or Chronic* refers to a medical illness, disease or physical ailment of long duration (three (3) month duration or longer according to U.S. National Center for Health Statistics) or frequent recurrence, associated with slow progress and long continuance.

*COBRA* refers to the federal continuation of coverage laws originally enacted in the Consolidated Omnibus Budget Reconciliation Act of 1985 with amendments.

*Co-insurance* means the percentage of the Vantage Allowable the Member is required to pay based on the type of Covered Service and may be due at the time of service. Co-insurance percentages are listed in the attached Cost Share Schedule and/or in Section IV: *Schedule of Covered Services & Benefits* of the Certificate of Coverage.

*Co-payment* means the amount the Member is required to pay based on the type of Covered Service and is due at the time of service. Tier I Co-payment amounts are listed in the attached Cost Share Schedule, apply before the In-Network Deductible, and do not apply toward any Deductible.

*Cosmetic Purposes* means services rendered to alter the texture or configuration of the skin, or the configuration or relationship with contiguous structures of any feature of the human body for primarily personal or emotional reasons.

*Cost Share* means the Co-insurance, Deductible, and Co-payment amounts or percentages that are the Member's financial responsibility and are based on the type of Covered Service and the Provider network. Member medical Cost Share amounts are applied in the following order: 1) Tier II Co-insurance, if applicable, 2) Out-of-Network Medical Deductible and Co-insurance, 3) Supplementary Benefit Co-insurance, 4) Tier I Co-payments, 5) In-Network Deductible, and 6) Tier I Co-insurance.

*Cost Share Schedule* means the attached document that details the Co-insurance, Co-payment, Deductible, and Out-of-Pocket Maximum amounts or percentages that are the Member's financial responsibility and are based on the type of Covered Service and the Provider network.

*Covered Service(s)* means any Medically Necessary services and supplies, including Prescription Drugs, received upon the recommendation and approval of a Physician and required for the treatment of a Member, subject to the health care benefit offered by Employers to Employees as part of a Group Health Plan under an agreement with Vantage and subject to the exclusions and limitations listed elsewhere in this Certificate of Coverage. Covered Services include services and supplies in accordance with PPACA and state laws, as applicable.

*Creditable Coverage* means coverage of the Member under any Group Health Plan.

*Custodial Care* means care that primarily meets personal, comfort or hygiene needs and can be provided by a person without professional skills or training. It also includes care for an illness or condition that is not expected to substantially improve.

*Deductible* means the amounts shown on the Cost Share Schedule that the Member must pay each Benefit Period before certain medical benefits are payable under the Plan. There are separate In-Network and Out-of-Network Deductibles in this Plan. The Deductibles apply to Eligible Charges to be paid by each Member or family during the Benefit Period and are based on the Benefit Level of the rendering Provider. The family

Deductibles can be met by two or more family Members. A single family Member has met his/her Deductible by reaching the applicable individual Deductible amount. Other family Members' payments for Eligible Charges combine to meet the remainder of the applicable family Deductible amount. Co-insurance and Co-payments do not apply toward the Deductibles. Charges above the Vantage Allowable for services provided by Out-of-Network Providers do not apply toward the Deductibles. Any portion of the In-Network Deductible which was met by services listed as exclusions and limitations in Section IV does not apply to the In-Network Out-of-Pocket Maximums.

Dependent(s) means the spouse or child(ren) or grandchild(ren) designated by an Employee who, by the terms of a Group Health Plan, are eligible or may become eligible to receive Health Insurance Coverage under the Plan.

Developmental Condition or Developmental Disorder refers to an impairment in normal development of language, cognitive and/or motor skills, generally recognized before age eighteen (18) which is expected to continue indefinitely and involves a failure or delay in progressing through the normal developmental stages of childhood.

Drug(s) or Medication(s) refers to all Prescription Drugs and Non-prescription Drugs, including narcotics.

Durable Medical Equipment (DME) is an item that serves a medical purpose only and is Medically Necessary for the treatment of Illness or injury, and can withstand long-term repeated use, and is appropriate for home use.

Electronic Medical Records (EMR) is a digital information system which keeps track of medical information and provides a Physician interface that allows the Physician and other Health Care Provider(s) to enter and retrieve patient-specific medical information to support patient medical care.

Eligible Charges means the charges for Covered Services, excluding Prescription Drugs.

Emergency Medical Condition or Emergency is a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in: (1) Placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy; (2) Serious impairment to bodily function; or (3) Serious dysfunction of any bodily organ or part.

Emergency Medical Services are those medical services necessary to screen, evaluate, and stabilize an Emergency Medical Condition.

Employee means any full-time Employee or former Employee as defined by the Employer and in accordance with state law, or any Member or former Member of an Employee organization, who is or may become eligible to receive a benefit of any type from an Employee benefit Plan which covers Employees of such Employer or Members of such organization, or whose Dependents may be eligible to receive any such benefit.

Employer means any person acting directly as an Employer, or indirectly in the interest of an Employer, in relation to an Employee benefit Plan; and includes a group or association of Employees acting for an Employer in such capacity.

Enrollment Date is defined as the date of enrollment of an individual in the Group Health Plan or if earlier, the first day of the Waiting Period for such enrollment.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Essential Health Benefits (EHB) means a set of health care service categories that must be covered by certain Plans. The Affordable Care Act ensures health Plans offer a comprehensive package of items and services, and must include items and services within at least the following ten (10) categories: ambulatory patient services; Emergency Medical Services; hospitalization; maternity and Newborn care; mental health and substance use disorder services, including behavioral health treatment; Prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Expedited Appeal means an Appeal related to a claim for urgent medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could 1) seriously jeopardize the life or health of the Member; or 2) jeopardize the ability of the Member to regain maximum function; or 3) in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Final Adverse Determination means an Adverse Determination, including medical judgment, involving a Covered Service that has been upheld by Vantage, or its designee utilization review organization, at the completion of Vantage's internal claims and Appeals process procedures provided pursuant to La. R.S. 22:2401.

Generic Drug means a prescribed therapeutic equivalent (approved by the FDA) of a brand name Prescription Drug that is usually available at a lower cost.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or family Member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes of chromosomes.

Genetic Testing or Assessment means the examination of Genetic Information contained inside a person's cells to determine if that person has or will develop a certain disease or could pass a certain disease to his or her offspring.

Grievance means the type of complaint a Member files with Vantage for complaints related to Vantage or a Participating Provider about the quality of care received.

Group Health Plan means an Employee welfare benefit Plan (as defined in 29 U.S.C. Chapter 18 (ERISA) and 42 CFR 3.20) to the extent that the Plan provides medical care, including items and services paid for as medical care to Employees or their Dependents, as defined under the terms of the Plan, directly or through insurance, reimbursement or otherwise.

Health Care Provider(s) may include a Hospital, medical doctor (MD), dentist (DDS or DMD), osteopath (DO), pharmacist (RPh) or pharmacy, registered nurse (RN), nurse practitioner (CNP), Physician assistant (PA), registered nurse first assistant (RNFA), occupational therapist, physical therapist, speech therapist, chiropractor, podiatrist (DPM), optometrist (OD) or anesthetist, including certified registered nurse anesthetist (CRNA), licensed by the proper regulatory agency of the state. Health Care Provider may also include a network(s) of any of the Providers listed above.

Health Insurance Coverage means benefits consisting of medical or surgical services, provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care, under any Hospital or medical service policy or certificate, Hospital or medical service plan contract, preferred Provider organization, or health maintenance organization contract offered by a health insurance issuer.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 (U.S. Public Law 104-191) and federal regulations promulgated pursuant thereto.

Hospital means an institution engaged in providing care and treatment for sick and injured people as bed-patients, which provides care by registered, graduate nurses, on duty or on call doctors available at all times, and has on its immediate premises (except in the case of a Hospital specializing in the care and treatment of Mental or Nervous Disorders) an operating room and related equipment for performing surgery.

Hospital does not include any establishment (even though it may be called a Hospital) or any part of any establishment which is primarily a place for any of the following: rest, convalescence, Custodial Care, the care or treatment of Drug addicts or alcoholics, rehabilitation, training, schooling or Occupational Therapy.

Illness means a disorder or disease of the body, or Mental or Nervous Disorder.

Independent Review Organization (IRO) means an entity that conducts independent external reviews of Adverse Determinations and Final Adverse Determinations.

In-Network means services obtained from In-Network Providers.

Initial Tier I Medical Out-of-Pocket Maximum means the specified dollar amounts listed in the Cost Share Schedule for which a Member or family is responsible for certain Tier I Essential Health Benefits (EHB) Eligible Charges. Initial Tier I Medical Out-of-Pocket Maximum exclusions and limitations are described in Section IV. The Initial Tier I family Medical Out-of-Pocket Maximum can be met by two or more family Members.

In-Network Provider(s) or Participating Provider(s) or Participating means those Health Care Providers who have current and valid agreements with Vantage to provide Covered Services to Members of Group Health Plans. In-Network Providers include Tier II Providers.

Late Enrollee is defined as an Employee or Dependent who enrolls under the Plan other than during: 1) the first period in which the individual is eligible to enroll under the Plan, or 2) a Special Enrollment Period.

Late Enrollment means enrollment under a Group Health Plan other than 1) the earliest date on which coverage can become effective under the terms of the Plan; or 2) a Special Enrollment Period for the individual.

Life-Threatening Illness means a disease or condition for which the likelihood of death is probable.

Medical Home Primary Care Physician (MH-PCP) means a Participating family practice, general practice, general pediatrician or general internal medicine Physician, selected by a Vantage Member, who provides the Member with entry into the health care system. The Medical Home Primary Care Physician: (1) evaluates the Member's total health needs; (2) provides personal medical care in one or more medical fields; (3) when Medically Necessary, preserves continuity of care and coordinates care with other Providers of health care services; and (4) coordinates Member care with the Vantage Medical Management department.

Medical Necessity or Medically Necessary means services or supplies, which under the provisions of the contract, are determined to be (1) appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition; (2) provided for the diagnosis or direct care and treatment of the medical condition; (3) within standards of accepted medical practice within the organized medical community; (4) not primarily for the convenience of the Member, the Member's Physician or other Provider; and (5) the most appropriate supply or level of service that can be safely provided.



For Hospital stays, this means that acute care as an inpatient is necessary due to the kinds of services the Member is receiving or the severity of the Member's condition, and that safe and adequate care cannot be received as an outpatient or in a less acute care medical setting.

Medicare Opt-out Physician means any Physician who has opted-out of the Medicare program. When a Physician "opts-out" of Medicare, no services provided by that individual will be covered or reimbursed by Medicare or Vantage, nor will any reimbursement be issued to a Member for items or services provided by that Physician. This Medicare opt-out list is available online at <https://vantagehealthplan.com/Members/optoutphysicians>.

Member(s) means an active or retired Employee, his/her eligible Dependent, or any other individual eligible for coverage under a Group Health Plan for whom the necessary application forms have been completed and executed and for whom the required premiums have been paid.

Mental or Nervous Disorder(s) means a mental, emotional or behavioral disorder, including, but not limited to neurosis, psychoneurosis, psychosis, personality disorder, and alcohol or Drug addiction.

Minimum Essential Coverage means the type of coverage an individual needs to have to meet the health coverage requirements under PPACA.

Newborn means infants from the time of birth until age one (1) month or until such time as the infant is well enough to be discharged from a Hospital or a neonatal special care unit to the infant's home, whichever period is longer.

Non-Essential Health Benefits (Non-EHB) means Covered Services other than Essential Health Benefits.

Non-prescription Drug(s) means any medicine that does not require a prescription from a Health Care Provider.

Occupational Therapy means a healthcare service to evaluate and treat individuals in order for the individual to participate in the things they want and need to do through the therapeutic use of everyday activities (occupations). Common occupational therapy interventions include helping people recovering from injury to regain skills and providing support for older adults experiencing physical and cognitive changes.

Out-of-Network means services obtained from Out-of-Network Providers.

Out-of-Network Provider(s) or Non-Participating Provider(s) means those Health Care Providers who do not have a current and valid contract with Vantage at the time services are rendered. Out-of-Network Providers may balance-bill a Member.

Out-of-Pocket Maximum - See *Initial Tier I Medical Out-of-Pocket Maximum* or *PPACA In-Network Out-of-Pocket Maximum* definitions.

Participating Provider(s) or Participating – See *In-Network Provider* definition.

Patient Protection and Affordable Care Act (PPACA) refers to the federal law enacted on March 23, 2010, along with the Health Care and Education Reconciliation Act of 2010, and all rules and regulations issued thereunder. This law is also sometimes referred to as the Healthcare Reform Law.

Physical Therapy means a healthcare service including evaluation and treatment of any physical or medical condition to restore normal function of the neuromuscular, musculoskeletal, cardiovascular and/or integumentary systems or prevent disability with the use of physical or mechanical means, including therapeutic exercise, mobilization, passive manipulation, therapeutic modalities and activities.

Physician means a medical doctor (MD) or osteopath (DO).

Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of such child. The child's placement with such person ends upon the termination of such legal obligation.

Plan means the Group Health Plan offered in this Certificate of Coverage.

Plan Administrator refers to the party responsible for administering the Group Health Plan for the exclusive benefit of the Members, including an Employer's third party administrator (TPA).

Plan Drug Formulary means a comprehensive listing of Drugs covered by this Plan.

PPACA In-Network Out-of-Pocket Maximum means the specified dollar amounts listed in the Cost Share Schedule for which a Member or family is responsible for In-Network Covered Services pursuant to PPACA regulations. PPACA limits the Member's Cost Share for most Covered Services to the annual out-of-pocket maximum as determined by the Internal Revenue Service. A Member's In-Network Cost Share, including portions of the In-Network Deductible, Co-payment and Co-insurance amounts for In-Network Covered Services and the Initial Tier I Medical Out-of-Pocket Maximum, will not exceed the PPACA In-Network Out-of-Pocket Maximum amount. Out-of-Network and Non-EHB Eligible Charges as well as certain other Member payments are excluded from the PPACA In-Network Out-of-Pocket Maximum as listed in Section IV. The family PPACA In-Network Out-of-Pocket Maximum can be met by two or more family Members.

Pre-Authorization means written authorization from Vantage before receiving certain health services.

Prescription Drug(s) means any medicine that requires a prescription from a Health Care Provider who is authorized by federal or state law to prescribe or refill the medicine.

Prosthetic Device or Prosthesis means an artificial limb designed to maximize function, stability, and safety of the patient. Prosthetic device or prosthesis also means an artificial medical device that is not surgically implanted and that is used to replace a missing limb. The term does not include artificial eyes, ears, nose, dental appliances, ostomy products, or devices such as eyelashes or wigs.

Prosthetic Services means the science and medically necessary practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting or servicing of a Prosthesis through the replacement of external parts of a human body lost due to amputation or congenital deformities to restore function, cosmeses, or both.

Reconstructive Services means reparative or therapeutic surgery or services done to restore the patient's function and appearance to pre-injury or pre-Illness state.

Recurrent Condition means defective state of health returning or happening time after time.

Rescission means cancellation or discontinuance of coverage under Vantage that has a retroactive effect. The term shall not include a cancellation or discontinuance of coverage under a Health Benefit Plan if either:

- (a) The cancellation or discontinuance of coverage has only a prospective effect.
- (b) The cancellation or discontinuance of coverage is effective retroactively to the extent that it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Skilled Nursing Facility means an institution or distinct part of an institution that:

1. Is operated in accordance with the applicable laws of the jurisdiction in which it is located to provide skilled nursing care for sick and injured people; and
2. Provides 24-hour-a-day nursing services under the supervision of a licensed Physician or registered nurse, who is devoted full-time to such supervision; and
3. Maintains clinical records of each patient; and

4. Has appropriate methods and procedures to administer Drugs to patients; and
5. Is not an institution, or part of an institution, that is:
  - a. A Hospital; or
  - b. Primarily for the care of mental illness, drug addiction, alcoholism, or tuberculosis; or
  - c. Primarily engaged in providing domiciliary care, custodial care, educational care, or care for the aged.

Special Enrollment Period is the thirty (30) days after an Employee has other coverage terminated due to: a) loss of eligibility as a result of separation, divorce, death or termination of employment, b) reduction in the number of hours worked, c) COBRA coverage which is exhausted or d) loss of coverage because the Employer contributions were terminated, in which case an Employee may enroll in this Plan.

Specialty Care Provider is a medical or surgical Physician other than those defined as Medical Home Primary Care Physicians.

Specialty Drugs include high cost Drugs and pharmaceuticals produced through DNA technology or biological processes that target chronic or complex disease states and require unique handling, distribution, or administration as well as a customized medical management program for successful use.

Speech Therapy means a healthcare service to evaluate, treat, and diagnose speech, language, cognitive-communication and swallowing disorders in individuals of all ages from infants to the elderly.

Stabilize means to provide treatment that assures that no material deterioration of the condition is likely to result from or occur during the transfer of the Member from a facility.

Supplementary Benefits are additional benefits above and beyond the basic health benefits. There is no Tier II or Out-of-Network coverage for these benefits.

Temporarily Medically Disabled Mother means a woman who has recently given birth and whose Physician has advised that normal travel would be hazardous to her health.

Tier I Cost Share means the Co-payments and Co-insurance referred to in the "Tier I In-Network" column in Section IV of this Certificate of Coverage.

Tier II Co-insurance means the Co-insurance the Member must pay in addition to the Member's Tier I Cost Share. Tier II Co-insurance is based on the applicable Tier II fee schedule and applies before the In-Network Deductible and before the Tier I Cost Share. Tier II Co-insurance is listed in the Cost Share Schedule.

Tier I Provider or Tier I - Members seeing Tier I Providers pay the Co-insurance, Co-payments and In-Network Deductible as shown in Section IV of this Certificate of Coverage, the Cost Share Schedule (Tier I Cost Share), and/or the Member ID Card. Tier I Providers cannot balance-bill the Member.

Tier II Provider or Tier II - Participating Providers whose cost may be higher than other similar Participating Providers. Members who choose to see these Providers will have to pay an additional Co-insurance (Tier II Co-insurance), in addition to the In-Network Deductible, Co-insurance and Co-payments as shown in the Cost Share Schedule (Tier I Cost Share). Tier II Providers cannot balance-bill the Member.

Urgent Care Center means a Physician's office or clinic or other facility primarily engaged in treating patients whose conditions require immediate medical attention. The term Urgent Care Center does not include Hospital emergency department or other outpatient emergency department or other outpatient Hospital facility.

Utilization Review/Quality Management (UR/OM) means a function performed by Vantage or its designee to review and approve or deny authorization or payment for Covered Services as to the Medical Necessity

and quality of the care and compliance with agreed-upon policies, procedures and protocols established by Vantage.

Vantage Allowable means the amount Vantage would pay to a Tier I Provider for the Covered Service as specified in the applicable Provider contract or the amount set forth in the Vantage Allowable fee schedule, as determined by Vantage.

Vantage Service Area means the geographic area served by Vantage as approved by the Louisiana Department of Insurance and defined by the Employer for purposes of eligibility and enrollment in this Plan.

Waiting Period is defined as the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the Plan.

## SECTION IV: SCHEDULE OF COVERED SERVICES & BENEFITS

Coverage will be provided for the Covered Services listed. Covered Services are the Medically Necessary services and supplies, including Prescription Drugs, received upon the recommendation and approval of a Physician and required for the treatment of a Member, subject to the health care benefit offered by Employers to Employees as part of a Group Health Plan under an agreement with Vantage and subject to the exclusions and limitations listed in Section V of this Certificate of Coverage.

The Benefit Level is usually determined by the Provider's network status. However, the Benefit Level for services cannot be better than the network status of the ordering Physician for outpatient services and the admitting Physician for inpatient services.

Covered Services are subject to the Co-insurance, Co-payments, and Deductibles shown in the Cost Share Schedule and/or in this Section IV. Co-insurance, Co-payments, and Deductibles are a Member's responsibility and may be due at the time services are rendered.

The In-Network Out-of-Pocket Maximums described in the Cost Share Schedule will limit the amount a Member will pay out-of-pocket for In-Network Benefit Level Covered Services each Benefit Period subject to the exclusions and limitations listed below.

### ***Deductibles***

Deductibles are the amounts shown on the Cost Share Schedule that the Member must pay each Benefit Period before certain medical benefits are payable under the Plan. The Deductibles apply to Eligible Charges to be paid by each Member or family during the Benefit Period and are based on the Benefit Level of the rendering Provider. Co-insurance and Co-payments do not apply toward the Deductibles. Charges above the Vantage Allowable for services provided by Out-of-Network Providers do not apply toward the Deductibles.

The family Deductible can be met by two or more family Members. A single family Member has met his/her Deductible by reaching the individual Deductible amount. Other family Members' payments for Eligible Charges combine to meet the remainder of the family Deductible amount.

There are separate In-Network and Out-of-Network Deductibles in this Plan.

The In-Network Deductible for Eligible Charges is the amount specified in the Cost Share Schedule and Member ID Card. In-Network Eligible Charges which are subject/not subject to the In-Network Medical Deductible are noted in the applicable benefits in this Section. All Out-of-Network Eligible Charges are subject to the Out-of-Network Deductible.

Any portion of the In-Network Deductible which was met by services listed as exclusions and limitations in Section IV does not apply to the In-Network Out-of-Pocket Maximums.

### ***In-Network Out-of-Pocket Maximums***

Co-payments or Co-insurance for In-Network Eligible Charges which are included in or excluded from one or both of the In-Network Out-of-Pocket Maximums below are noted in the applicable benefits in Section. Most In-Network Eligible Charges that are included in the Deductible are included in the Initial Tier I Medical Out-of-Pocket Maximum and the PPACA In-Network Out-of-Pocket Maximum.

#### ***Initial Tier I Medical Out-of-Pocket Maximum***

**Individual:** The Initial Tier I Medical Out-of-Pocket Maximum for Tier I Benefit Level Eligible Charges is the amount specified in the Cost Share Schedule. After a Member's share of Tier I Benefit Level Eligible Charges to be paid during a Benefit Period equals the applicable individual Initial Tier I Medical Out-of-Pocket Maximum specified in the Cost Share Schedule, the Plan will pay Tier I Benefit Level Eligible Charges for that Member at 100% of the Vantage Allowable for the remainder of the Benefit Period subject to the exclusions and limitations listed below.

Family: The Out-of-Pocket Maximum for Tier I Benefit Level Covered Services is the amount specified in the Cost Share Schedule. The family Initial Tier I Medical Out-of-Pocket Maximum can be met by two or more family Members. A single family Member has met his or her Initial Tier I Medical Out-of-Pocket Maximum by reaching the individual Initial Tier I Medical Out-of-Pocket amount. Other family Members' payments for Eligible Charges combine to meet the remainder of the family Initial Tier I Medical Out-of-Pocket Maximum amount. After a Member's and his or her Dependent's shares of Tier I Benefit Level Eligible Charges to be paid during a Benefit Period equals the applicable family Initial Tier I Medical Out-of-Pocket Maximum specified in the Cost Share Schedule, the Plan will pay Tier I Benefit Level Eligible Charges for that Member and his or her Dependents at 100% of the Vantage Allowable for the remainder of the Benefit Period subject to the exclusions and limitations listed below.

**Exclusions and limitations for Initial Tier I Medical Out-of-Pocket Maximum**

Charges incurred by a Member for the following will NOT be applied to the Initial Tier I Out-of-Pocket Maximum:

- i. Office visit Co-payments
- ii. Durable Medical Equipment Co-insurance
- iii. Urgent Care Centers Co-payments
- iv. Certain Other Covered Services (as noted in the applicable benefits in this Section)
- v. Outpatient Mental Health Services Co-payments
- vi. Approved Transplant Services Co-payments and Co-insurance
- vii. Prescription Drug Co-payments and Co-insurance
- viii. Approved clinical trials
- ix. Services performed by Tier II In-Network Providers
- x. Accidental Dental Co-insurance
- xi. Supplementary Benefits Deductible, Co-insurance or Co-payments
- xii. Services performed by Out-of-Network Providers (except for Emergency Medical Services)
- xiii. Services performed by Medicare Opt-Out Physicians
- xiv. Charges in excess of the maximum benefit available
- xv. Charges that are not Eligible Charges
- xvi. Charges above the Vantage Allowable for Covered Services performed by Out-of-Network Providers
- xvii. Monthly premium payments
- xviii. Prescription Drugs not included in the Plan Drug Formulary, except when approved through the Drug exception process
- xix. Charges in excess of the maximum Prescription Drug benefit available (e.g., the difference between the cost of a brand name Prescription Drug and the cost of its Generic Drug equivalent)
- xx. Prescription Drugs received from Out-of-Network pharmacies (unless approved as an out-of-area Emergency)
- xxi. Charges above the Vantage Participating pharmacy reimbursement rate for Prescription Drugs received from an Out-of-Network Provider in an approved out-of-area Emergency
- xxii. Specialty Drugs not provided by the Plan's contracted specialty pharmacy

***PPACA In-Network Out-of-Pocket Maximum***

PPACA limits the Member's Cost Share for Essential Health Benefits (EHB) to the annual out-of-pocket maximum as determined by the Internal Revenue Service. A Member's In-Network Cost Share, including In-Network portions of the In-Network Deductible, Co-payment and Co-insurance amounts for In-Network Covered Services and the Initial Tier I Medical Out-of-Pocket Maximum, will not exceed the PPACA In-Network Out-of-Pocket Maximum amount. Prescription Drug Covered Services are EHB Covered Services. The PPACA In-Network Out-of-Pocket Maximum is \$6,850 for an individual policy and \$13,700 for a family policy.

**For single-coverage individual policy Members (Members with no Dependents):**

The PPACA In-Network Out-of-Pocket Maximum is a Member's share of In-Network EHB Covered Services (including items i. – ix. above in the Initial Tier I Medical Out-of-Pocket Maximum exclusions list) and is subject to the exclusions and limitations noted below. After a Member's share of such In-

Network Covered Services to be paid during a Benefit Period equals the PPACA In-Network Out-of-Pocket Maximum, the Plan will pay those In-Network Covered Services for the Member at 100% of the Vantage Allowable for the remainder of the Benefit Period.

For family-coverage policy Members (Members with one or more Dependents):

The PPACA In-Network Out-of-Pocket Maximum is a Member's and his or her Dependents' shares of In-Network EHB Covered Services (including items i. – ix. above in the Initial Tier I Medical Out-of-Pocket Maximum exclusions list) and is subject to the exclusions and limitations noted below. The family PPACA In-Network Out-of-Pocket Maximum can be met by two or more family Members. A single family Member has met his or her PPACA In-Network Out-of-Pocket Maximum by reaching the individual PPACA In-Network Out-of-Pocket amount. Other family Members' payments for Covered Services combine to meet the remainder of the family PPACA In-Network Out-of-Pocket Maximum amount. After a Member's and his or her Dependent's shares of such In-Network Covered Services to be paid during a Benefit Period equals the applicable family PPACA In-Network Out-of-Pocket Maximum specified in the Cost Share Schedule, the Plan will pay those In-Network Covered Services for that Member and his or her Dependents at 100% of the Vantage Allowable for the remainder of the Benefit Period.

**Exclusions and limitations for PPACA In-Network Out-of-Pocket Maximum**

Out-of-Network and Non-EHB Eligible Charges as well as certain other Member payments (shown below) are excluded from the PPACA In-Network Out-of-Pocket Maximum. Charges incurred by a Member or any Dependent for the following will NOT be applied to the PPACA In-Network Out-of-Pocket Maximum:

- i. Any portion of the In-Network Deductible which was met by any of the exclusions listed below
- ii. Routine Vision Exam Co-payments for Adults
- iii. Accidental Dental Co-insurance
- iv. Supplementary Benefits Co-insurance or Co-payments
- v. Services performed by Out-of-Network Providers (except for Emergency Medical Services)
- vi. Services performed by Medicare Opt-Out Physicians
- vii. Charges in excess of the maximum benefit available
- viii. Charges that are not Covered Services
- ix. Charges above the Vantage Allowable for Covered Services performed by Out-of-Network Providers
- x. Monthly premium payments
- xi. Prescription Drugs not included in the Plan Drug Formulary, except when approved through the Drug exception process
- xii. Charges in excess of the maximum Prescription Drug benefit available (e.g., the difference between the cost of a brand name Prescription Drug and the cost of its Generic Drug equivalent)
- xiii. Prescription Drugs received from Out-of-Network pharmacies (unless approved as an out-of-area Emergency)
- xiv. Charges above the Vantage Participating pharmacy reimbursement rate for Prescription Drugs received from an Out-of-Network Provider in an approved out-of-area Emergency
- xv. Specialty Drugs not provided by the Plan's contracted specialty pharmacy

***Out-of-Network Out-of-Pocket Maximum***







There is no Out-of-Pocket Maximum for Out-of-Network Covered Services.

**The Tier I In-Network benefits that appear on the following pages:**

- ▶ **Must be arranged by your MH-PCP.**
- ▶ **Reflect the coverage provided by Tier I Providers. If the Covered Service is performed by a Tier II Provider, the Member will pay the Tier II Co-insurance in addition to the Tier I Cost Share.**



**The same Covered Services which require Pre-Authorization for Tier I Providers also require Pre-Authorization for Tier II Providers.**

-  **Certain benefits require that care must be received from Participating Providers and arranged by your MH-PCP. Such benefits included in this section are designated as “No Out-of-Network coverage” in the service category heading or are noted in the “Out-of-Network” column.**
-  **If you receive services from an Out-of-Network Provider, the charges may be significantly more than an In-Network Provider’s fees and/or the Vantage Allowable. You may be balance-billed by the Out-of-Network Provider for the cost of services exceeding the Vantage Allowable. In-Network Providers cannot balance-bill Members. Charges above the Vantage Allowable for Covered Services provided by Out-of-Network Providers do not apply to any Deductible or to any Out-of-Pocket Maximum.**
-  **All Covered Services except Emergency Medical Services performed by Out-of-Network Providers require Pre-Authorization.**
-  **Coverage shall not be provided and no payment shall be made under this Plan for services performed by Medicare Opt-out Physicians.**
-  **Specialty Drugs must be provided by the Plan’s contracted specialty pharmacy. When Specialty Drugs are not provided by the Plan’s contracted specialty pharmacy, regardless of place of service (e.g., inpatient, outpatient, Physician’s office, etc.), Pre-Authorization is required and the Plan’s payment is limited to what the Plan would have paid its specialty pharmacy less the Prescription Drug Co-payment.**
-  **Please refer to the following important information concerning Co-insurance, Co-payments, Deductibles, and the Out-of-Pocket Maximums when reviewing this section.**
- ▶ Covered Services are subject to the Co-insurance, Co-payments, Deductibles and maximums shown in this Certificate of Coverage and/or the Cost Share Schedule.
  - ▶ Co-insurance, Co-payments and Deductibles are a Member’s responsibility and may be due at the time services are rendered.
  - ▶ Member medical Cost Share amounts are applied in the following order: 1) Tier II Co-insurance, 2) Out-of-Network Medical Deductible and Co-insurance, 3) Supplementary Benefit Co-insurance, 4) Tier I Co-payments, 5) In-Network Deductible, and 6) Tier I Co-insurance.
  - ▶ Co-insurance and Co-payment amounts do not apply *toward* any Deductible.
  - ▶ Certain Tier I Co-payments and Co-insurance amounts or percentages do not apply to the In-Network Out-of-Pocket Maximums and are noted in the applicable benefits in this section.
  - ▶ There is no Out-of-Pocket Maximum for Out-of-Network Covered Services.
  - ▶ Cost Share for certain specified Covered Services and mail-order Prescription Drugs provided by AHN Providers is lower than the Cost Share for such services provided by standard Vantage In-Network Providers.



## Physician Office Services

Physician office services are Medically Necessary services for the treatment of Accidental Bodily Injury, Illness, injury or disease that are rendered in the Physician's office.

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO DEDUCTIBLE)
<p><b>Medical Home Primary Care Physician (“MH-PCP”) Office Visits:</b> Family practice, general practice, general pediatrician and general internal medicine Physician office visits.</p>	<p>100% Coverage of Vantage Allowable less applicable Medical Home Primary Care Physician office visit Co-payment. Not subject to Deductible. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p>	<p>Member pays Out-of-Network Co-insurance. See Cost Share Schedule.</p>
<p><b>Specialty Care Provider Office Visits (including consultation visits):</b></p> <ul style="list-style-type: none"> <li>▶ Medical or surgical Physician other than those defined as Medical Home Primary Care Physicians.</li>   <li>▶ Routine Vision Exam for Children: One (1) each Benefit Period for children age 18 and younger. Includes dilation (refraction).</li>   <li>▶ Routine Vision Exam for Adults: One (1) each Benefit Period.</li> </ul>	<p>100% Coverage of Vantage Allowable less applicable Specialty Care office visit Co-payment. Not subject to Deductible. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p> <p>100% Coverage of Vantage Allowable less applicable Specialty Care office visit Co-payment. Not subject to Deductible. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p> <p>100% Coverage of Vantage Allowable less applicable Specialty Care office visit Co-payment. Not subject to Deductible. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Excluded</b></p>	<p>Member pays Out-of-Network Co-insurance. See Cost Share Schedule.</p> <p>Member pays Out-of-Network Co-insurance. See Cost Share Schedule.</p> <p>Member pays Out-of-Network Co-insurance. See Cost Share Schedule.</p>

\* When you seek treatment from an Out-of-Network Provider, the charges may be more than the Vantage Allowable. The Out-of-Network Provider may balance-bill you for any charges over the Vantage Allowable. In-Network Providers cannot balance-bill Members. All services except Emergency Medical Services performed by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

**Physician Office Services (continued)**

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO DEDUCTIBLE)
<p><b>Office Diagnostic Services:</b> Lab and x-ray services performed in the Physician office.</p> <ul style="list-style-type: none"> <li>▶ Lab</li>   <li>▶ X-rays and other office diagnostic services, excluding major diagnostic tests.</li>   <li>▶ Major diagnostic testing (See list of services in the outpatient Hospital services category.) <b>Requires Pre-Authorization.</b></li> </ul>	<p>100% Coverage of Vantage Allowable. May be subject to Deductible. Contact Plan for details.</p> <p>Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p> <p>100% Coverage of Vantage Allowable. Not subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p> <p>100% Coverage of Vantage Allowable less the major diagnostic Co-payment per test. Not subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p>	<p>Member pays Out-of-Network Co-insurance. See Cost Share Schedule.</p> <p>Member pays Out-of-Network Co-insurance. See Cost Share Schedule.</p> <p>Member pays Out-of-Network Co-insurance. See Cost Share Schedule.</p>

\* When you seek treatment from an Out-of-Network Provider, the charges may be more than the Vantage Allowable. The Out-of-Network Provider may balance-bill you for any charges over the Vantage Allowable. In-Network Providers cannot balance-bill Members. All services except Emergency Medical Services performed by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.





## Wellness & Preventive Care

Wellness and preventive care services include health evaluation for the prevention and early detection of illness, injury or disease provided or arranged by your MH-PCP.

### PPACA Wellness & Preventive Care Services

Vantage wellness and preventive care services shall be Covered Services in accordance with the Patient Protection and Affordable Care Act (PPACA or Affordable Care Act) and all rules and regulations issued thereunder. These services shall be provided by In-Network Providers without cost-sharing (i.e., Co-payment and Co-insurance will not apply to wellness and preventive care In-Network Covered Services.) PPACA wellness and preventive care services are listed online at the following websites:

U.S. Preventive Services Task Force

<http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>

Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention

<http://www.cdc.gov/vaccines/hcp/acip-recs/index.html>

Health Resources and Services Administration

<http://www.hrsa.gov/index.html>

COVERED SERVICE	IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO DEDUCTIBLE)
<p><b>Annual Examination:</b></p> <ul style="list-style-type: none"> <li>▶ One (1) routine physical exam per Member per Benefit Period.</li> <li>▶ Routine lab services performed as part of the routine physical exam: CBC, CMP, TSH, Lipid Panel and UA.</li> <li>▶ <b>Colorectal Cancer Screening:</b> <ul style="list-style-type: none"> <li>▪ Fecal immunochemical test for blood (FIT): One (1) every year as part of the routine physical exam. No Pre-Authorization required.</li> <li>▪ Flexible sigmoidoscopy: One (1) every five (5) years for ages 50 and over. <b>Pre-Authorization required.</b></li> <li>▪ Screening Colonoscopy: One (1) every ten (10) years for ages 50 and over (age 45 for African Americans). <b>Pre-Authorization required.</b></li> </ul> </li> </ul>	<p>100% Coverage of Vantage Allowable. Not subject to Deductible.</p>	<p>Member pays Out-of-Network Co-insurance. See Cost Share Schedule.</p>
<p><b>Immunizations &amp; Vaccines:</b></p>	<p>100% Coverage of Vantage Allowable. Not subject to Deductible.</p>	<p>Member pays Out-of-Network Co-insurance. See Cost Share Schedule.</p>

\* When you seek treatment from an Out-of-Network Provider, the charges may be more than the Vantage Allowable. The Out-of-Network Provider may balance-bill you for any charges over the Vantage Allowable. In-Network Providers cannot balance-bill Members. All services except Emergency Medical Services performed by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

**Wellness & Preventive Care (continued)**

<b>COVERED SERVICE</b>	<b>IN-NETWORK COVERAGE</b>	<b>OUT-OF-NETWORK* (SUBJECT TO DEDUCTIBLE)</b>
<p><b>Vantage Wellness Program (administered by Affinity Health Network):</b> Vantage offers the following four (4) wellness incentive programs:</p> <ul style="list-style-type: none"> <li>▶ Health Maintenance;</li> <li>▶ Tobacco Cessation;</li> <li>▶ Weight Loss; and</li> <li>▶ Combination Weight Loss and Tobacco Cessation.</li> </ul>	<p>100% Coverage of Vantage Allowable for Affinity Health Network services only.  Not subject to Deductible.</p>	<p>No Out-of-Network coverage.</p>
<p><b>Men’s Health:</b></p> <ul style="list-style-type: none"> <li>▶ Routine prostate test (PSA) per Member per Benefit Period.</li> <li>▶ Digital rectal examination for men over age 50 and as Medically Necessary for men ages 40-50.</li> </ul>	<p>100% Coverage of Vantage Allowable.  Not subject to Deductible.</p>	<p>Member pays Out-of-Network Co-insurance. See Cost Share Schedule.</p>
<p><b>Women’s Health:</b></p> <ul style="list-style-type: none"> <li>▶ <b>Routine pelvic examination:</b> Includes one (1) routine Pap test per Member per Benefit Period.</li>   <li>▶ <b>Screening Mammogram:</b> <ul style="list-style-type: none"> <li>▪ One (1) baseline mammogram for any woman who is 35-39 years of age.</li> <li>▪ One (1) mammogram every twelve (12) to twenty-four (24) months for any woman who is 40-49 years of age, or more frequently if recommended by a Physician.</li> <li>▪ One (1) mammogram every twelve (12) months for any woman who is 50 years of age or older.</li> </ul> </li> </ul>	<p>100% Coverage of Vantage Allowable. Not subject to Deductible. (Any gynecological examination other than the routine pelvic exam and PAP test is subject to the Deductible and is included in the PPACA In-Network Out-of-Pocket Maximum.)</p> <p>100% Coverage of Vantage Allowable. Not subject to Deductible. (Any mammography other than the screening mammogram is subject to the Deductible and is included in the PPACA In-Network Out-of-Pocket Maximum.)</p>	<p>Member pays Out-of-Network Co-insurance. See Cost Share Schedule.</p> <p>Member pays Out-of-Network Co-insurance. See Cost Share Schedule.</p>

\* When you seek treatment from an Out-of-Network Provider, the charges may be more than the Vantage Allowable. The Out-of-Network Provider may balance-bill you for any charges over the Vantage Allowable. In-Network Providers cannot balance-bill Members. All services except Emergency Medical Services performed by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

## Inpatient Hospital Services

Providers' services which are Medically Necessary for the treatment of Accidental Bodily Injury, Illness, injury or disease rendered while admitted as an inpatient to a facility. Perioperative services rendered by a Registered Nurse First Assistant will be covered if the same service would be covered when rendered by a Physician.

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO DEDUCTIBLE)
<p><b>Inpatient Semi-Private Room:</b> Including Intensive Care Units (ICU) and Cardiac Care Units (CCU).  <b>Requires Pre-Authorization.</b></p>	<p>100% Coverage of Vantage Allowable less applicable inpatient Co-payment. Subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p>	<p>Member pays Out-of-Network Co-insurance. See Cost Share Schedule.</p>
<p><b>Physician Services:</b> Surgery, pre- and post-operative medical visits, assistant surgeon services if warranted, approved anesthesia services by CRNA or Physician, consultations, concurrent care, and in-hospital visits.</p>	<p>100% Coverage of Vantage Allowable. Subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p>	<p>Member pays Out-of-Network Co-insurance. See Cost Share Schedule.</p>

## Ambulatory Surgery Unit (ASU) or Outpatient Surgery

Providers' services which are Medically Necessary for the treatment of Accidental Bodily Injury or Illness, injury or disease rendered in a Hospital or a free-standing surgical facility, whether affiliated with a Physician's office or not.

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO DEDUCTIBLE)
<p><b>Ambulatory Surgery Unit (ASU) or Outpatient Surgery:</b>  <b>Requires Pre-Authorization.</b></p>	<p>100% Coverage of Vantage Allowable less applicable ASU/outpatient surgery Co-payment. Subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p>	<p>Member pays Out-of-Network Co-insurance. See Cost Share Schedule.</p>
<p><b>Physician Services:</b> Surgery, pre- and post-operative medical visits, assistant surgeon services if warranted, approved anesthesia services by CRNA or Physician and consultations.</p>	<p>100% Coverage of Vantage Allowable. Subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p>	<p>Member pays Out-of-Network Co-insurance. See Cost Share Schedule.</p>

\* When you seek treatment from an Out-of-Network Provider, the charges may be more than the Vantage Allowable. The Out-of-Network Provider may balance-bill you for any charges over the Vantage Allowable. In-Network Providers cannot balance-bill Members. All services except Emergency Medical Services performed by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.






**Outpatient Hospital Services (continued)**

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO DEDUCTIBLE)
<p><b>Other Hospital Outpatient Services:</b></p> <ul style="list-style-type: none"> <li>▶ Lab services.</li>   <li>▶ Diagnostic tests, ultrasounds, x-rays, and other Hospital outpatient services not listed elsewhere in this Section IV and not performed in an office visit setting.</li> </ul>	<p>100% Coverage of Vantage Allowable. Not subject to Deductible. Lab services performed in the emergency room are subject to Deductible and are included in the PPACA Tier I Out-of-Pocket Maximum.</p> <p>Not subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p>	<p>Member pays Out-of-Network Co-insurance. See Cost Share Schedule.</p> <p>Member pays Out-of-Network Co-insurance. See Cost Share Schedule.</p>

**After-Hours/Walk-In Clinics and Urgent Care Centers**

Urgent Care Centers do not include Hospital Emergency departments or other outpatient emergency departments or other outpatient Hospital facility.

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO DEDUCTIBLE)
<p><b>After-Hours/Walk-In Clinics:</b></p>	<p>100% Coverage of Vantage Allowable less the applicable office visit Co-payment. Not subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p>	<p>Member pays Out-of-Network Co-insurance. See Cost Share Schedule.</p>
<p><b>Urgent Care Centers:</b></p> <p> <b>Follow-up visits require Pre-Authorization.</b></p>	<p>100% Coverage of Vantage Allowable less urgent care Co-payment. Not subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p>	<p>Member pays Out-of-Network Co-insurance. See Cost Share Schedule.</p>

\* When you seek treatment from an Out-of-Network Provider, the charges may be more than the Vantage Allowable. The Out-of-Network Provider may balance-bill you for any charges over the Vantage Allowable. In-Network Providers cannot balance-bill Members. All services except Emergency Medical Services performed by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

## Emergency Medical Services

Emergency Medical Services are those medical services necessary to screen, evaluate, and stabilize an Emergency Medical Condition. Coverage is available for Accidental Bodily Injury or sudden onset of an acute Illness (see Emergency criteria below). **Return visits** to the Emergency facility for follow-up care are **not covered**. If Emergency Medical Services are provided by Tier II Providers, the Tier II Co-insurance applies. Payments of claims for Emergency Medical Services rendered by a Non-Participating Health Care Provider are not made directly to the Member.

Emergency criteria:

- Severe pain or the sudden onset of pain. Examples include: chest pain, headache with neurological changes or acute severe abdominal pain.
- Severe hemorrhage or bleeding
- Respiratory distress
- Accidental Bodily Injuries. Examples include: 2<sup>nd</sup> & 3<sup>rd</sup> degree burns, lacerations requiring sutures, or bone fractures.
- Obvious severe emotional distress requiring treatment with IM or IV Drugs
- Unconsciousness
- Convulsions

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK COVERAGE*
<p><b>Emergency Room Service and Supplies (Emergency Medical Services only):</b></p> <ul style="list-style-type: none"> <li>▶ If treated and released within 24 hours of onset of Illness or injury.</li>   <li>▶ If admitted within 24 hours subsequent to treatment.</li> </ul>	<p>100% Coverage of Vantage Allowable less applicable emergency room Co-payment for each visit. Not subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p> <p>100% Coverage of Vantage Allowable. Emergency room Co-payment waived if admitted. Not subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p>	<p>100% Coverage of Vantage Allowable less applicable emergency room Co-payment for each visit. Subject to In-Network Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p> <p>100% Coverage of Vantage Allowable. Emergency room Co-payment waived if admitted. Subject to In-Network Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p>

\* When you seek treatment from an Out-of-Network Provider, the charges may be more than the Vantage Allowable. The Out-of-Network Provider may balance-bill you for any charges over the Vantage Allowable. In-Network Providers cannot balance-bill Members. All services except Emergency Medical Services performed by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

**Emergency Medical Services (continued)**

COVERED SERVICE	IN-NETWORK COVERAGE	OUT-OF-NETWORK COVERAGE*
<p><b>Ambulance Service:</b> Ambulance service provided by a professional ambulance service for local ground transportation to a Hospital for a covered medical Emergency. Air ambulance services are available only if this type of Ambulance Service is requested by policing or medical authorities at the site in an Emergency situation or the Member is in a location that cannot be reached by a ground ambulance.</p>	<p>Member pays applicable In-Network Co-insurance. Subject to Deductible. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p>	<p>Member pays applicable In-Network Co-insurance. Subject to In-Network Deductible. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p>
<p><b>Ambulance Transfers:</b> Ambulance transfers by a professional ambulance service from an Out-of-Network Provider Hospital to an In-Network Provider Hospital or from a Hospital to other medical facility or home if Medically Necessary. <b>Requires Pre-Authorization.</b></p>	<p>Member pays applicable In-Network Co-insurance. Subject to Deductible. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p>	<p>Member pays applicable In-Network Co-insurance. Subject to In-Network Deductible. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p>

\* When you seek treatment from an Out-of-Network Provider, the charges may be more than the Vantage Allowable. The Out-of-Network Provider may balance-bill you for any charges over the Vantage Allowable. In-Network Providers cannot balance-bill Members. All services except Emergency Medical Services performed by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

## Durable Medical Equipment and Supplies

Durable Medical Equipment (DME) are items that serve a medical purpose only and are Medically Necessary for the treatment of illness or injury, and can withstand long-term repeated use, and are appropriate for home use.



**Supplies must be Medically Necessary and provided by or under the direction of a Physician outside of a Hospital, Skilled Nursing Facility (SNF), or other Vantage approved health care facility. Replacement of an item *previously* furnished will be solely at Vantage’s option.**



**DME Co-insurance does not apply to the Initial Tier I Medical Out-of-Pocket Maximum.**

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO DEDUCTIBLE)
<p><b>Durable Medical Equipment and Supplies as defined in “Definitions” (Section III):</b></p> <ul style="list-style-type: none"> <li>▶ Oxygen and rental of equipment for its administration. <b>Requires Pre-Authorization.</b></li> <li>▶ Rental, not to exceed purchase price, of: <ul style="list-style-type: none"> <li>▪ Wheelchair, crutches, canes or walkers</li> <li>▪ Hospital bed</li> <li>▪ Home ventilation equipment for treatment of Chronic and acute respiratory failure. <b>Requires Pre-Authorization.</b></li> </ul> </li> </ul>	<p>Member pays applicable In-Network Co-insurance. Subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p>	<p>Member pays Out-of-Network Co-insurance. See Cost Share Schedule.</p>
<p><b>Diabetic Supplies:</b> Limited to Glucocard Shine Meter Kit blood glucose monitoring system (1 meter per Benefit Period) and Glucocard Shine Test Strips (50-count packages) manufactured by ARKRAY USA, Inc. Members may receive up to a 90-day supply per order. No Pre-Authorization required.</p> <ul style="list-style-type: none"> <li>▶ Affinity Health Network’s Saint John Pharmacy in Monroe, LA (available direct or through the mail)</li> <li>▶ All other Providers</li> </ul>	<p>100% Coverage of Vantage Allowable. Not subject to Deductible.</p> <p>Member pays applicable In-Network Co-insurance. Subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p>	<p>Not applicable.</p> <p>Member pays Out-of-Network Co-insurance. See Cost share Schedule.</p>

\* When you seek treatment from an Out-of-Network Provider, the charges may be more than the Vantage Allowable. The Out-of-Network Provider may balance-bill you for any charges over the Vantage Allowable. In-Network Providers cannot balance-bill Members. All services except Emergency Medical Services performed by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

**Durable Medical Equipment and Supplies (continued)**

<b>COVERED SERVICE</b>	<b>TIER I IN-NETWORK COVERAGE</b>	<b>OUT-OF-NETWORK* (SUBJECT TO DEDUCTIBLE)</b>
<p><b>Hearing Aid for Minor Member:</b> Member must be under the age of eighteen (18). The hearing aid must be fitted and dispensed by a Participating licensed audiologist or hearing aid specialist following a medical clearance by a Participating Physician and an audiological evaluation medically appropriate to the age of the minor Member. The maximum benefit shall cover a mid-level digital hearing aid for each impaired ear not to exceed one every thirty-six (36) months. <b>Requires Pre-Authorization.</b></p>	<p>Member pays applicable In-Network Co-insurance. Subject to Deductible. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p>	<p>Member pays Out-of-Network Co-insurance. See Cost Share Schedule.</p>
<p><b>Insulin Pump, Training and Supplies:</b> ▶ Limited to one pump per Member per lifetime. No replacements are covered. Medical Necessity criteria must be met. ▶ Training, supplies, and other services specific to the insulin pump. <b>Requires Pre-Authorization.</b></p>	<p>Member pays applicable In-Network Co-insurance. Subject to Deductible. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p>	<p>No coverage for Out-of-Network Providers.</p>
<p><b>Prosthetic Devices and Prosthetic Services:</b> Artificial limbs, braces and appliances to replace physical organs or parts that are not surgically implanted. Must be designed to aid or maximize function, stability, and safety. Prosthetic Device or Prosthesis must be Medically Necessary as a result of injury or Illness. <b>Requires Pre-Authorization.</b></p>	<p>Member pays applicable In-Network Co-insurance. Subject to Deductible. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p>	<p>Member pays Out-of-Network Co-Insurance. See Cost Share Schedule.</p>

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## Extended Care Facilities

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO DEDUCTIBLE)
<p><b>Long-Term Acute Care Facility (post-acute illness or injury):</b> Semi-private room and board and Medically Necessary services. Benefit limit of sixty (60) days per Benefit Period. <b>Requires Pre-Authorization.</b></p>	<p>Extended care facility Co-payment may apply. Subject to Deductible. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p>	<p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p>
<p><b>Rehabilitation Facility (post-acute illness or injury, non-custodial):</b> Semi-private room and board and Medically Necessary services and supplies. Member must be able to tolerate a minimum of three (3) hours of active therapy per day. Must begin within seventy-two (72) hours following the discharge from an inpatient Hospital admission for the same or similar condition. Benefit limit of sixty (60) days per Benefit Period. <b>Requires Pre-Authorization.</b></p>	<p>100% Coverage of Vantage Allowable less extended care facility Co-payment. Subject to Deductible. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p>	<p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p>
<p><b>Skilled Nursing Facility (post-Hospital, non-custodial):</b> Semi-private room and board and Medically Necessary services and supplies. Benefit limit of sixty (60) days per Benefit Period. <b>Requires Pre-Authorization.</b></p>	<p>100% Coverage of Vantage Allowable less extended care facility Co-payment. Subject to Deductible. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p>	<p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p>

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## Other Covered Services

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO DEDUCTIBLE)
<p><b>Accidental Dental:</b> Repair to sound and natural teeth damaged or injured (See “Definitions” Section III for <i>Accident</i> and <i>Accidental Bodily Injury</i>). Dental implants are not covered. Extractions of wisdom teeth are not covered. <b>Requires Pre-Authorization.</b> <b>Follow-up visits require Pre-Authorization.</b></p>	<p>Member pays applicable In-Network Co-insurance. Subject to Deductible. See Cost Share Schedule.  Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Excluded</b></p>	<p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p>
<p><b>Allergenic Testing:</b> Diagnostic testing and immuno-therapy. <b>Requires Pre-Authorization.</b></p>	<p>Member pays applicable In-Network Co-insurance. Subject to Deductible. See Cost Share Schedule.  Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p>	<p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p>
<p><b>Anesthesia and Hospitalization for Dental Procedures:</b> Only applies when the mental or physical condition of the insured requires dental treatment to be rendered in a Hospital setting. Coverage does not apply to treatment rendered for temporal mandibular joint (TMJ) disorders. <b>Requires Pre-Authorization.</b></p>	<p>100% Coverage of Vantage Allowable less applicable inpatient or ASU/outpatient surgery Co-payment. Subject to Deductible. See Cost Share Schedule.  Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p>	<p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p>

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**Other Covered Services (continued)**

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO DEDUCTIBLE)
<p><b>Attention Deficit/Hyperactivity Disorder:</b> Diagnosis and treatment of attention deficit/hyperactivity disorder.</p>	<p><b>Office Visits:</b> 100% Coverage of Vantage Allowable less applicable Medical Home Primary Care Physician or Specialty Care office visit Co-payment. Not subject to Deductible. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p> <p><b>Other Services:</b> Member pays applicable In-Network Co-insurance. Subject to Deductible. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p> <p><b>Requires Pre-Authorization.</b></p>	<p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p> <p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p>
<p><b>Autism Spectrum Disorders:</b> Member must be under the age of seventeen (17). Includes coverage for diagnosis and treatment for Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, and any other pervasive Developmental Disorder defined in the most recent edition of the Diagnostic and Statistical Manual of mental Disorders (DSM). Treatment by Providers that includes Applied Behavior Analysis must be certified by the Behavior Analyst Certification Board or provide documented evidence of equivalent education, professional training, and supervised experience. <b>Requires Pre-Authorization.</b></p>	<p>Member pays applicable In-Network Co-insurance. Not subject to Deductible. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p>	<p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p>

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**Other Covered Services (continued)**

<b>COVERED SERVICE</b>	<b>TIER I IN-NETWORK COVERAGE</b>	<b>OUT-OF-NETWORK* (SUBJECT TO DEDUCTIBLE)</b>
<p><b>Bone Density (Bone Mass Measurement):</b></p> <ul style="list-style-type: none"> <li>▪ One (1) preventive bone density screening for women over age 50. No Pre-Authorization required.</li> <li>▪ All other bone density tests for the following Members:               <ul style="list-style-type: none"> <li>(a) An estrogen-deficient woman at clinical risk of osteoporosis who is considering treatment;</li> <li>(b) An individual receiving long-term steroid therapy; or</li> <li>(c) An individual being monitored to assess the response to or efficacy of approved osteoporosis drug therapies.</li> </ul> </li> </ul> <p><b>Requires Pre-Authorization.</b></p>	<p>100% Coverage of the Vantage Allowable. Not subject to Deductible.</p> <p>100% Coverage of the Vantage Allowable. Subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p>	<p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p> <p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p>
<p><b>Cardiac Rehabilitation:</b> Maximum of eighteen (18) visits in a six (6) week period per Benefit Period. Cardiac rehabilitation following services provided for myocardial infarction, coronary artery bypass surgery, or stable angina pectoris. <b>Requires Pre-Authorization.</b></p>	<p>Member pays applicable In-Network Co-insurance. Not subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p>	<p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p>
<p><b>Chemotherapy/Radiation Therapy:</b> <b>Requires Pre-Authorization.</b></p>	<p>Subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p>	<p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p>

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**Other Covered Services (continued)**

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO DEDUCTIBLE)
<p><b>Cleft Lip and Cleft Palate:</b> Treatment and correction of cleft lip and cleft palate includes coverage for secondary conditions and treatment attributable to primary diagnosis of cleft lip/cleft palate including:</p> <ul style="list-style-type: none"> <li>▶ Oral/facial surgery, management and follow-up</li> <li>▶ Prosthetic Devices</li> <li>▶ Orthodontic treatment and management</li> <li>▶ Preventive/restorative dentistry associated with prosthetic and/or orthodontic treatment</li> <li>▶ Speech-language evaluation/therapy</li> <li>▶ Audiological assessments and amplification devices</li> <li>▶ Otolaryngology treatment</li> <li>▶ Psychological assessment and counseling</li> <li>▶ Genetic Assessment and counseling for patient and parents</li> </ul>	<p><b>Office Visits:</b> 100% Coverage of Vantage Allowable less applicable Medical Home Primary Care Physician or Specialty Care office visit Co-payment. Not subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p> <p><b>Surgery:</b> 100% Coverage of Vantage Allowable less applicable ASU/outpatient surgery Co-payment. Subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b> <b>Requires Pre-Authorization.</b></p> <p><b>Other Cleft Lip and Cleft Palate Services:</b> Member pays applicable In-Network Co-insurance. Subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b> <b>Requires Pre-Authorization.</b></p>	<p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p> <p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p> <p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p>

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**Other Covered Services (continued)**

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO DEDUCTIBLE)
<p><b>Diabetes Management:</b>                      Outpatient self-management training (including the initial equipment and supplies) and education/medical nutrition therapy for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes if prescribed by the primary attending Physician. Such outpatient training and nutrition therapy programs shall be provided by a health care professional in compliance with the National Standards for Diabetes Self-Management Education Program, as developed by the American Diabetes Association. Additional training may be covered based on Medical Necessity. Maximum of ten (10) visits during the initial Benefit Period and four (4) visits per Benefit Period thereafter. Diabetic supplies are limited to a specific manufacturer, products and/or brands.  <b>Requires Pre-Authorization.</b></p>	<p>100% Coverage of Vantage Allowable less applicable Medical Home Primary Care Physician office visit Co-payment per visit.                      Not subject to Deductible. See Cost Share Schedule.                      Out-of-Pocket Maximum:                      Initial: <b>Excluded</b>                      PPACA: <b>Included</b></p>	<p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p>
<p><b>Dialysis:</b>                      Treatment must be obtained from a certified Dialysis Treatment Center. Treatments covered may include hemodialysis, peritoneal dialysis and hemofiltration.  <b>Requires Pre-Authorization.</b></p>	<p>Subject to Deductible. See Cost Share Schedule.                      Out-of-Pocket Maximum:                      Initial: <b>Excluded</b>                      PPACA: <b>Included</b></p>	<p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule</p>
<p><b>Home Health Care (non-custodial):</b>                      Furnished in Member's home by a Participating home health agency. Maximum of 150 days per Benefit Period.  <b>Requires Pre-Authorization.</b></p>	<p>Subject to Deductible. See Cost Share Schedule.                      Out-of-Pocket Maximum:                      Initial: <b>Excluded</b>                      PPACA: <b>Included</b></p>	<p>No Out-of-Network coverage.</p>

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**Other Covered Services (continued)**

<b>COVERED SERVICE</b>	<b>TIER I IN-NETWORK COVERAGE</b>	<b>OUT-OF-NETWORK* (SUBJECT TO DEDUCTIBLE)</b>
<p><b>Hospice Care:</b> Medically Necessary services and supplies of Participating Provider. <b>Requires Pre-Authorization.</b></p>	<p>Subject to Deductible. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p>	<p>No Out-of-Network coverage.</p>
<p><b>Interpreter for the Hearing Impaired:</b> Includes coverage for expenses incurred by any hearing impaired Member for services performed by a qualified interpreter/transliterator, other than a family Member of the Member, when such services are used by the Member in connection with medical treatment or diagnostic consultations performed by a Health Care Provider. <b>Requires Pre-Authorization.</b></p>	<p>Member pays applicable In-Network Co-insurance. Subject to Deductible. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p>	<p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p>
<p><b>Intrauterine Device (IUD) for Birth Control:</b> Contraceptive device, such as Mirena, Paragard, or Skyla, furnished and administered by a MH-PCP or OB/GYN. Coverage includes insertion and/or removal of device.</p>	<p>100% Coverage of Vantage Allowable. Not subject to Deductible.</p>	<p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p>
<p><b>Low Protein Foods for Treatment of Inherited Metabolic Diseases:</b> Low protein foods, defined as less than one gram of protein per serving, that are intended to be used under the direction of a Physician for the Medically Necessary dietary treatment of the following inherited metabolic diseases:  <ul style="list-style-type: none"> <li>▶ Glutaric Acidemia,</li> <li>▶ Isovaleric Acidemia (IVA),</li> <li>▶ Maple Syrup Urine Disease,</li> <li>▶ Methylmalonic Acidemia (MMA),</li> <li>▶ Phenylketonuria (PKU),</li> <li>▶ Propionic Acidemia,</li> <li>▶ Tyrosinemia and</li> <li>▶ Urea Cycle Defects</li> </ul> Vantage must approve the food source prior to coverage. Low protein foods shall not include food that is naturally low in protein. <b>Requires Pre-Authorization.</b></p>	<p>Member pays applicable In-Network Co-insurance. Subject to Deductible. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p>	<p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p>

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**Other Covered Services (continued)**

<b>COVERED SERVICE</b>	<b>TIER I IN-NETWORK COVERAGE</b>	<b>OUT-OF-NETWORK* (SUBJECT TO DEDUCTIBLE)</b>
<p><b>Nutritional Counseling:</b> Maximum of four (4) visits per Benefit Period. <b>Requires Pre-Authorization.</b></p>	<p>100% Coverage of Vantage Allowable less Medical Home Primary Care Physician Co-payment per visit. Not subject to Deductible. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p>	<p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p>
<p><b>Outpatient Rehabilitation Services:</b></p> <ul style="list-style-type: none"> <li>▶ <b>Occupational and Speech Therapy:</b> Services after Illness or injury to restore pre-existing function. Services must be obtained from a licensed occupational or speech therapist, other than an individual who resides in the Member's home or who is a family Member. Maximum combined total of twenty (20) visits per Benefit Period for Occupational and Speech Therapy. <b>Requires Pre-Authorization.</b></li> <li>▶ <b>Physical Therapy:</b> Services provided by a licensed physical therapist other than an individual who resides in the Member's home or who is a family Member. Not covered for Chronic or Recurrent Conditions. (Example: Fibromyalgia and muscle tension headaches). Maximum of twenty (20) visits per Benefit Period. <b>Requires Pre-Authorization.</b></li> </ul>	<p>Member pays applicable In-Network Co-insurance. Not subject to Deductible. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p> <p>Member pays applicable In-Network Co-insurance. Not subject to Deductible. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p>	<p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p> <p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p>
<p><b>Spinal Manipulation and Spinal Adjustment:</b> Treatment of dislocation, subluxation or misplacement of vertebrae and/or strains and sprains of soft tissues related to the spine provided by a Health Care Provider. <b>Requires Pre-Authorization.</b></p>	<p>100% Coverage of Vantage Allowable less applicable Medical Home Primary Care Physician or Specialty Care office visit Co-payment. Not subject to Deductible. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p>	<p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p>

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## Mental Health and Alcohol & Chemical Dependency Services

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO DEDUCTIBLE)
<p><b>Outpatient Mental Health Services:</b> Includes coverage for mental illness and the following severe mental illnesses:</p> <ul style="list-style-type: none"> <li>▶ Anorexia</li> <li>▶ Bipolar disorder</li> <li>▶ Bulimia</li> <li>▶ Intermittent explosive disorder</li> <li>▶ Major depressive disorder</li> <li>▶ Obsessive-compulsive disorder</li> <li>▶ Panic disorder</li> <li>▶ Posttraumatic stress disorder</li> <li>▶ Psychosis not otherwise specified when diagnosed in a child under 17 years of age</li> <li>▶ Rett's Disorder</li> <li>▶ Schizophrenia or schizoaffective disorder</li> <li>▶ Tourette's Disorder</li> </ul>	<p><b>Facility:</b> 100% Coverage of Vantage Allowable less applicable Specialty Care Co-payment per visit. Not subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p> <p><b>Physician:</b> 100% Coverage of Vantage Allowable less applicable Medical Home Primary Care Physician or Specialty Care office visit Co-payment. Not subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p>	<p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p> <p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p>
<p><b>Inpatient Mental Health Services:</b> Includes coverage for mental illness and the following severe mental illnesses:</p> <ul style="list-style-type: none"> <li>▶ Anorexia</li> <li>▶ Bipolar disorder</li> <li>▶ Bulimia</li> <li>▶ Intermittent explosive disorder</li> <li>▶ Major depressive disorder</li> <li>▶ Obsessive-compulsive disorder</li> <li>▶ Panic disorder</li> <li>▶ Posttraumatic stress disorder</li> <li>▶ Psychosis not otherwise specified when diagnosed in a child under 17 years of age</li> <li>▶ Rett's Disorder</li> <li>▶ Schizophrenia or schizoaffective disorder</li> <li>▶ Tourette's Disorder</li> </ul> <p><b>Requires Pre-Authorization.</b></p>	<p>100% Coverage of Vantage Allowable less applicable inpatient Co-payment. Subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p>	<p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p>

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**Mental Health and Alcohol & Chemical Dependency Services (continued)**

<b>COVERED SERVICE</b>	<b>TIER I IN-NETWORK COVERAGE</b>	<b>OUT-OF-NETWORK* (SUBJECT TO DEDUCTIBLE)</b>
<p><b>Outpatient Alcohol &amp; Chemical Dependency:</b></p>	<p><b>Facility:</b> 100% Coverage of Vantage Allowable less applicable Specialty Care Co-payment per visit. Not subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p> <p><b>Physician:</b> 100% Coverage of Vantage Allowable less applicable Medical Home Primary Care Physician or Specialty Care office visit Co-payment. Not subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Excluded</b> PPACA: <b>Included</b></p>	<p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p> <p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p>
<p><b>Inpatient Alcohol &amp; Chemical Dependency:</b> <b>Requires Pre-Authorization.</b></p>	<p>100% Coverage of Vantage Allowable less applicable inpatient Co-payment. Subject to Deductible. See Cost Share Schedule.</p> <p>Out-of-Pocket Maximum: Initial: <b>Included</b> PPACA: <b>Included</b></p>	<p>Member pays the Out-of-Network Co-insurance. See Cost Share Schedule.</p>

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**Supplementary Benefits**  
(NO TIER II OR OUT-OF-NETWORK COVERAGE)



**Subject to the Deductible and excluded from both the Initial Tier I Medical and PPACA In-Network Out-of-Pocket Maximums.**

COVERED SERVICE	TIER I IN-NETWORK COVERAGE
<p><b>Alcohol- and Drug-related Injuries:</b> Treatment for injuries sustained while under the influence of alcohol or the illegal use of Drugs.</p>	Member pays Supplementary Benefits Co-insurance. See Cost Share Schedule.
<p><b>Breast Reduction:</b> Medical Necessity criteria must be met. <b>Requires Pre-Authorization.</b></p>	Member pays Supplementary Benefits Co-insurance. See Cost Share Schedule.
<p><b>Cochlear Implant:</b></p> <ul style="list-style-type: none"> <li>▶ Limited to one (1) unilateral cochlear implant per Member per lifetime. No replacements are covered. Medical Necessity criteria must be met.</li> <li>▶ Training and other services specific to the cochlear implant.</li> </ul> <p><b>Requires Pre-Authorization.</b></p>	Member pays Supplementary Benefits Co-insurance. See Cost Share Schedule.
<p><b>Pain Management:</b> Medical Necessity criteria must be met. <b>Requires Pre-Authorization.</b></p>	<p><b>Facility:</b> Member pays the greater of a) the Supplementary Benefits Co-insurance or b) the Member's applicable ASU/outpatient surgery Co-payment. See Cost Share Schedule.</p> <p><b>Physician:</b> Member pays Supplementary Benefits Co-insurance. See Cost Share Schedule.</p>

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## **Explanation of Approved Transplant Services (NO TIER II OR OUT-OF-NETWORK COVERAGE)**

- ▶ It is the Member's responsibility to ensure that all requested services are reviewed and authorized by Vantage prior to provision of those services. Failure to do so for any transplant-related service will result in non-payment of those services. In order to be approved by Vantage for payment, the transplant services must be included in Vantage coverage (see below) and performed at a designated Vantage transplant facility and deemed Medically Necessary and appropriate for the medical condition for which the transplant is proposed.
- ▶ Approved Transplant Services is defined to include all Medically Necessary health services and supplies rendered at a Designated Transplant Facility (defined below) during the Benefit Period which are related to transplantation, and approved in writing by Vantage prior to the delivery of any services. Such services shall include, but are not limited to, Hospital charges, Physician charges, organ procurement and tissue typing, and ancillary services rendered during the Benefit Period. Only for the purposes of this benefit, a Benefit Period is defined as the period of time from the date the Member receives prior authorization and an initial evaluation for the transplant procedure, until the earliest of: (a) one year from the date the transplant procedure was actually performed; (b) the date coverage under this Plan terminates; or (c) the date of the Member's death.
- ▶ A Designated Transplant Facility is defined as a facility that has entered into an agreement with Vantage to render Approved Transplant Services. The Designated Transplant Facility will be determined by Vantage and may or may not be located within the Member's geographic area. Applications from transplant facilities shall be considered and approved by Vantage in accordance with the requirements of Louisiana R.S. 22:1231 and 22:1232.
- ▶ Approved Transplant Services include: (a) kidney; (b) bone marrow or peripheral stem cell transplantation (except in conjunction with High Dose Chemotherapy for the treatment of solid tumors including breast cancer unless coverage is extended by the Utilization Review/Quality Management Committee); (c) liver; (d) heart; (e) heart-lung; (f) pancreas; (g) lung (single/double); (h) kidney/pancreas; and (i) small bowel.
- ▶ The following tissue transplants are also covered: (a) blood transfusions; (b) autologous parathyroid transplants; (c) corneal transplants; (d) bone and cartilage grafting; (e) skin grafting; and (f) autologous islet cell transplants.  
  
Other tissue/solid organ transplant procedures which Vantage determines have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures will be considered on a case-by-case basis.
- ▶ Immunosuppressive Drugs after Approved Transplant Services are covered under the Prescription Drug benefit and according to the Plan Drug Formulary.
- ▶ No benefits are payable under this Transplant Benefit for: (a) organ transplants which are not listed as Approved Transplant Services, (b) animal to human transplants; (c) artificial or mechanical devices designed to replace human organs; (d) services required to keep a donor alive for the transplant.

**Member pays Approved Transplant Services Cost Share. See Cost Share Schedule.**

**Approved Transplant Services are subject to the Deductible, excluded from the Initial Tier I Medical Out-of-Pocket Maximum, and included in the PPACA In-Network Out-of-Pocket Maximum.**

**Approved Transplant Services require Pre-Authorization.**

**There is no Tier II or Out-of-Network coverage for Approved Transplant Services.**

## **Prescription Drug Benefits** **(NO OUT-OF-NETWORK COVERAGE)**

The Plan Drug Formulary is a comprehensive listing of Drugs covered by this Plan. Vantage reserves the right to make changes to its Plan Drug Formulary consistent with federal and state law and FDA recommendations. Plan Drug Formulary changes are made at the Benefit Plan effective date, unless immediate action is required by the FDA. All Prescription Drugs included in the Plan Drug Formulary are either approved by the Food and Drug Administration (“FDA”) for the diagnosis or condition for which it is being prescribed or supported by the American Hospital Formulary Service Drug Information book, the DRUGDEX Information System, and the USPDI or its successor. Vantage’s team of doctors and pharmacists perform a comprehensive review and update of the Plan Drug Formulary annually, but revisions are made monthly as new updates are released by the FDA.

Your pharmacy Plan is mandatory generic meaning if a brand name Prescription Drug is available as a Generic Drug and you receive the brand name Prescription Drug, you pay the Generic Drug Co-payment and the difference between the cost of the brand name Prescription Drug and the cost of the Generic Drug.

Specialty Drugs must be provided by the Plan’s contracted specialty pharmacy. When Specialty Drugs are not provided by the Plan’s contracted specialty pharmacy, regardless of place of service (e.g., inpatient, outpatient, Physician’s office, etc.), Pre-Authorization is required and the Plan’s payment is limited to what the Plan would have paid its specialty pharmacy less the Member’s Cost Share. Specialty Drugs will be subject to the Prescription Drug Deductible, if applicable, and the Tier V Specialty Drug Cost Share. Specialty Drugs include high cost Drugs and pharmaceuticals produced through DNA technology or biological processes that target Chronic or complex disease states and require unique handling, distribution, or administration as well as a customized medical management program for successful use.

All Prescription Drugs dispensed according to the Vantage Plan Drug Formulary and incidental to outpatient care prescribed by a Participating Physician and dispensed by a Participating pharmacy are covered at the current Vantage Participating pharmacy reimbursement rate less the applicable Member Cost Share not to exceed a consecutive 30-day supply of a Prescription Drug, unless limited by the manufacturer’s packaging.

If you have questions regarding the Plan Drug Formulary, coverage of a Drug, or how to request Plan Drug Formulary exceptions, please call Vantage’s Member Services toll-free at (855) 934-6847. You can also view the Plan Drug Formulary, documents providing information on Pre-Authorization, quantity limit, and step therapy requirements, or the Plan Drug Formulary exception process by accessing our website, [www.VantageHealthPlan.com](http://www.VantageHealthPlan.com).

Prescription Drugs associated with an approved out-of-area emergency will be covered at an amount not to exceed the current Vantage Participating pharmacy reimbursement rate less applicable Cost Share. The remaining amount is the Member’s financial responsibility.

Co-payments and Co-insurance are applied to the total cost of the Prescription Drug, including the sales tax.

**Some Prescription Drugs require Pre-Authorization. All Specialty Drugs require Pre-Authorization.**

**Mail Order is not available for Specialty Drugs.**

**Prescription Drug Cost Shares are excluded from the Initial Tier I Medical Out-of-Pocket Maximum and included in the PPACA In-Network Out-of-Pocket Maximum.**

## Prescription Drug Benefits (continued)

A Prescription Drug benefit which includes a Deductible on some or all Prescription Drugs may have been elected by the Employer. If elected, the Prescription Drug Deductible is the amount shown on the Cost Share Schedule that the Member must pay each Benefit Period before Prescription Drug benefits are payable under the Plan. The Prescription Drug Deductible may be applicable to some or all Prescription Drug Tiers. After the Prescription Drug Deductible is met on the applicable Prescription Drug Tier(s) (noted in the Cost Share Schedule), the Co-payment/Co-insurance as shown in the Cost Share Schedule applies.

See Section V of this Certificate for applicable Prescription Drug benefit exclusions and limitations.

PRESCRIPTION DRUG BENEFIT	TIER I IN-NETWORK COVERAGE
<b>Prescription Drug Deductible</b>	See Cost Share Schedule
<b>Tier I: Preferred Generic Prescription Drugs (Low-cost Generics)</b> <ul style="list-style-type: none"> <li>• Affinity Health Network’s Saint John Pharmacy in Monroe, LA (available direct or through the mail)</li> <li>• All other pharmacies</li> </ul>	100% Coverage.  Member pays Tier I Preferred Generic Co-payment per low-cost Generic Prescription Drug. See Cost Share Schedule.
<b>Tier II: Non-Preferred Generic Prescription Drugs</b>	Member pays Tier II Non-Preferred Generic Co-payment per Non-Preferred Generic Prescription Drug. See Cost Share Schedule.
<b>Tier III: Preferred Brand Prescription Drugs</b>	Member pays Tier III Preferred Brand Co-payment or Co-insurance per Preferred Brand Prescription Drug. Subject to Prescription Drug Deductible, if elected. See Cost Share Schedule.
<b>Tier IV: Non-Preferred Brand Prescription Drugs</b>	Member pays Tier IV Non-Preferred Brand Co-payment or Co-insurance for Non-Preferred Brand Prescription Drugs. Subject to Prescription Drug Deductible, if elected. See Cost Share Schedule.
<b>Tier V: Specialty Drugs</b>	Member pays Tier V Specialty Co-payment or Co-insurance for Specialty Drug prescription order or refill up to a 30-day supply, up to \$150 for a 30-day supply of a single Drug. Subject to Prescription Drug Deductible, if elected. See Cost Share Schedule.
<b>Mail Order Prescription Drugs:</b> Tiers I, II, III, and IV  Tier V	See Cost Share Schedule.  Not Available

<b>Diabetic Supplies and Meters at a Pharmacy</b>	See Cost Share Schedule.
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## Additional Benefits

### **Continuity Of Care:**

If any Health Care Provider in the Vantage network is in the process of being contractually terminated or has been terminated and that Health Care Provider is rendering services to a Member that has been diagnosed as having a high-risk pregnancy or is past the 24<sup>th</sup> week of pregnancy or has been diagnosed with a Life-Threatening Illness or acute condition, the Member may continue to receive Covered Services from the Health Care Provider until the delivery and discharge of the child from the Hospital or until the course of treatment is completed, not to exceed six months from the effective date of contract termination, whichever situation is applicable. However, in the event that the termination or proposed termination of the Health Care Provider's contract is the result of suspension or revocation by the State of Louisiana of the Health Care Provider's license to practice in Louisiana, then this Continuity of Care provision shall not apply.

### **Federal Disclosure Concerning Hospital Length Of Stay In Connection With Childbirth:**

Vantage will not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or Newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a Caesarean section. However, Federal law generally does not prohibit the mother's or Newborn's attending Provider, after consulting with the mother, from discharging the mother or her Newborn earlier than 48 hours (or 96 hours as applicable). Vantage shall not require that a Provider obtain authorization to prescribe a length of stay less than 48 hours following delivery (or 96 hours as applicable). With the exception of Emergency services or Emergency admission to a Hospital related to childbirth, Vantage still requires Pre-Authorization prior to being admitted to a Hospital for delivery.

### **Telemedicine:**

Covered Services performed via transmitted electronic imaging or telemedicine will not be denied on the basis that such Covered Services are performed via transmitted electronic imaging or telemedicine.

### **Travel Benefit:**

Limited travel arrangements may be covered **ONLY** if we require you to travel outside the Vantage Service Area to obtain treatment that could be provided locally, but only by Out-of-Network Providers. Call the Vantage Medical Management department at (318) 361-2125 for details.

### **Wellness or Health Improvement Programs:**

Vantage may offer a voluntary wellness or health improvement program that allows incentives to encourage participation in the program.

## Clinical Trials

Vantage shall provide coverage for the cost of healthcare services, treatments or testing, that are incurred as part of the protocol treatment being provided to the Member for purposes of a clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. Costs for investigational treatments and protocol related patient care shall be covered if all of the following criteria are met:

- ▶ The treatment is being provided with a therapeutic or palliative intent for patients with cancer or other life-threatening disease or condition, or for the prevention or early detection of cancer or other life-threatening disease or condition, and
- ▶ The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer or other life-threatening disease or condition, and
- ▶ The treatment is being provided in accordance with a clinical trial approved by one of the following entities:
  - The United States National Institutes of Health (NIH)
  - A cooperative group funded by the NIH
  - The Federal Food and Drug Administration in the form of an investigational New Drug Application
  - The United States Department of Veteran Affairs
  - The United States Department of Defense
  - A federally funded general clinical research center
  - The Coalition of National Cancer Cooperative Groups; and
- ▶ The proposed protocol has been reviewed and approved by a qualified institutional review board which operates in this state and which has a multiple project assurance contract approved by the office of protection from research risks, and
- ▶ The facility and personnel providing the protocol provided the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, and
- ▶ There is no clearly superior, non-investigational approach; and
- ▶ The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-investigational alternative; and
- ▶ The Member has signed an institutional review board approved consent form.



**Approved clinical trials are subject to the Deductible, excluded from the Initial Tier I Medical Out-of-Pocket Maximum, and included in the PPACA In-Network Out-of-Pocket Maximum.**



**Approved clinical trials require Pre-Authorization.**



**There is no Tier II or Out-of-Network coverage for approved clinical trials.**

## SECTION V: EXCLUSIONS & LIMITATIONS

Coverage shall not be provided and no payment shall be made under this Plan for services or expenses incurred in connection with:

1. Accidental Bodily Injury or sickness arising out of, or in the course of, employment entitling the Member to benefits under Workers' Compensation, Occupational Disease or any similar Federal or State law.
2. Any incidental procedure, unbundled procedure, or mutually exclusive procedure.
3. Losses, injuries, or contracted diseases which are due to insurrection, war, or any act of war, whether declared or undeclared.
4. Losses or injuries, excluding those received by victims of domestic abuse, suffered as a result of participating in a riot, civil disturbance or while committing or attempting to commit a crime or treatment of any Member confined in a prison, jail, or other penal institution.
5. Treatment or care for which there is no legal obligation of Vantage or the Plan to pay. The existence of this Plan will not create an obligation to pay.
6. Services, equipment, or supplies, which are not Medically Necessary for the treatment of Illness, injury, or symptomatic complaint. The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make it Medically Necessary to make the charge a Covered Service, even though the service or supply is not specifically listed as an exclusion. The final approval and discretion for determining whether services or supplies or days of care are Medically Necessary lies solely with Vantage.
7. Services, surgery, supplies, treatment or expenses which are performed by or upon the direction of a Health Care Provider, Physician or allied health professional acting outside the scope of his license.
8. Any treatment or services rendered for orthodontic, orthognathic (including temporomandibular joint (TMJ)), periodontic, or dental implants, except as covered in *Section IV* under the Cleft Lip and Cleft Palate benefit.
9. Services, surgery, supplies, treatment, or expenses received from a dental or medical department maintained by or on behalf of an Employer, a mutual benefit association, labor union, trust, or similar person or group.
10. Eyeglasses and contact lenses.
11. Corneal surgery (except corneal transplants as specified).
12. Hearing aids, related testing and follow-up except for Newborn hearing loss screening tests and the Hearing Aid benefit for minor Members under the age of 18 in *Section IV*.
13. Services, surgery, supplies, treatment, or expenses in connection with or related to:
  - a. Eye exercises, visual training, or orthoptics;
  - b. The correction of refractive errors of the eye, including, but not limited to, radial keratotomy and laser surgery; or
  - c. Visual therapy.

14. Services or supplies for purely Cosmetic Purposes (including cosmetic surgery) or for complications resulting from treatment/procedures for Cosmetic Purposes (including Reconstructive Services secondary to a cosmetic procedure):
  - a. To change the texture or appearance of the skin (including, but not limited to, the treatment of acne); or
  - b. To change the relative size or position of any part of the body (such as enlargement, reduction, or implantation) when such surgery is performed primarily to improve an individual's physical appearance and does not improve the function or usefulness of the body; or
  - c. To modify the physical body in order to improve psychological, mental, or emotional well-being; or
  - d. To eliminate psychological stress or impairment; or
  - e. Treatment the sole purpose of which is to promote or stimulate hair growth; or
  - f. Removal of excess fat or skin, or services at a health spa or similar facility; or
  - g. Hair pieces, wigs, or hair implants.

NOTE: Reconstructive services and supplies will be covered if Medically Necessary and due to Accidental Bodily Injury or organic Illness suffered, including reconstruction to produce a symmetrical appearance of the breasts following a mastectomy.

15. Services, surgery, supplies, treatment, or expenses in connection with or related to, or complications from the following regardless of claim of Medical Necessity:
  - a. rhinoplasty;
  - b. blepharoplasty services identified by CPT codes 15820, 15821, 15822, 15823; brow ptosis identified by CPT code 67900; or any revised or equivalent codes;
  - c. gynecomastia;
  - d. breast enlargement or reduction, except for breast Reconstructive Services as specifically provided in this Certificate of Coverage;
  - e. implantation, removal and/or re-implantation of breast implants and services, Illnesses, conditions, complications and/or treatment in relation to or as a result of breast implants;
  - f. implantation, removal and/or re-implantation of penile prosthesis and services, Illnesses, conditions, complications and/or treatment in relation to or as a result of penile prosthesis;
  - g. diastasis recti; or
  - h. idiopathic short stature.
16. Surgical and medical treatment for snoring in the absence of obstructive sleep apnea, including laser-assisted uvulopalatoplasty (LAUP).
17. Penile implant devices and related supplies.
18. Paternity tests and tests performed for legal purposes.
19. Genetic Testing, unless the results are specifically required for a medical treatment decision on the Member, or required by law.
20. Treatment of and services related to infertility, including surgical procedures to reverse voluntarily induced sterilization, in vitro fertilization and artificial insemination, and treatment and services related to surrogate pregnancies, and Drugs related to treatment of infertility.
21. Personal comfort and convenience items.
22. Any procedures, services, Drugs or supplies, or benefits which are experimental or investigational in nature and certain newly introduced technologies, Drugs or other treatment. The fact that a Physician may prescribe, order, recommend or approve a procedure, service, Drug or supply does

not mean that such service or supply is not experimental or investigational. The final determination as to whether any given service or supply is excluded under this section lies within the sole discretion of Vantage. For purposes of this section, “experimental or investigational” shall include and be defined as any treatment, service or supply for which:

- a. there is no consensus in the medical community as to safety or effectiveness of the technology as applied to the particular circumstances of the Member or for treatment of the patient’s particular medical problem;
  - b. there is insufficient evidence to determine its appropriateness in a given situation;
  - c. the technology warrants further study or is in the process of undergoing clinical trials, particularly if undergoing Phase I, II, III, or IV clinical trials (except as described in the Clinical Trials benefit in Section IV);
  - d. use of the technology for the given indication in the specified patient population is confined largely to research protocols; or
  - e. the Physician or facility rendering the treatment classifies the treatment as experimental or investigational for purposes of obtaining an informed consent.
23. Drugs and surgical procedures related to weight loss. Treatment of complications secondary to surgery for weight loss (*e.g., gastric bypass and lap band procedures*), including, but not limited to, nutritional deficits, bowel obstructions, and abdominal pain.
  24. Services or supplies for the treatment of eating disorders, unless otherwise required by law.
  25. Food or food supplements, formulas and medical foods, including those used for gastric tube feedings. This exclusion does not apply to Low Protein Foods as described in this Plan.
  26. Any services or supplies related to:
    - a. organ transplants which are not listed as Approved Transplant Services;
    - b. animal to human transplants;
    - c. artificial or mechanical devices designed to replace human organs;
    - d. services to keep a donor alive for the transplant operation;
    - e. charges related to donor services; or
    - f. transplants otherwise excluded by this Plan.
  27. Hospitalization primarily for Physical Therapy or hydrotherapy.
  28. Services or supplies for physical examination for employment, licensing, travel, school, insurance, adoption, participation in athletics, or examination or treatment ordered by a court.
  29. Services or supplies, which were provided prior to Member’s effective date with Vantage or after Member’s termination date for coverage with Vantage, except as otherwise provided herein.
  30. Services, surgery, supplies, treatment, or expenses rendered by a Provider who is the Member’s spouse, child, stepchild, parent, stepparent or grandparent.
  31. Whole blood and blood products that are covered under a Member’s blood bank program (autologous blood bank services).
  32. Services or supplies for the prophylactic storage of cord blood.
  33. Megavitamin therapy, biofeedback, psychosurgery and nutrition-based therapy for alcoholism or substance abuse and mental health disorders.
  34. Salabrasion, chemosurgery or other such skin abrasion procedures associated with removal of scars, tattoos, and/or which are performed as a treatment of acne scarring.



35. Services related to sex transformation.
36. Services or supplies in connection with charges for failure to keep a scheduled visit; charges for completion of a claim form, telephone charges or charges to obtain medical records.
37. Standby availability of a Health Care Provider when no treatment is rendered.
38. Services, supplies or treatment not specifically listed as a Covered Service. This includes, but is not limited to, the following:
  - a. travel or transportation, whether recommended by a Physician or not;
  - b. self-help training and other forms of non-medical care, except as required by PPACA;
  - c. charges for anesthesia for non-Covered Services;
  - d. over the counter support hose, ace or elastic bandages, and pressure garments other than those prescribed as medically necessary;
  - e. corrective footwear;
  - f. wigs or hairpieces;
  - g. prosthetic garments or apparel;
  - h. wet nurse or milk bank services;
  - i. holistic medical services;
  - j. unproven methods of allergy testing (i.e., cytotoxic allergy testing);
  - k. supportive devices for the foot, except when used in the treatment of diabetic foot disease; or
  - l. marriage/family counseling.
39. Treadmill, swimming pool, or special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program.
40. Contraceptive devices not approved by the Food and Drug Administration whether prescribed by a Physician or not, including Norplant.
41. Elective abortions except when provided to save the life of the mother.
42. Fetal reduction surgery.
43. Services or supplies for treatment related to and/or complications resulting from a non-Covered Service.
44. Charges in excess of the Vantage Allowable.
45. Emergency department visits for injections, Drugs, removal of sutures, or any other non-emergency service.
46. Admission to a Hospital primarily for diagnostic services which could have been provided safely and adequately in some other setting, e.g., outpatient department of a Hospital or Physician's office.
47. Counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and job counseling, except as required by PPACA.
48. Diagnosis or care and treatment of:
  - a. weak, strained, unstable or flat feet;
  - b. toenails (except for the diabetic patient or treatment of ingrown toenails);
  - c. cutting or removal of superficial lesions of the feet such as corns, calluses or hyperkeratosis (except as warranted for the diabetic patient);
  - d. tarsalgia, metatarsalgia or bunions, except surgery which involves exposure of bones, tendons, or ligaments; or
  - e. other services performed in the absence of localized Illness or injury.

49. Body piercing or complications due to body piercing. Injuries related to objects being inserted or removed from a pierced body part whether accidental or purposeful. Reconstructive Services or surgery to repair damage due to body piercing whether directly or indirectly. Tattoos and the treatment of complications from tattoos including, but not limited to, infections and Hepatitis.
50. Magnet therapy, external bone growth stimulators, spinal cord stimulators, artificial spinal disc, electro-muscular stimulators and implanted devices for pain control.
51. Physical Therapy for Chronic or Recurrent conditions, including fibromyalgia and muscle tension headaches. Physical Therapy is not covered when maintenance level of therapy is attained as determined by your Physician and/or a Vantage Medical Director.
52. Occupational Therapy is not covered when maintenance level of therapy is attained as determined by your Physician and/or a Vantage Medical Director.
53. Therapy received from lifestyle/habit changing clinics and/or programs, recreational programs, recreational therapy, or other therapy primarily to enhance athletic abilities, except as required by PPACA.
54. Alternative treatments, except as specifically covered, including acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing, and other alternative treatments defined by the Office of Alternative Medicine of the National Institutes of Health.
55. Alternative or complementary medicine using non-orthodox practices, including but not limited to: wilderness or outdoor therapy, boot camp, and equine therapy.
56. Professional charges for clinical lab.
57. Anodyne (infrared) treatments.
58. Treatment for varicose veins and telangiectasia by any method including, but not limited to, endovenous laser treatments, sclerosis or surgical stripping.
59. Pulmonary rehabilitation.
60. The cost of health care services, treatment or testing for clinical trials except as provided for in Section IV of this Certificate.
61. Botox used for Cosmetic Purposes or for the treatment of hyperhidrosis, migraine headaches, musculoskeletal pain, fibromyalgia or other conditions not specifically listed as covered.
62. Separate anesthesia charges for endoscopies.
63. Custodial Care.
64. Outpatient private-duty nursing.
65. Durable and non-durable medical supplies (except as specified by Vantage).
66. Educational testing services unrelated to the diagnosis or treatment of autism spectrum disorders, attention deficit disorders or hyperactivity.

67. Education services and supplies including training or re-training for a vocation, except as specifically provided in this Plan for diagnosis, testing, or treatment for remedial reading and learning disabilities, including dyslexia, except as required by PPACA.
68. Applied Behavior Analysis (ABA) that:
  - a. Vantage has determined is not Medically Necessary;
  - b. Is rendered to Members seventeen (17) years of age and older; or
  - c. Is rendered by a Health Care Provider that has not been certified as a behavior analyst by the Behavior Analyst Certification Board or rendered by a Health Care Provider that has not provided, to the satisfaction of Vantage, documented evidence of equivalent education, professional training, and supervised experience in ABA.
69. Hospital charges for a well Newborn.
70. Services or supplies for pre-implantation genetic diagnosis and pre-genetic determination.
71. Any Durable Medical Equipment, disposable medical equipment, items and supplies over reasonable quantity limits as determined by Vantage; all defibrillators other than implantable defibrillators authorized by Vantage.
72. Listening therapy or auditory therapy except as covered for autism spectrum disorders.
73. Anti-aging treatment, including but not limited to office visits, laboratory tests, hormone treatments, and other services associated with anti-aging treatment.
74. Items or services provided by Medicare Opt-out Physicians.
75. Drug screenings performed solely to ensure compliance with medical treatments.
76. Member reimbursements other than those submitted with itemized procedures and diagnoses documented by a Provider.
77. Extraction of wisdom teeth.
78. Blood product injection therapies (e.g., autologous blood, platelet rich plasma, bone marrow plasma).
79. Suboxone and methadone dispensed by free standing clinics for treatment for opioid dependence.
80. Sleep studies, unless obtained in a facility that is accredited by the Joint Commission or the American Academy of Sleep Medicine (AASM). If a sleep study is obtained from a facility that is not accredited by one of these bodies, then neither the sleep study nor any professional claims associated with the sleep study are eligible for coverage.
81. Industrial or employment-related testing or self-help programs other than PPACA preventive services including, but not limited to stress management programs, work hardening programs and/or functional capacity evaluation, including driving evaluations, etc.
82. Inpatient pain rehabilitation and pain control programs.
83. Diabetic testing supplies are limited to Glucocard Shine Meter Kit blood glucose monitoring system (1 meter per Benefit Period) and Glucocard Shine Test Strips (50-count packages) manufactured by ARKRAY USA, Inc.

84. Expenses resulting from intoxication, as defined by state law where the Illness or injury occurred, or while under the influence of illegal narcotics or controlled substances, unless administered or prescribed by a Physician.
85. Continuous glucose monitoring systems for long-term use. Includes sensors, transmitters, and receivers.
86. For injuries sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following:
  - a. Sports (professional, or semi-professional, or intercollegiate);
  - b. Parachute jumping;
  - c. Hang-gliding;
  - d. Racing or speed testing any motorized vehicle or conveyance;
  - e. Scuba/skin diving (when diving 60 or more feet in depth);
  - f. Skydiving;
  - g. Bungee jumping; or
  - h. Rodeo sports.
87. For injuries sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following if the covered person is paid to participate or to instruct:
  - a. Operating or riding on a motorcycle;
  - b. Racing or speed testing any non-motorized vehicle or conveyance;
  - c. Horseback riding;
  - d. Rock or mountain climbing; or
  - e. Skiing.
88. Prescription Drug benefit exclusions and limitations:
  - a. Non-prescription Drugs, including over-the-counter (OTC) Medications with the exception of generic Zyrtec® (cetirizine), generic Claritin® (loratadine), aspirin to prevent cardiovascular disease, tobacco cessation, and others as specified by Vantage;
  - b. Any Medication not proven effective in general medical practice, other than Medications used as a part of a clinical trial;
  - c. Medications for erectile dysfunction such as Viagra®, Cialis®, Levitra® and Caverject®;
  - d. Anorexiant (weight control and obesity treatment products);
  - e. Fertility agents;
  - f. Lunelle® Injection or other implantable Drugs for hormone replacement therapy, pain control or any other reason, other than required PPACA contraceptive coverage;
  - g. Pregnancy Termination Drugs (Abortifacients);
  - h. Nutritional or dietary supplements, herbal supplements and treatments except as required by PPACA;
  - i. Cosmetic Agents: Retin-A (except for acne) or other like products for Cosmetic Purposes;
  - j. Minoxidil and Rogaine® or other like products for hair loss;
  - k. Drugs received at Out-of-Network pharmacies;
  - l. Drugs for the treatment of an Illness for which there is no FDA approval for such use except when medically appropriate and an accepted standard of practice, other than Medications used as a part of a clinical trial;
  - m. Drugs used for experimental indications and/or dosage regimens determined by Vantage to be experimental, other than Medications used as a part of a clinical trial;
  - n. Replacement Drugs resulting from loss or theft;
  - o. The *additional* cost for multi-source Prescription Drugs which are not dispensed in accordance with the Plan Drug Formulary, whether the request for the Prescription Drug originates with the Member or a Participating Physician;

- p. Prescription Drugs related to a non-Covered Service including those written for quantities in excess of the covered benefit;
- q. Compounded Drugs;
- r. Pharmacy benefits when Vantage is not the primary insurer;
- s. Prescription vitamins and mineral products, prenatal vitamins and fluoride preparations, except as required by PPACA;
- t. Growth hormone therapy unless an endocrinologist confirms growth hormone deficiency with an abnormal provocative stimulation test;
- u. Prescription Drugs for and/or treatment of idiopathic short stature;
- v. Any Prescription Drug that is equivalent to an OTC medicine or OTD supplement product, except as required by federal law and specified by Vantage; or
- w. Any Drug which is listed as not covered, other than Medications used as a part of a clinical trial.

## SECTION VI: ELIGIBILITY FOR COVERAGE

### A. Employees

1. Employees eligible for coverage under this Plan are: a) permanent Employees of the Employer (including an Affiliated Employer) who have completed any required “Eligibility Waiting Period” and are working for the Employer on a regular weekly schedule as set forth under “Minimum Number of Hours At Work Per Week;” or b) are retirees of the Employer.

Most permanent Employees must live or work in the Vantage Service Area.

The Affiliated Employers, Eligibility Waiting Period and Minimum Number of Hours at Work Per Week are set forth in the Group Enrollment Agreement.

2. For Employees who meet these requirements, coverage will become effective if a written request for coverage is made within thirty (30) days after the date the Employee becomes eligible. Coverage will be effective on the date eligibility requirements have been met, unless otherwise specified by the Employer and approved by Vantage.

#### 3. Special Enrollment Periods

If you decline enrollment in writing for yourself or your Dependents (including your spouse) because of other Health Insurance Coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends.

Individual losing other coverage. An Employee who is eligible but not enrolled in this Plan may enroll if all of the following conditions are met:

- a) The Employee was covered under a Group Health Plan or had Health Insurance Coverage at the time coverage under this Plan was previously offered to the individual;
  - b) If required, the Employee stated in writing at the time that coverage under this Plan was offered, that the other health coverage was the reason for declining enrollment;
  - c) The Employee who lost coverage had coverage under COBRA and the COBRA coverage was exhausted, or the Employee did not have coverage under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or Employer contributions toward the coverage were terminated;
  - d) The Employee requests enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of coverage or Employer contributions, described above;
  - e) Employee did not lose the other coverage as a result of failure to pay premiums or for cause (such as making a fraudulent claim); and
4. If a former Employee is re-employed, prior service will be included in determining the new date of eligibility for coverage, provided that:
    - a) The Employee resumed active work status within one year after prior employment was terminated; or

- b) The prior employment was terminated due to entry into the armed forces, and the Employee has resumed active work status within the time set by law for the reinstatement of employment rights; or
- c) The prior employment was terminated due to disability, and the Employee has resumed active work status within one month after ceasing to be disabled.

5. Military Personnel Eligibility

If the Employee is on active duty for more than 30 days, the Employee and Dependents should be covered by military health care. Dependents have medical and dental services provided through uniformed services facilities and are eligible for health benefits from civilian sources through the federally funded TRICARE program, formerly known as CHAMPUS (Civilian Health and Medical Program of the Uniformed Services).

Your right to continue health coverage under an employment-based Group Health Plan is covered by federal law. The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides health coverage continuation rights to Employees and their families after an event such as reduction in employment hours. The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) is intended to minimize the disadvantages that occur when a person needs to be absent from civilian employment to serve in the uniformed services. Both COBRA and USERRA generally allow individuals called for active duty to continue coverage for themselves and their Dependents under an employment-based Group Health Plan for up to 24 months. In the event such coverage is not continued but the Employee's coverage is later reinstated in accordance with this Plan, coverage shall also be reinstated for the Employee's Dependents previously covered under this Plan at the time of the Employee's termination of employment.

Any Member who is called to active military duty, upon deactivation, shall have their health insurance coverage resumed for that person and his or her Dependents.



**Any Member who is on active duty with any branch of the military will cease to be eligible under this Plan while he or she remains on active duty.**

6. Surviving Spouse Continuation

If eligibility for Group Health Plan coverage ceases upon the death of the Employee, a surviving spouse covered as a Dependent who is fifty (50) years of age or older, has ninety (90) days from the date of the Employee's death to notify his Employer and Vantage of his election to continue the same coverage for himself, and if already covered, for his Dependents.

Coverage is automatic during the ninety (90) day election period. Premium is owed for this coverage. If continuation is not chosen, or if premium is not received for the ninety (90) days of automatic coverage, the ninety (90) days of automatic coverage is terminated retroactive to the end of the billing cycle in which the death occurred.

If the continuation coverage is chosen within the ninety (90) day period, coverage will continue without interruption. Premium is owed from the last date for which premium has been paid. No physical exams are required. Premium for continuing coverage will not exceed the premium assessed for each Member by class of coverage under the Group Health Plan.

The Employer will be responsible for notifying the spouse of the right to continue and for billing and collection of premium. However, if Vantage is aware of the death of the Employee, Vantage may also notify the surviving spouse of the right to continue.

Coverage continues on a premium-paying basis until the earliest of:

- a) the date premium is due and is not paid on a timely basis; or

- b) the date the surviving spouse or a Dependent becomes eligible for Medicare; or
- c) the date the surviving spouse or a Dependent becomes eligible to participate in another Group Health Plan; or
- d) the date the surviving spouse remarries or dies; or
- e) the date this Group Health Plan ends; or
- f) the date a Dependent is no longer eligible.

**B. Dependents (see “Dependent(s)” definition)**

1. The following Dependents of an Employee are eligible for coverage:
  - a) The Employee’s legal spouse as defined by law who resides or works in the Vantage Service Area.
  - b) Each of the Employee’s natural or legally adopted children under the age of 26. “Children” also includes stepchildren, foster children, adopted children, or a child or grandchild in the legal custody of and residing with the Employee (proof of legal custody required).
  - c) The Employee’s child, or a grandchild in the legal custody of and residing with the Employee (proof of legal custody required), who is incapable of self-sustaining employment by reason of intellectual or physical disability, who became so incapable prior to attainment of age 26. Proof of disability must be submitted to Vantage within thirty-one days of the child’s or grandchild’s attainment of age 26 and subsequent proof of such incapacity for self-support shall also be required not more than once every two years.
  - d) Dependent child(ren), when there is a Qualified Medical Child Support Order (QMCSO) or court order for a Covered Member to cover a Dependent child (*QMCSO or court order must be submitted to Vantage for verification*).
2. For Dependents who meet eligibility requirements and for whom applicable premiums have been paid, coverage will become effective as follows:
  - a) If written request for coverage is made at the time of the Employee’s application for coverage, coverage will be effective for the Dependent on the date the Employee becomes eligible; or
  - b) If the Employee makes written request for Dependent coverage for a newly acquired Dependent due to birth, adoption, legal guardianship or marriage within 30 days of these events, Dependent will be covered from the date of the event; or
  - c) If the Employee makes written request for coverage within 30 days of eligibility for a Dependent whose status changes and meets eligibility requirements outside the enrollment period, coverage will be effective on the date eligibility requirements have been met.



Coverage will become effective for an Employee’s eligible Dependents only if the Employee makes a written request for Dependent coverage within the time limits for eligible Dependent enrollment requests on a form approved by Vantage, and once the Employee and Dependents have met all eligibility requirements listed above. **Vantage may require validation of a Dependent’s status.**



### 3. Special Enrollment Periods

You may be able to enroll your Dependents during a special enrollment period, provided that you request enrollment within 30 days after the marriage, birth, adoption, Placement for Adoption, or effective date of legal custody.

- a) Eligible Dependents may enroll in the Plan if all of the following conditions are met:
  - i. The Employee is a Member under this Plan or has met the Waiting Period applicable to becoming a Member under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period; and
  - ii. If a person becomes a Dependent of the Employee through marriage, birth, adoption, Placement for Adoption, or custody change then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a child, the spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the spouse is otherwise eligible for coverage.
- b) Individual losing other coverage. A Dependent who is eligible, but not enrolled in this Plan, may enroll if all of the following conditions are met:
  - i. The Dependent was covered under a Group Health Plan or had Health Insurance Coverage at the time coverage under this Plan was previously offered to the individual;
  - ii. If required, the Employee stated in writing at the time that Dependent coverage was offered that the other health coverage for the Dependent was the reason for declining enrollment;
  - iii. The Dependent who lost coverage had coverage under COBRA and the COBRA coverage was exhausted, or the Dependent did not have coverage under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or Employer contributions toward the coverage were terminated;
  - iv. The Employee, on behalf of the Dependent, requests enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of coverage or Employer contributions, described above;
  - v. Dependent did not lose the other coverage as a result of failure to pay premiums or for cause (such as making a fraudulent claim); and
- c) Coverage for Dependents who are enrolled during a Special Enrollment Period will become effective:
  - i. In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received.
  - ii. In the case of a Dependent's birth, as of the date of birth.
  - iii. In the case of a Dependent's adoption or Placement for Adoption, the date of the adoption or Placement for Adoption.
  - iv. In any other case where coverage is required by law, the date the law specifies.

## SECTION VII: TERMINATION OF COVERAGE

### A. Cancellation or Non-Renewal

This Plan may be terminated by the Employer or Vantage at the anniversary date of the Master Group Contract by giving written notice to the other party at least sixty (60) days prior to the anniversary date. Unless otherwise terminated, this Plan will automatically renew from year to year and will be subject to new subscription rates on an annual basis.

### B. Discontinuation of Plan

1. If Vantage decides to discontinue offering this Plan, coverage may be discontinued only if:
  - (a) Vantage provides notice of discontinuation at least ninety (90) days prior to the date of coverage discontinuation to each Employer Group and Member covered under this Group Health Plan;
  - (b) Vantage offers the affected Employer Group the option to purchase another Group Health Plan currently being offered by Vantage;
  - (c) Vantage acts uniformly in exercising the option to discontinue the Group Health Plan, without regard to the claims experience or any health status-related factor relating to any current Members or eligible Employees or their Dependents; and
  - (d) Prior to providing the discontinuation notice, Vantage files such notice and Plan being discontinued with the Louisiana Department of Insurance and Commissioner of Insurance.
2. If Vantage elects to discontinue offering all Health Insurance Coverage Plans in the state of Louisiana, Health Insurance Coverage may be discontinued if:
  - (a) Vantage provides notice to the Louisiana Department of Insurance and Commissioner of Insurance and to each Employer, Employee and Dependents covered under such coverage of such discontinuation at least one hundred eighty (180) days prior to the date of the discontinuation of such coverage. Notice shall not be issued to the Members until the expiration of twenty (20) days after submission to the Commissioner of Insurance, unless the Commissioner of Insurance gives his written approval prior to that time.
  - (b) Any Group Health Plan's policy or coverage whose renewal date falls within the minimum one hundred eighty (180) day notice period shall remain in force for one hundred eighty (180) days from the date that the notice of discontinuation was issued.
  - (c) In the case of a Health Insurance Coverage discontinuation in an entire market in the state of Louisiana, Vantage may not provide for the issuance of any Health Insurance Coverage in the market and state during the five (5) year period beginning on the date of the discontinuation of the last Health Insurance Coverage Plan.

### C. Grace Period

This Plan has a thirty (30) day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the following grace period. During the grace period, this Plan will stay in force, except that for groups where premiums have not been received when due, claims for Members covered by this Plan may, at the option of Vantage, be held and suspended from processing until the premiums have been paid by Employer. This Plan will be considered terminated unless the premiums past due and current are fully paid by the end of the grace period. This Certificate constitutes notice of the termination and necessary action for reinstatement.

### D. Employees

An Employee's coverage will terminate on the first to occur of the following:

1. the end of the month during which the Employee no longer meets eligibility requirements under this Plan (unless otherwise stated in the Master Group Contract); or

2. the last day of the month the Employer or Member ceases to make premium payments within the specified grace period, unless otherwise specified by the Employer and approved by Vantage; or
3. for any specific benefit, the date the benefit terminates or the date an Employee's eligibility status changes so that the Employee is no longer eligible for that benefit; or
4. the date the group contract terminates; or
5. the date Vantage determines the Employee is ineligible due to intentional material misrepresentation and/or noncompliance with Vantage procedures; or
6. if the Member breaches any provision of this Plan.

Vantage may choose to rescind coverage or terminate a Member's coverage if a Member performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of this Plan. The issuance of this coverage is conditioned on the representations and statements contained at application and enrollment. All representations made are material to the issuance of this Plan. Any information provided on the application or enrollment form or intentionally omitted therefrom, as to any proposed or covered Member, shall constitute an intentional misrepresentation of material fact. A Member's coverage may be rescinded retroactively to the effective date or terminated within three (3) years of the Member's effective date, for fraud or intentional misrepresentation of material fact. Vantage will give the Member thirty (30) days advance written notice prior to rescinding or terminating coverage under this section.



**The Employee will be notified by Vantage of coverage termination at his/her last known address. The Employee is responsible for the cost of all benefits which are provided after the date of termination of coverage.**

#### E. Dependents

Dependents' coverage will terminate on the first to occur of the following:

1. the end of the month during which the Employee or Dependent is no longer eligible for coverage under this Plan (unless otherwise stated in the Master Group Contract); or
2. the last day of the month the Employer or Member ceases to make the premium payment within the specified grace period, unless otherwise specified by the Employer and approved by Vantage; or
3. for any specific benefit, the date the benefit terminates or the date a Dependent's eligibility status changes so that the Dependent is no longer eligible for that benefit; or
4. the date the group contract terminates; or
5. the date Vantage determines the Dependent is ineligible due to intentional material misrepresentation and/or noncompliance with Vantage procedures; or
6. if the Dependent breaches any provision of this Plan.

Vantage may choose to rescind coverage or terminate a Member's coverage if a Member performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of this Plan. The issuance of this coverage is conditioned on the representations and statements contained at application and enrollment. All representations made are material to the issuance of this Plan. Any information provided on the application or enrollment form or intentionally omitted therefrom, as to any proposed or covered Member, shall constitute an intentional misrepresentation of material fact. A Member's coverage may be rescinded retroactively to the effective date or terminated

within three (3) years of the Member's effective date, for fraud or intentional misrepresentation of material fact. Vantage will give the Member thirty (30) days advance written notice prior to rescinding or terminating coverage under this section.



**The Employee and/or Dependent is responsible for the cost of all benefits which are provided after the date of termination of coverage.**

**F. Consolidated Omnibus Budget Reconciliation Act (COBRA) & Public Health Service Act**

Health Plans of Employers with twenty (20) or more Employees in the preceding year (other than church Plans as defined in Internal Revenue Code § 414(e)) and all state or local governments subject to the PHSA, must provide for the continuation of coverage for certain "qualified beneficiaries" at their expense upon the occurrence of certain "qualifying events." This continued coverage will be referred to herein as "COBRA." These terms are defined as follows:

**Qualified Beneficiary:**

- A covered Employee.
- A covered spouse or Dependent of an Employee, including children born to the covered Employee, adopted by the covered Employee or Placed for Adoption by the covered Employee while on COBRA.

**Qualifying Events:** Member loses coverage as a result of any of the following events:

- Termination of employment (for reason other than gross misconduct) of the Employee or reduction in hours worked.
- The Employee becoming entitled to Medicare.
- Any Plan provision that would result in the cessation of coverage for a Dependent child due to the loss of Dependent status.
- Death of a covered Employee.
- The divorce or legal separation of a covered Employee from the Employee's spouse.
- The Employer's filing of a Chapter 11 bankruptcy proceeding.

The COBRA continuation coverage under this Plan includes all benefits for which the qualified beneficiary was covered just prior to the COBRA "qualifying event" as defined above.

If the qualifying event was the Employee's termination of employment or reduction in hours, the maximum period of continued coverage is 18 months from the qualifying event; provided that this 18-month period may be extended 11 months for a total coverage period of 29 months if the Employee or his covered spouse or Dependent is disabled (as determined under Title II or Title XVI of the Social Security Act) within the first 60 days of COBRA coverage AND the Social Security determination of disability is provided to the Plan Administrator prior to the expiration of the first 18 months of coverage. For all other reasons for COBRA coverage, the maximum period of coverage is 36 months from the date of the original qualifying event. If multiple qualifying events occur (such as a divorce after the Employee has terminated employment), the maximum period is still 36 months from the qualifying event.

Coverage ceases upon, (1) expiration of the 18-month, 29-month or 36-month continuation period; or (2) failure to pay the premium; 3) the disabled qualified beneficiary ceases to be disabled and COBRA coverage is in the 11-month disability extension period; or (4) group coverage is obtained elsewhere; or (5) the qualified beneficiary obtains Medicare eligibility; or (6) the date the Employer discontinues this Plan for all active Employees.

**The Type of Health Coverage Available to Qualified Beneficiaries under COBRA**

The type of health coverage available to qualified beneficiaries is the same coverage they had before the qualifying event occurred. However, if coverage under the Plan is subsequently modified for all beneficiaries who are similarly situated to the qualified beneficiary, but for whom no qualifying event has occurred, then the qualified beneficiary's coverage will change also.

### **New Children**

A child born to, adopted, or Placed for Adoption with the covered Employee during a period of COBRA coverage will be eligible to become a qualified beneficiary in accordance with the terms of the Plan and the requirements of federal law. These new children can be added to COBRA coverage upon proper notification to the Plan Administrator within 30 days of the birth or adoption.

### **Qualified Beneficiary's Notice Obligations**

If a covered Employee divorces or becomes legally separated or if a Dependent child is no longer eligible as a Dependent for coverage under the Plan, then the affected individual(s) are required to notify the Plan Administrator, which in most cases is the Employer, in writing of the occurrence of the event within 60 days of the event.

In addition, if a qualified beneficiary is disabled (as determined under Title II or Title XVI of the Social Security Act) within the first 60 days of COBRA coverage, then the qualified beneficiary must notify the Plan Administrator of the determination of disability within 60 days of the determination and before the end of the initial 18 months of COBRA continuation coverage in order to be eligible to elect an additional 11 months of COBRA coverage. The disabled individual and all family Members on COBRA may elect the extended coverage. They may be required to pay a higher premium for this additional 11 months of coverage. In addition, the disabled individual is required to notify the Plan Administrator of a determination under the Social Security Act that he is no longer disabled within 30 days of such determination.

Each qualified beneficiary must also notify the Plan Administrator as soon as possible after the date the qualified beneficiary is covered under another Group Health Plan or Medicare.

In addition, if an Employee loses coverage due to termination of employment, reduction in hours or Medicare entitlement, or an Employee dies, the Employer has an obligation to notify the Plan Administrator of the occurrence of the qualifying event within 30 days of the event.

### **Notice Obligations**

Once a Plan Administrator receives timely notification of a qualifying event, the Plan Administrator must notify the affected qualified beneficiaries of their COBRA election rights within 14 days. Qualified beneficiaries have 60 days from the date on which they were given notice of their COBRA election rights (or, if later, 60 days from the date of the qualifying event) to elect COBRA continuation coverage. Applicable premium payments are due within 45 days of the initial COBRA election. All subsequent premium payments must be submitted on a timely basis (within 30 days of the due date) to avoid termination of continuation benefits.



**Vantage is not responsible for issuing any COBRA notices.** This responsibility is solely the Employer's. If a qualified beneficiary fails to make a timely COBRA election by the applicable deadlines, then Vantage is not contractually responsible to insure the COBRA coverage offered under this Plan, even if a qualified beneficiary validly elects COBRA coverage after all applicable deadlines have expired.

For example, a qualified beneficiary must elect COBRA coverage following loss of coverage due to termination of employment within 104 days of the qualifying event, which includes the 30 days for the Employer to notify the Plan Administrator, the 14 days for the Plan Administrator to notify the qualified beneficiaries, and the 60 days for the qualified beneficiaries to elect COBRA coverage. In this termination of employment example, if the Employer or Plan Administrator fails to provide the required COBRA notices and the Employee fails to make an election within 104 days, Vantage would not be contractually responsible to provide COBRA coverage during the 104 day election period even if a qualified beneficiary validly elects COBRA coverage more than 104 days after the qualifying event.

## SECTION VIII: CLAIMS PROVISIONS

### A. Proof of Loss

If a Member incurs a charge for which benefits are payable under this Plan as the primary carrier, written proof of such charge must be furnished to Vantage within ninety (90) days after the charge is incurred. Written proof for medical claims must consist of procedures and diagnoses itemized by the Provider on a claim form (CMS-1450 or CMS-1500) or a superbill along with documentation of any payments you have made. Written proof for Prescription Drug claims must consist of a Prescription Drug receipt from the Pharmacy and proof of payment. When a Member must first file claims with another primary carrier, Vantage being the secondary Plan, the explanations of benefits from the primary carrier must be submitted to Vantage within twelve (12) months of the date of service. **Under no circumstance will Vantage consider a claim for payment that is submitted more than twelve (12) months after the date the services were rendered.**

Mail your request for payment together with the written proof for claims to Vantage at the address below. It is a good idea to make a copy of this documentation for your records.

Vantage Health Plan, Inc.  
Attn: Member Services Department  
130 DeSiard Street, Suite 300  
Monroe, LA 71201

Contact Member Services at (318) 361-2125 or toll-free at (855) 934-6847 if you have any questions or if you want to give us more information about a request for payment you have already sent to Vantage.

### B. Payment of Claims

All Vantage approved benefits for services of In-Network Providers must be received from and paid directly to the institution or person rendering the service.

Vantage approved benefits for services of Out-of-Network Providers may be paid directly to the institution or person rendering the service or, if payment by the Member was required at the time of service, may be reimbursed to the Member. Reimbursements to Members will be made only if documentation of procedures are itemized by the Provider on a claim form (CMS-1450 or CMS-1500), a superbill or a Prescription Drug receipt from the Pharmacy submitted to Vantage. Reimbursements are not available for items or services provided by Medicare Opt-out Physicians. The Medicare opt-out list is available online at <https://vantagehealthplan.com/Members/optoutphysicians>. If such benefits are not paid as of the date the Member dies, or if the Member is a minor or is not capable of giving a legally binding receipt for the payment of any benefits, Vantage, at its option, may pay the benefit to:

- the person or institution rendering the service; or
- one or more of the following relatives of the Member: spouse, parent(s), child(ren), brother(s) or sister(s), the Member's beneficiary or estate.

Any payments made in this manner will discharge Vantage of its duty to the extent of such payments. Vantage will not be liable as to the application of such payment.

Member may NOT assign benefits to Providers. However, Member understands that Participating Providers reserve the ability to directly pursue any third parties who cause accidental injury or illness to Members for the full amount of the cost of the medical services rendered to Member and forego submitting claims to Vantage for payment. In the event that a Participating Provider elects to pursue a third party recovery and not submit a claim or proof of loss to Vantage, prior written consent of the Member must be obtained and the Member may be responsible for any unpaid Participating Provider charges not compensated by the third parties.

Vantage shall pay claims timely and in accordance with the state law. Electronic clean claims received from all Health Care Providers shall be paid within twenty-five (25) days from date of receipt by Vantage. Non-electronic clean claims received from Participating Providers within forty-five (45) days from the date of service shall be paid within forty-five (45) days from date of receipt by Vantage. Non-electronic clean claims received from Participating Providers after forty-five (45) days from the date of service shall be paid within sixty (60) days of date of receipt by Vantage. All non-electronic clean claims received from Non-Participating Providers shall be paid within thirty (30) days from date of receipt by Vantage.

**C. Examination**

Vantage will have the right, at its own expense, to have a Physician examine any Member whose Illness or injury is the basis of a claim under this Plan. Such examinations will be performed as often as Vantage may reasonably require while a claim is pending.

**D. Authorization to Examine Health Records**

The Member consents to and authorizes any Participating Provider or Out-of-Network Provider of Covered Services to permit the examination and copying of any portion of the Member's Hospital or medical records, when requested by Vantage. Information from medical records of Members and information received from Physicians or Hospitals incident to the Physician-patient relationship or Hospital-patient relationship shall be kept confidential. Processing of related claims may be pended until such information is provided.

**E. Legal Actions**

No action at law or in equity may be brought to recover under this Plan before the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Plan. Under no conditions may any legal action be brought after the expiration of one (1) year after the time written proof of loss is required to be furnished, or prior to completion by the Member of the Appeal and Grievance Procedures under this Plan.

## SECTION IX: COORDINATION OF BENEFITS

If a Member is entitled to benefits for medical care under two or more Plans, including this Plan, the amount of benefits provided under this Plan for that care may be reduced to an amount which, together with the benefits provided under all other Plans, will not exceed 100% of the Vantage Allowable of any Covered Services under this Plan. This process is called *Coordination of Benefits*. Member must inform Vantage and any Participating Providers rendering services, if the Member and/or Dependent(s) receive services through Vantage that may be covered by Another Health Plan, including this Plan.

The definition of “Another Health Plan” includes any Plan providing medical care benefits under (1) group coverage, or any other arrangement of coverage for individuals in a group other than franchised insurance, or (2) coverage under any governmental Plan except Medicaid.

Vantage may, without the consent of any person, release or obtain any information that it deems necessary for determining benefits in accordance with the Coordination of Benefits provision in this Plan. Any person claiming benefits under this Plan will furnish Vantage any information it deems necessary for this purpose. All benefits provided are subject to Coordination of Benefits.

If, at any time, Vantage determines that payments have been made which are in excess of the amount necessary to satisfy the conditions of the Coordination of Benefits provision in this Plan, Vantage will have the right to recover the overpayments.

If payments are made under Another Health Plan, which in accordance with this Coordination of Benefits provision payments should have been made under this Plan, Vantage will have the right to pay any organization making the payments any amount it determines will satisfy the intent of that provision. Amounts so paid will be deemed to be benefits paid under this Plan. Vantage will be discharged from liability under this Plan to the extent of the amounts so paid.

1. If coverage is provided in the manner defined below under Another Health Plan, benefits provided under this Plan and the other health Plans might exceed actual medical expenses incurred. If this is the case, the combined benefits payable under this Plan and other health Plan(s) will not exceed 100% of the Vantage Allowable.
2. The benefits that would be paid under this Plan in the absence of this provision will be reduced so that the sum of the reduced benefits and all benefits to be paid under all other health Plans will not be more than the total of allowable expenses in any Benefit Period. Benefits payable under the other health Plans include benefits that would have been paid if the Member had properly claimed such benefits.
3. The benefits of this Plan will not be reduced as noted in item 2 above, if the rules of benefit determination in item 4 below require that the benefits of this Plan be determined prior to the benefits of such other Plan.
4. Services that are not covered by the primary Health Plan will not be covered by Vantage unless Pre-Authorization was obtained from Vantage prior to the services being rendered.
5. The rules by which the order of benefits is determined are:
  - a. The Plan that covers the person as an Employee or as the certificate holder is the Plan that pays first. This is called the “primary Plan.” The Plan that covers the person as Dependent is the Plan that pays second, called the “secondary Plan.”
  - b. If children are covered as Dependents under the Plans of both parents, the primary Plan is the Plan of the parent whose birthday (excluding year of birth) occurs earlier in a calendar year.
  - c. When the parents are separated or divorced: (1) if there is a court decree that establishes financial responsibility for the medical, dental, or other health care expenses with respect to the child, the



benefits are determined to be primary in agreement with the court; or (2) if the parent with custody has remarried, the Plan of the parent with custody is primary, the step-parent's Plan is secondary, and the Plan of the parent without custody pays third.

- d. If the above rules do not establish an order of benefit determination, the Plan that has covered the person for the longer period of time shall be primary, with the following exception: the benefits of a Plan covering a person who is laid-off or a retired Employee, or a Dependent of such person, shall be determined after the benefits of any other Plan covering the person as an Employee.
- e. Any Plan that does not contain a Coordination of Benefits provision is automatically primary.

## SECTION X: SUBROGATION

### **Recovery of the Cost of Benefits**

If a Member is injured or becomes ill through the act of another person or party or entity and Vantage provides benefits for the injury or Illness, Member is entitled to benefits under this Plan and Vantage shall have the right under this Plan to repayment of the cost of any and all benefits paid on behalf of the Member that are associated with the injury or Illness for which the other person or entity is liable.

### **Subrogation**

Subrogation means that Vantage can regain by legal action, if necessary, the cost of benefits paid by Vantage from any person or entity against whom the Member may have a claim. Subrogation will result in savings for the benefit of all Vantage Plan Members because the cost of treatment for sickness or injury will be paid by the persons or entities that are legally responsible for such payment. In the event that benefits are provided under this Plan, Vantage shall be subrogated to the Member's rights of recovery against any person or entity to the extent of the amount of the benefits provided. This includes Vantage's right to bring suit against the person or entity in Vantage's name or the name of the Member. At Vantage's request, the Member shall execute and deliver the necessary documentation (as determined by Vantage) to secure and protect Vantage's subrogation rights. The Member agrees to cooperate with Vantage and/or representatives of Vantage, including its attorneys, in completing such forms and in giving such documentation and information surrounding any Accident or incident the Member was involved in, as Vantage or its representatives deem necessary to fully investigate the Accident or incident. Members also have the following obligations under this subrogation provision:

- To notify Vantage within thirty (30) days of any event which could result in legal action, a claim by or against a third party, or a claim against the Member's own insurance. If the Member is in an automobile accident, he/she should contact Vantage within five (5) business days to coordinate who shall pay the Member's claims. Vantage shall pay claims related to the Member's injury and will be reimbursed by automobile insurance.
- To seek recovery from the responsible person or entity (or his/her insurer) of all amounts in connection with benefits paid by Vantage under this Plan and to notify Vantage within five (5) business days of any such actions taken by the Member.
- To refrain from doing anything to impair, prejudice or discharge Vantage's rights of subrogation.
- To fully cooperate and assist Vantage, as is deemed necessary by Vantage, to enforce Vantage's rights of subrogation. This obligation to assist Vantage will apply to Member's legal representative.
- To notify Vantage of and pay to Vantage any amounts received by Member or Member's legal representative to the extent of the cost of the benefits provided by Vantage to which Vantage is entitled to because of its rights of subrogation.

### **Reimbursement**

Vantage has the right to be reimbursed by its Members the cost of any and all benefits that were paid by Vantage that are associated with the Member's injury or Illness caused by another person or entity. This right of reimbursement will apply where Vantage has paid benefits and the Member and/or the Member's representative has been reimbursed any amounts by another person or entity or by any other source as set forth below. If a Member, or any other person or entity on the Member's behalf, that has been paid, does not properly refund the full amount to Vantage for the cost of benefits paid by Vantage, Vantage may reduce the amount of any future benefits that are payable for the Member under this Plan. Vantage's right of reimbursement as to a Member is limited, however, to the extent of the actual cost of the benefits provided by Vantage.

### **Lien**

Vantage, by paying any benefits under this Plan, is granted a lien on the proceeds of any settlement, judgment or other payment received by the Member. The Member hereby consents to Vantage's lien and agrees to take whatever steps are necessary to assist Vantage in securing its lien.

### **Assignment**

Vantage, by the payment of any benefits under this Plan, is granted an assignment of the proceeds of any settlement, judgment or other payment received by the Member to the extent of the benefits paid. By accepting benefits hereunder, the Member consents to Vantage's assignment and authorizes and directs his or her attorney, personal representative or any insurance company to directly reimburse Vantage or its designee to the extent of the cost of the benefits paid. Any such assignment is effective and binding upon the Member's attorney, personal representative or any insurance company upon notice of this provision.

### **Participating Providers' Subrogation Rights**

Participating Providers have a contractual right to pursue third parties for the full recovery of the cost of the medical services rendered to Member in lieu of submitting claims to Vantage for payment. In such an instance, and with the written consent of the Member, Participating Providers may request appropriate information from the Member regarding the third parties responsible for the injury or Illness of the Member, and Member shall cooperate in providing this information to Participating Providers. Participating Providers who elect to pursue third parties for a recovery will not, under any circumstances submit their claims to Vantage for payment, but will only pursue the third parties for recovery. In such an event, and if full recovery is not made by the Participating Providers, Member understands that he or she may have a further financial responsibility to Participating Providers for the cost of medical services not recovered from the third parties.

### **Other Vantage Rights**

The subrogation and reimbursement rights of Vantage, including the foregoing right of assignment, is applicable to any recoveries made by, or on behalf of, the Member as a result of the injuries or Illnesses sustained including, but not limited to, the following sources:

- Payments made directly by the tortfeasor or any insurance company on behalf of the tortfeasor or any other payments on behalf of the tortfeasor.
- Any payments, settlements, judgment or arbitration awards paid by any insurance company under an uninsured or underinsured motorists coverage policy, whether on behalf of a Member or other person.
- Any workers' compensation award or settlement.
- Medical payments coverage under any automobile insurance policy.
- Premises or homeowners insurance coverage including premises or homeowners medical payments coverage.
- Any other payments from any other source designed or intended to compensate a Member for injuries sustained as a result of negligence or alleged negligence of any person or entity.

Vantage's right to recover, whether by subrogation or reimbursement, shall also apply to the Member's Dependents and minor children, whether or not adjudged incompetent or disabled, heirs, and any settlement or recovery attributable thereto.

To the extent not preempted by federal law, Vantage will not attempt to subrogate until the Member is made whole and Vantage will pay its portion of attorney's fees therewith. No Member shall enter into any type of settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the cost of benefits provided by Vantage. Vantage's recovery rights shall not be defeated or impaired in any respect by an allocation of settlement proceeds exclusively to non-medical expense damages. Further, no Member shall incur any expenses on behalf of Vantage in pursuit of Vantage's rights hereunder.

Vantage shall recover the full amount of benefits provided under this Plan without regard to any claim of fault on the part of any Member, whether by comparative negligence or otherwise. Benefits payable by Vantage under this Plan are secondary to any coverage under no fault or similar insurance.

In the event that a Member fails or refuses to comply with the terms of this Plan and this provision specifically, the Member shall reimburse Vantage for any and all costs and expenses including attorney fees incurred by Vantage in enforcing its rights hereunder. Further, the failure of any Member to comply and/or assist Vantage with its subrogation rights may result in termination of the Member's participation in this Plan and the Member shall be responsible for the cost of all benefits and services paid by Vantage related to the injury. It is specifically recognized that this Plan and the rights of Vantage and its Members herein may be governed by ERISA.

## SECTION XI: APPEAL & GRIEVANCE PROCEDURES

Vantage recognizes its responsibility to provide Members with adequate methods to make inquiries and express concerns regarding Vantage or a Health Care Provider. Members are encouraged to contact Vantage's Member Service department for assistance with complaints or suggestions concerning the Plan.

As a Member of this Plan, you have the right to file a complaint if you have concerns related to:

- (a) Availability, delivery, or quality of health care services, including a complaint regarding an Adverse Determination made by Vantage's utilization review procedures;
- (b) Claims payment, handling, or reimbursement for health care services; or
- (c) Matters pertaining to your contract with Vantage.

Members also have the right to notices of the decisions rendered on claims and Appeals to be provided in a culturally and linguistically appropriate manner, of available internal and external Appeals processes and the availability of the Louisiana Department of Insurance to assist with the Appeals process. You have the right, upon request and free of charge, to review and have copies of all documents relevant to the claim for benefits and to submit comments and documents relating to the claim, without regard to whether that information was submitted or considered in the initial benefit determination, and to receive continued coverage pending the outcome of the Appeals process where required by applicable law of the Plan.

Vantage considers a **Grievance** to be the type of complaint you file if you have any *concerns* related to the quality of care or services received from Vantage or a Health Care Provider. *Examples of a Grievance:*

- (a) Unpleasant attitudes or behavior at a Health Care Provider;
- (b) Lengthy wait times in a Health Care Provider's facility;
- (c) Difficulty scheduling an appointment or contacting a Health Care Provider;
- (d) Complaints that a procedure or item during a course of treatment did not meet accepted standards for delivery of health care; or
- (e) Concerns or difficulty when contacting Vantage or communicating with a Vantage Employee.

Members always have the right to file a complaint with the Louisiana Department of Insurance.

An **Appeal** is the type of complaint you file when you want Vantage to reconsider an *Adverse Determination* made by Vantage. *Examples of an Appeal:*

- (a) A determination that a request for a benefit does not meet Vantage's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.
- (b) Vantage's denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit due to your eligibility to participate in our Plan.
- (c) Any pre-service or post-service review where Vantage denies, reduces, or terminates or fails to provide or make payment, in whole or in part for a benefit.
- (d) A Rescission of coverage determination, meaning if Vantage cancels or discontinues coverage after services have already been provided, except for circumstances when coverage is terminated due to a failure to timely pay your required premiums or contributions towards the cost of coverage.

## APPEALS AND GRIEVANCES PROCEDURE

Any Member that wishes to file an Appeal or Grievance should call Vantage's Member Service department. Member Services is available Monday through Friday from 8:00 a.m. to 8:00 p.m. by calling:

(318) 361-2125  
Toll-free (855) 934-6847 Ext. 1

The Vantage Member Services Representative will review the situation and can often resolve the complaint during the call. If the Member's complaint is resolved, a report of the communication, description of the findings, and the resolution or actions taken will be placed in the Member's file.

If the Member Services Representative is unable to resolve the complaint to the Member's satisfaction, the Member may file a formal Appeal or Grievance.

### First Level Review

Members may file a formal Appeal or Grievance for further review of a complaint. A formal Appeal or Grievance must be submitted within **one hundred eighty (180) days** from the date of the initial decision. Written requests for review can be faxed, mailed or hand-delivered to:

Vantage Health Plan, Inc.  
Attn: Appeals and Grievances  
130 DeSiard Street, Suite 300  
Monroe, LA 71201  
Standard Fax: 318-361-2159  
Expedited Fax: 318-807-1042

Please include the following:

- Member's name, address and Member identification number
- A summary of the reason for the review
- A description of the solution desired by the Member
- Signature of the Member or Authorized Representative

The letter will be forwarded to the Vantage Medical Director and will be adjudicated in a manner designed to ensure independence and impartiality without regard to the initial denial. The Medical Director will review the letter and information related to the complaint. If any evidence generated by Vantage is utilized in connection with the review to which the Member does not have access, Vantage will, if needed, make that information available to the Member and allow Members, upon request and free of charge, to review and have copies of all documents relevant to the claim for benefits and to submit comments and documents relating to the claim, without regard to whether that information was submitted or considered in the initial benefit determination, prior to a decision being rendered. The Medical Director will determine the resolution for the complaint and respond in writing to the Member within thirty (30) days from the date of receipt, or as allowed by law.

### Second Level Review (Voluntary Level)

Should the Member decline to accept an adverse First Level Internal decision, the Member may request a second level voluntary review in writing. The Second Level Review is voluntary, meaning that the Member may choose to request an External Review after receipt of determination of the First Level Internal Decision. The Member must file a formal written request to the Appeals and Grievances Committee within **thirty (30) days** of the adverse First Level Internal review decision. This can be faxed, mailed or hand-delivered.

The Appeals and Grievances Committee will review all the information submitted by the Member and documented by the Member Services Representative and Medical Management department. The Appeals and Grievances Committee meets on a monthly basis to review internal Appeals and Grievances. The

Member will be notified in writing of the Appeals and Grievances Committee decision within five (5) calendar days of completing the review, but in no case later than **forty-five (45) days** from receipt of a second level review request.

### **Expedited Review**

If a complaint involves an urgent care request, a Member or Authorized Representative may request a first or second level review orally or in writing. An urgent care request is one that should not be handled in the standard process because it could seriously jeopardize a Member's life or health or ability to regain maximum function. Or, would in the opinion of a Physician with knowledge of a Member's medical condition, subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of a Member's request. All requests for urgent care submitted by a Physician on a Member's behalf will be considered urgent and will be handled as soon as possible, taking into account a Member's medical situation, but in no case later than **seventy-two (72) hours** from receipt of the expedited review request.

### **Standard External Review**

For matters involving an issue of medical necessity, appropriateness, health care setting, level of care, effectiveness or a Rescission of coverage, Members have the right for external review. This includes matters involving health care service or treatment determined to be experimental or investigational. Within **one hundred eighty (180) calendar days** from the receipt of a notice of an Adverse Determination or Final Adverse Determination, a Member or Authorized Representative may request an external review, regardless of the claim amount. Also, an external review may be requested if Vantage has not issued a decision within thirty (30) days following the filing date of an initial Grievance or Appeal with Vantage, provided the Member has not requested or agreed to a delay.

Within five (5) business days following the date of receipt of the external review request from the Member or Authorized Representative, Vantage will complete a preliminary review to determine whether the request is eligible for external review, based upon Louisiana RS 22:2436 (B). Within these five (5) days, Vantage will notify the Commissioner of Insurance, the Member and Authorized Representative, if applicable, that the request is complete and eligible for external review.

Should the request not be complete or is not eligible for external review, Vantage will provide written notification to the Member and Authorized Representative outlining the additional information needed or reasons for its ineligibility. Decisions regarding ineligibility may be appealed to the Commissioner of Insurance. The Commissioner may determine that a request is eligible for external review. If so, the Commissioner will notify Vantage and the Member or his Authorized Representative, if applicable, of this determination regarding eligibility within five (5) business days of the receipt of the request from the Member.

Once a case has been determined to be eligible for external review, Vantage will proceed with the following Independent Review Organization (IRO) process:

- (1) Vantage will submit a request for assignment of an IRO by the Department of Insurance.
- (2) The Commissioner will randomly assign an IRO from the list of approved IRO's compiled and maintained by the Commissioner to conduct the external review and will notify Vantage of the assigned IRO.
- (3) Within one (1) business day, the Commissioner will send written notice to the Member and, if applicable, his Authorized Representative, of the request's eligibility and acceptance for external review and the identity and contact information of the assigned IRO. The Commissioner will include in the notice that the Member or Authorized Representative may submit additional information in writing to the assigned IRO within five (5) days of receipt of the notice of assignment.
- (4) Vantage must provide to the IRO within five (5) business days the documents and any information considered in making the Adverse Determination or Final Adverse Determination.

The IRO will have **forty-five (45) days** after receipt of the request for an external review to issue a written notice of its decision to the Member; the Member's Authorized Representative, if applicable; Vantage and the Commissioner. If the decision is favorable for the Member, Vantage will immediately approve the coverage or payment that was the subject of the review.

### **Expedited External Review**

An expedited external review is available to Members in either of the following scenarios:

1. An Adverse Determination issued and the Adverse Determination (a) involves a medical condition for which the time for completion of an expedited internal review of a grievance involving Adverse Determination would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function and (b) the Member has simultaneously filed request for expedited internal appeal of the Adverse Determination.
2. A Final Adverse Determination is issued and the Final Adverse Determination (a) involves a medical condition for which the time for completion of Standard External Review of the Final Adverse Determination would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function OR (b) concerns a service/treatment for emergency services and Member has not been discharged from facility.

The same process will be followed as outlined in the Standard External Review process; however, the time frames outlined will be changed to immediately and as expeditiously as the Member's medical condition or circumstances requires, but in no case more than seventy-two (72) hours after the date that Vantage receives the request for an expedited external review. If the notification is provided orally and not in writing, within forty-eight (48) hours after the date of providing the notice, the IRO will provide written confirmation of the decision. If the decision is favorable to the Member, Vantage will approve the coverage that was subject of the review.

**Per Louisiana RS 22:2437, an expedited external review will not be provided for retrospective Adverse Determinations in which services have already been provided to a Member.**

**External Review decisions are binding on Vantage and the Member except to the extent that other remedies are available under applicable federal or state law.**

**DUPLICATE REQUESTS TO APPEAL THE SAME CLAIM, SERVICE, ISSUE, OR DATE OF SERVICE WILL NOT BE CONSIDERED.**

The Office of Consumer Advocacy of the Louisiana Department of Insurance is also available to assist Members with the Appeal process. Contact information is as follows:

Louisiana Department of Insurance  
Office of Consumer Advocacy  
P.O. Box 94214  
Baton Rouge, LA 70804-9214  
Phone: (225) 219-0619 or (800) 259-5300  
[www.ldi.la.gov](http://www.ldi.la.gov)

## SECTION XII: WHCRA NOTICE

### **Women's Health and Cancer Rights Act of 1998 Notice**

For Vantage Health Plan Members receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to authorizations, Co-payments, and/or Co-insurance that are applicable to your medical and surgical benefits provided under this Plan. If you would like more information on WHCRA benefits, call the Vantage Member Services department at (318) 361-2125 or (855) 934-6847.



## SECTION XIII: HIPAA NOTICE

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

At Vantage Health Plan, Inc. (Vantage), we respect the confidentiality of your health information and will protect it in a responsible and professional manner. We consider this information private and confidential and have policies and procedures in place to protect the information against unlawful use and disclosure.

This notice describes what types of information we collect, explains when and to whom we may disclose it, and provides you with additional important information. Vantage is allowed by law to use and disclose your health information to carry out the operations of our business. We are required by law to maintain the privacy of your health information, to provide you with this notice and abide by the notice in effect. It also informs you of your rights with respect to your health information and how you can exercise those rights.

### **What is Protected Health Information or PHI?**

When we talk about “information” or “health information” in this notice we mean Protected Health Information or PHI. PHI is information that identifies an individual enrolled in a Vantage benefit Plan. It relates to the person’s participation in the Plan, the person’s physical or mental health or condition, the provision of health care to that person, or payment for the provision of health care to that person. It does not include publicly available information, or information that is available or reported in a summarized fashion that does not identify any individual person.

### **What types of personal information does Vantage collect?**

Like all health benefits companies, we collect the following types of information about you and your Dependents:

- Information we receive directly or indirectly from you through applications, surveys, or other forms, in writing, in person, by telephone, or electronically, including our website (e.g., name, address, social security number, date of birth, marital status, Dependent information, employment information, medical history).
- Information about your relationship and transactions with us, our affiliates, our Providers, our agents, and others (e.g., health care claims and encounters, medical history, eligibility information, payment information, service request, and Appeal and Grievance information).

### **How does Vantage protect this information?**

Vantage has policies that limit internal and external sharing of PHI to only persons who have a need for it to provide benefit services to you and your Dependents. We maintain physical, electronic and procedural safeguards to protect PHI against unauthorized access and use. For example, access to our facilities is limited to authorized personnel and we protect information electronically through a variety of technical tools. We also have established a Privacy Committee, which has overall responsibility for the development, implementation, training, oversight and enforcement of policies and procedures to safeguard PHI against inappropriate access, use and disclosure, consistent with applicable law.

### **How may Vantage use or share your information?**

To effectively operate your health benefit Plan, Vantage may use and share PHI about you to:

- Perform our duties of certificate of insurance, which may involve claims review and payment or denial; coordination of benefits; Utilization Review; Medical Necessity review; coordination of care; response to Member inquiries or requests for services; conduct of Grievance, Appeals, and external review programs; benefits and program analysis and reporting; risk management; detection and investigation of fraud and other unlawful conduct; auditing; administration and coordination of reinsurance contracts.
- Operate preventive health programs, disease early detection programs, disease management programs and case management programs in which we or our affiliates or contractors send educational materials and screening reminders to eligible Members and Providers; perform health risk assessments; identify and contact Members who may benefit from participation in disease or case management programs; and send relevant information to those Members who enroll in the programs, and their Providers.

- Conduct quality improvement activities, such as the credentialing of Participating network Providers; and accreditation by the National Committee for Quality Assurance (NCQA), Centers for Medicare & Medicaid Services (CMS), and/or other independent organizations, where applicable.
- Conduct performance measurement and outcomes assessment; health claims analysis and reporting.
- Provide data to outside contractors who help us conduct our business operations. **We will not share your PHI with these outside contractors unless they agree in writing to keep it protected.**
- Manage data and information systems.
- Perform mandatory licensing, regulatory compliance/reporting, and public health activities; responding to requests for information from regulatory authorities, responding to government agency or court subpoenas as required by law, reporting suspected or actual fraud or other criminal activity; conducting litigation, arbitration, or similar dispute resolution proceedings; and performing third-party liability and subrogation activities.
- Change policies or contracts from and to other insurers, HMOs, or third party administrators.

We consider the activities described above as essential for the operation of our health Plan. For example Vantage may feature:

- Cancer screening reminder programs that promote early detection of breast, ovarian, and colorectal cancer, when these illnesses are most treatable.
- Disease management programs that help Members work with their Physicians to effectively manage Chronic conditions like asthma, diabetes, and heart disease to improve quality of life and avoid preventable emergencies and hospitalizations.
- Quality assessment programs that help us review and improve the services we provide.
- A variety of outreach programs that help us educate Members about the programs and services that are available to them, and let Members know how they can make the most of their health benefits.

There are also state and federal laws that may require us to release your health information to others. We may be required to provide information as follows:

- To state and federal agencies that regulate us such as the US Department of Health and Human Services and the Louisiana Department of Insurance.
- For public health activities. For example, we may report information to the Food and Drug Administration for investigating or tracking of Prescription Drug and medical device problems.
- To public health agencies if we believe there is a serious health or safety threat.
- With a health oversight agency for certain oversight activities (for example, audits, inspections, licensure, and disciplinary actions.)
- To a court or administrative agency (for example, pursuant to a court order, search warrant or subpoena).
- For law enforcement purposes. For example, we may give information to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness or missing person.
- To a government authority regarding child abuse, neglect or domestic violence.
- To a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also share information with funeral directors as necessary to carry out their duties.
- For procurement, banking or transplantation of organs, eyes or tissue.
- To specialized government functions, such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- For on the job-related injuries because of requirements of state worker compensation laws.

Vantage does not share PHI for any purpose other than those listed above. If one of the above reasons does not apply, **we must get your written authorization to use or disclose your health information.** In the event that you are unable to provide the authorization (for example, if the Member is medically unable to give consent), we accept authorization from any person legally authorized to give consent on behalf of the Member, such as a parent or guardian. If you give us written authorization and change your mind you may revoke your written authorization at any time.

## What are your rights?

The following are your rights with respect to your PHI. If you would like to exercise any of these rights, please contact Vantage at the address or phone numbers listed at the end of this notice. We will require that you make your request in writing and will provide you with the appropriate forms.

***You have the right to inspect and/or obtain a copy or summary of information*** that Vantage maintains about you in your designated record set. A “designated record set” is a group of records maintained by or for Vantage that are your enrollment, payment, claims determination, and case or medical management records or a group of records, used in whole or in part, by Vantage to make decisions about you, such as Appeal and Grievance records. Provided the records are readily reproducible in an electronic format, we will make them available to you electronically. If not, we will work with you to provide the records in a mutually agreeable electronic format. If you prefer, a hard copy of the records will be provided. We may charge you a reasonable administrative fee for copying, postage or summary preparation depending on your specific request. If a fee is charged for records, it will not exceed our costs in responding to the request, in accordance with 45 CFR 164.524.

*However*, you do not have the right to inspect certain types of information and we cannot provide you with copies of the following information:

- contained in psychotherapy notes;
- compiled in reasonable anticipation of, or for use in a civil, criminal or administrative action or proceeding; or
- subject to certain federal laws governing biological products and clinical laboratories.

We will respond to your request no later than 30 days after we receive it. If we are unable to respond within 30 days, we may extend that time by no more than an additional 30 days. If we need this additional time, we will provide you with a written statement of the reasons for the delay and the date by which we will provide the information.

*Additionally*, in certain other situations, we may deny your request to inspect or obtain a copy of your information. If we deny your request, we will notify you in writing and may provide you with a right to have the denial reviewed.

***You have the right to ask us to amend information*** we maintain about you in your designated record set. We will require that your request be in writing and that you provide a reason for your request. We will respond to your request no later than 30 days after we receive it. If we are unable to act within 30 days, we may extend that time by no more than an additional 30 days. If we need to extend this time, we will notify you of the delay and the date by which we will complete action on your request.

If we make the amendment, we will notify you that it was made. In addition, we will provide the amendment to any person that we know has received your health information. We will also provide the amendment to other persons identified by you.

If we deny your request to amend, we will notify you in writing of the reason for the denial. The denial will explain your right to file a written statement of disagreement. We have a right to dispute your statement. However, you have the right to request that your written request, our written denial and your statement of disagreement be included with your information for any future disclosures.

**NOTE:** If you want to access or amend information about yourself, you should first go to your Provider (e.g., doctor, pharmacy, Hospital or other caregiver) that generated the original records, which are more complete than any we may maintain.

***You have the right to receive an accounting of certain disclosures*** of your information made by us during the six years prior to your request. Please note that we are not required to provide you with an accounting of the following information:

- Any information collected prior to April 14, 2003;
- Information disclosed or used for treatment, payment, and health care operations purposes;
- Information disclosed to you or pursuant to your authorization;
- Information that is incident to a use or disclosure otherwise permitted;
- Information disclosed for a facility's directory or to persons involved in your care or other notification purposes;
- Information disclosed for national security or intelligence purposes;

- Information disclosed to correctional institutions, law enforcement officials or health oversight agencies; or
- Information that was disclosed or used as part of a limited data set for research, public health, or health care operations purposes.

We will act on your request for an accounting within 30 days. We may need additional time to act on your request, and therefore may take up to an additional 30 days. If we need this additional time, we will notify you of the delay, the reason for the delay, and the date by which we will complete action on your request. Your first accounting will be free, and we will continue to provide to you one free accounting upon request every 12 months. However, if you request an additional accounting within 12 months of receiving your free accounting, we may charge you a fee. We will inform you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

***You have the right to ask us to restrict*** how we use or disclose your information for treatment, payment, or health care operations. You also have the right to ask us to restrict information that we have been asked to give to family Members or to others who are involved in your health care or payment for your health care.

***You have the right to ask to receive confidential communications*** of information, if you believe that you would be harmed if we send your information to your current mailing address. For example, in situations involving domestic disputes or violence, you can ask us to send the information by alternative means (for example by fax) or to an alternative address. We will try to accommodate a reasonable request made by you.

**What does Vantage Health Plan, Inc. do with Member PHI when the Member is no longer enrolled in a Vantage Plan?**

Vantage Health Plan, Inc. does not destroy PHI when individuals terminate their coverage. The information is necessary and used for many purposes as described in this document, even after the individual leaves a Plan. However, the policies and procedures that protect that information against inappropriate use and disclosure apply regardless of the status of any individual Member. In many cases, PHI is subject to legal retention requirements, and after that requirement for record maintenance, PHI is destroyed in a confidential process.

**Exercising your rights:**

- **You have a right to receive a copy of this notice upon request at any time.** We provide this notice to Members upon enrollment in a Vantage Plan. You can also view a copy of the notice on our website at [www.VantageHealthPlan.com](http://www.VantageHealthPlan.com). Should any of our privacy practices change, **we reserve the right to change the terms of this notice and to make the new notice effective for all protected health information that we maintain.** Once revised, we will provide the new notice to you and post it on our website.
- If you have any questions about this notice or about how we use or share information, please write to the Vantage Privacy Officer or contact the Vantage Member Services department at the address and phone numbers listed at the end of this notice.

If you are concerned that your privacy rights may have been violated, you may file a complaint with Vantage. You also have the right to complain to the Secretary of the U.S. Department of Health and Human Services. If you have any questions about the complaint process, including the address of the Secretary of Health and Human Services, please write to Vantage’s Privacy Officer or contact Vantage’s Member Service department at the address and phone numbers listed at the end of this notice.

**Vantage will not take any action against you for filing a complaint. This notice is effective April 14, 2003. Contact Information for Questions or Complaints Regarding Privacy:**

**Mailing Address**  
 Vantage Health Plan, Inc.  
 ATTENTION: Privacy Officer  
 130 DeSiard Street, Suite 300  
 Monroe, LA 71201  
 E-mail: [Privacy.Officer@vhpla.com](mailto:Privacy.Officer@vhpla.com)

**Questions**  
 Member Services Department  
 (855) 934-6847