



Vista Healthplan™, Inc.
Summary of Benefits
HMO Large Group
National Employees Health Plan

Copayment Maximums (Individual / Family)	\$1,500 / \$3,000
Lifetime Maximum Benefit	Unlimited
➤ Major Copayment Provisions	Member Responsibility
Primary Care Physician (PCP) office visits	\$15 copay
Specialist office visits	\$25 copay
Hospital admission	\$150/day for the first 5 days
Emergency room (waived if admitted)	\$100 copay
Prescription drugs:* 30-day supply at participating pharmacy includes contraceptives	Tier 1 - \$5; MO: 1 copay Tier 2 - \$20; MO: 2 copays Tier 3 - \$40; MO: 3 copays
Mail order (MO) 90-day supply	
➤ Inpatient Hospital / Physician Services	Member Responsibility
Inpatient hospital facility services (includes pre-admission testing, room and board, diagnostic tests, x-rays, operating & recovery room, intensive & special care units, general nursing care, anesthesia, prescribed drugs, radiation therapy & chemotherapy, surgeon services, anesthesiologist services, specialist consultation, physician visits, human organ transplants, maternity care)	\$150/day for the first 5 days
Rehabilitative Services Limitation: 30 days per calendar year	No additional copay
Inpatient Neonatal Intensive Care Unit (NICU) (admission and subsequent inpatient care)	\$150/day for the first 5 days
➤ Outpatient Medical Care	Member Responsibility
Preventive care, including physical exams, eye exams, health education and counseling and immunizations	No copay
Well-child care to age 16 including immunizations	No copay
Annual well-woman care, including pap smears	No copay
Routine mammography (based on established guidelines)	No copay
Diagnostic procedures, tests, chest x-rays, blood tests, urinalysis, EKG's performed: <ul style="list-style-type: none"> • in a physician's office • at a separate lab 	No additional copay No copay
Outpatient diagnostic services (MRI, CAT scans, etc) <ul style="list-style-type: none"> • at Hospital • at Freestanding Facility 	\$25 copay No copay
Outpatient Surgery (including physician and facility services) <ul style="list-style-type: none"> • at Hospital • at Ambulatory Surgical Center 	\$25 copay No copay
Maternity Prenatal / Postnatal Care <ul style="list-style-type: none"> • in a physician's office • in a Sub-Specialty office 	One time \$25 copay No copay
Radiation and chemotherapy <ul style="list-style-type: none"> • at Hospital • at Freestanding Facility 	\$25 copay No copay
Second medical and surgical opinion <ul style="list-style-type: none"> • Participating Provider • Non-Participating Provider 	No copay 40% of Allowed Amount
Non-Surgical Spine and Back services	See OV copay

➤ Mental Health, Alcohol & Substance Abuse	Member Responsibility
Mental health care	
• Inpatient Limitation: 30 days per calendar year	\$150/day for the first 5 days
• Outpatient Limitation: 20 visits per calendar year	\$25 copay
Alcohol and substance abuse care	
• Inpatient detoxification Limitation: 30 days per calendar year	\$150/day for the first 5 days
• Inpatient rehabilitation treatment Limitation: 30 days per calendar year	\$150/day for the first 5 days
• Outpatient rehabilitation treatment Limitation: 30 visits per calendar year	\$25 copay
➤ Special Kinds of Care	Member Responsibility
Emergency and urgent care	
• In hospital emergency room (waived if admitted)	\$100 copay
• In urgent care facility	\$25 copay
• In physician's office	See OV copay
• Ambulance service to hospital	No copay
Home Health Care Limitation: 60 visits per calendar year	No copay
Hospice Care Limitation: 210 days maximum lifetime benefit	No copay
Skilled Nursing Facility Care Limitation: 60 days per calendar year	No copay
Dialysis treatment (outpatient)	\$25 copay per treatment
Insulin	Applicable copay per prescription
Diabetic supplies (includes glucose monitors, test strips, lancets, etc.)	Applicable copay per month
Outpatient physical, speech, occupational and respiratory therapy Limitation: 60 visits per calendar year, combined for all therapies	\$25 copay
Outpatient cardiac therapy	
• at Hospital	\$25 copay
• at Freestanding Facility	No copay
Durable medical equipment; other external orthotics and prosthetics	No copay
Hearing Aids	Not covered
Family Planning	
• Voluntary counseling	\$25 copay
• Infertility diagnosis	\$25 copay
• Infertility treatment	Not covered
• Elective abortion (outpatient hospital or office)	Not covered
Elective sterilization	
• at Hospital	\$25 copay
• at Freestanding Facility	No copay
Vision care - at a participating Optometrist	
• Refractive eye exams	\$15 copay
• Eyeglasses	\$69 for contact lens eye exam & fitting
	Discounts available at participating provider

* If you or your physician requests a brand name medication when a generic is available, you must pay 100% of the difference in price between the generic and brand name medication, plus the applicable brand copayment. Prescription drug copays do not apply toward the annual copayment maximum.

Certain services require Prior Authorization. Please refer to the Certificate of Coverage for further details on Prior Authorization requirements.

Services must be rendered within the VISTA network. VISTA participating physicians and providers have contracted with VISTA to provide care to our members.

This summary is provided for information only; it does not contain complete details of the Plan which are available only in the Certificate of Coverage and Schedule of Benefits, and it does not constitute an Agreement.

This plan has exclusions and limitations and terms under which the plan may be continued in force or discontinued. For cost and complete details of coverage, contact your agent.