



Vista Healthplan™, Inc.
Summary of Benefits
HMO Large Group
Focused Deductible Plan – FD1520B Option 7 (\$15/\$35/\$50/20%)

Copayment Maximums (Individual / Family)	\$1,500 / \$4,500
Lifetime Maximum Benefit	Unlimited
Annual Hospital Deductible (per calendar year): applies to all inpatient and outpatient services at hospital	\$500
Annual Pharmacy Deductible (per calendar year)	\$0
Annual Pharmacy Benefit Maximum (per calendar year)	Unlimited
Major Copayment Provisions	Member Copay
Primary Care Physician (PCP) office visits	\$15 copay
Specialist office visits	\$30 copay
Hospital admission	After Hospital Deductible: \$200/day for the first 5 days
Emergency room (waived if admitted)	\$100 copay
Prescription drugs: *30-day supply at participating pharmacy (includes contraceptives); \$250 per month out-of-pocket limit on Tier 4 (except for diabetic supplies). Mail Order available for formulary drugs only (mail order – 3 copays for a 90-day supply)	After Pharmacy Deductible: Tier 1 - \$15 Tier 2 - \$35 Tier 3 - \$50 Tier 4 – 20%
Inpatient Hospital / Physician Services	Member Copay
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)	After Hospital Deductible: \$200/day for the first 1-5 days
Rehabilitative Services Limitation: 30 days per calendar year	After Hospital Deductible: No additional copay
Outpatient Medical Services	Member Copay
Wellness care: preventive care, including physical exams, eye exams, health education and counseling and immunizations	See office visit copay
Well-child care to age 16 including immunizations	See office visit copay
Annual well-woman care, including pap smears	See office visit copay
Routine mammography (based on established guidelines)	No copay
Diagnostic procedures, tests, chest x-rays, blood tests, urinalysis, EKG's performed: • in a physician's office • at a separate facility	No additional copay No copay
Outpatient diagnostic services (MRI, CAT scans, etc) • at Hospital • at Freestanding Facility	After Hospital Deductible: \$60 copay \$30 copay
Outpatient Surgery (including physician and facility services) • at Hospital • at Ambulatory Surgical Center	After Hospital Deductible: \$200 copay \$100 copay
Prenatal & postnatal care in physician's office	One time \$30 copay
Radiation and chemotherapy • at Hospital • at Ambulatory Surgical Center	After Hospital Deductible: \$30 copay \$30 copay
Second medical and surgical opinion • Participating Provider • Non-Participating Provider	See office visit copay 40% of Allowed Amount
Non-Surgical Spine and Back services Limitation: 20 visits per calendar year	See office visit copay

Mental Health, Alcohol & Substance Abuse Services	Member Copay
Mental health care <ul style="list-style-type: none"> Inpatient Limitation: 30 days per calendar year Outpatient Limitation: 30 visits per calendar year 	After Hospital Deductible: \$200/day for the first 5 days
	\$30 copay
Alcohol and substance abuse care <ul style="list-style-type: none"> Inpatient detoxification Limitation: 5 days per calendar year Inpatient rehabilitation treatment Limitation: 30 days per calendar year Outpatient rehabilitation treatment Limitation: 30 visits per calendar year 	After Hospital Deductible: \$100 copay per day
	After Hospital Deductible: \$200/day for the first 5 days
	\$30 copay
Special Kinds of Care	Member Copay
Emergency and urgent care <ul style="list-style-type: none"> In hospital emergency room (waived if admitted) In urgent care facility In physician's office Ambulance service to hospital 	\$100 copay
	\$30 copay
	See office visit copay
	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: 30 days per calendar year	\$25/day for the first 5 days of each admission
Dialysis treatment (outpatient) <ul style="list-style-type: none"> at Hospital at Freestanding Facility 	After Hospital Deductible: \$30 copay per treatment
	\$30 copay per treatment
Insulin Diabetic supplies (includes glucose monitors, test strips, lancets, etc.)	After Pharmacy Deductible: Applicable copay per prescription Applicable copay per month
Outpatient physical, speech and occupational therapy Limitation: 60 visits per calendar year, combined for all therapies <ul style="list-style-type: none"> at Hospital at Freestanding Facility 	After Hospital Deductible: \$30 copay
	\$30 copay
Outpatient cardiac and respiratory therapy <ul style="list-style-type: none"> at Hospital at Freestanding Facility 	After Hospital Deductible: \$30 copay
	\$30 copay
Durable medical equipment; other external orthotics and prosthetics	No copay
Hearing Aids	Not covered
Family Planning <ul style="list-style-type: none"> Voluntary counseling Infertility diagnosis Infertility treatment Elective abortion (outpatient hospital or office) Elective sterilization <ul style="list-style-type: none"> at Hospital at Freestanding Facility 	
	\$30 copay
	\$30 copay
	Not covered
	Not covered
Dental care <ul style="list-style-type: none"> Preventive dental care General dental care 	Cleaning, fluoride treatment & bitewing x-rays every 6 months, \$5 per service, maximum \$10 copay per visit
	Discounted fee schedule
Vision care - at a participating Optometrist <ul style="list-style-type: none"> Refractive eye exams Eyeglasses 	\$15 copay
	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 Covered 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.**