



Vista Healthplan™, Inc.
Summary of Benefits
HMO Large Group

Focused Deductible Coinsurance Plan – FDC2020 Option 7 (\$10/\$35/\$50/20%)

Out-of-Pocket Maximums (Individual / Family)	\$2,000 / \$4,000
Lifetime Maximum Benefit	Unlimited
Annual Hospital Deductible (per calendar year): applies to all inpatient and outpatient services at hospital	\$500
Hospital Coinsurance: applies to all inpatient and outpatient services at hospital	20%
Major Copayment Provisions	Member Pays
Primary Care Physician (PCP) office visits	\$20 copay
Specialist office visits	\$40 copay
Hospital admission	After Hospital Deductible: 20% Coinsurance
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 - \$10 Tier 2 - \$35 Tier 3 - \$50 Tier 4 – 20%
Inpatient Hospital / Physician Services	Member Pays
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: 20% Coinsurance
Rehabilitative Services Limitation: 30 days per calendar year	After Hospital Deductible: 20% Coinsurance
Outpatient Medical Services	Member Pays
Wellness care: preventive care, including physical exams, eye exams, health education and counseling and immunizations	Same as office visit copay
Well-child care to age 16 including immunizations	No copay
Annual well-woman care, including pap smears	Same as office visit copay
Routine mammography (based on established guidelines)	No copay
Outpatient diagnostic services <ul style="list-style-type: none"> at a Hospital at an Ambulatory Surgical Center at an Outpatient Diagnostic Center in a Physician's Office 	After Hospital Deductible: 20% Coinsurance \$125 copay \$40 copay No additional copay
Outpatient surgery (including physician and facility services) <ul style="list-style-type: none"> at a Hospital at an Ambulatory Surgical Center at an Outpatient Diagnostic Center in a Physician's Office 	After Hospital Deductible: 20% Coinsurance \$125 copay \$40 copay No additional copay
Outpatient endoscopic procedures (colonoscopy, endoscopy, sigmoidoscopy) <ul style="list-style-type: none"> at a Hospital at an Ambulatory Surgical Center at an Outpatient Diagnostic Center in a Physician's Office 	After Hospital Deductible: 20% Coinsurance \$125 copay \$125 copay No additional copay
Prenatal / postnatal care in physician's office	One time \$40 copay
Outpatient physical, speech and occupational therapy Limitation: 60 visits per calendar year, combined for all therapies <ul style="list-style-type: none"> at a Hospital at a Freestanding Facility 	After Hospital Deductible: 20% Coinsurance \$40 copay
Outpatient cardiac and respiratory therapy <ul style="list-style-type: none"> at a Hospital at a Freestanding Facility 	After Hospital Deductible: 20% Coinsurance \$40 copay
Radiation and chemotherapy <ul style="list-style-type: none"> at a Hospital at a Freestanding Facility 	After Hospital Deductible: 20% Coinsurance \$40 copay

Second medical and surgical opinion • Participating Provider • Non-Participating Provider	Same as office visit copay 40% of Allowed Amount
Non-Surgical Spine and Back services Limitation: 20 visits per calendar year	Same as office visit copay
Mental Health, Alcohol & Substance Abuse Services	Member Pays
Mental health care • Inpatient Treatment Limitation: 30 days per calendar year • Outpatient Treatment Limitation: 30 visits per calendar year	After Hospital Deductible: 20% Coinsurance \$40 copay
Alcohol and substance abuse care • 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: 20% Coinsurance After Hospital Deductible: 20% Coinsurance \$40 copay
Special Kinds of Care	Member Pays
Emergency and urgent care • in hospital emergency room (waived if admitted) • in urgent care facility • in physician's office • Ambulance service to hospital	\$100 copay \$40 copay Same as 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	\$50/day for the first 5 days per admission
Dialysis treatment (outpatient) • at a Hospital • at a Freestanding Facility	After Hospital Deductible: 20% Coinsurance \$40 copay per treatment
Insulin Diabetic supplies (includes glucose monitors, test strips, lancets, etc.)	\$35 copay per prescription \$35 copay per month
Durable medical equipment; external orthotics and prosthetics	No copay
Hearing Aids	Not covered
Family Planning • Voluntary counseling • Infertility diagnosis • Infertility treatment • Elective abortion Elective sterilization • at a Hospital • at a Freestanding Facility	\$40 copay \$40 copay Not covered Not covered After Hospital Deductible: 20% Coinsurance \$250 copay
Dental care • 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 • 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. Out-of-Pocket Maximums include copayment and coinsurance amounts. Deductibles do not apply to Out-of-Pocket Maximums.

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 VISTA or your agent.