
 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, 1-866-607-0117 or visit us at <https://www.vista360health.com/wp-content/uploads/SBC-IND-Traditional-silver-plan-2018.pdf>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/healthreform> or call 1-866-607-0117 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$4,000/Individual or \$8,000/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care and primary care services are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	For participating providers \$7,350 individual / \$14,700 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.vista360health.com or call 1-866-607-0117 for a list of participating providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	Yes, for certain specialists .	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see certain specialists .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$40 copay per visit	Not covered	None
	Specialist visit	\$65 copay per visit	Not covered	None
	Preventive care/screening/immunization	No charge	Not covered	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance after deductible	Not covered	Pre-Authorization is required for some imaging services. If proper pre-authorization is not obtained, services will not be covered.
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.vista360health.com	Preferred generic drugs	No charge for 90-day supply (retail or mail order).	Not covered	Pre-Authorization is required for some specialty drugs. If proper pre-authorization is not obtained, services will not be covered.
	Non-preferred generic drugs	\$30 copay . Covers up to a 90-day supply (retail or mail order) with 3 month copay for 90 day supply at retail or 2 month copay for 90 day supply by mail-order.	Not covered	
	Preferred brand drugs	\$40 copay . Covers up to a 90-day supply (retail or mail order) with 3 month copay for 90 day supply at retail or 2 month copay for 90 day supply by mail-order.	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Non-preferred brand drugs	\$70 copay Covers up to a 90-day supply (retail or mail order) with 3 month copay for 90 day supply at retail or 2 month copay for 90 day supply by mail-order.	Not covered	Pre-Authorization is required for some specialty drugs. If proper pre-authorization is not obtained, services will not be covered.
	Specialty drugs	60% coinsurance after deductible . Covers up to a 30-day supply (retail or mail order)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	Not covered	Pre-Authorization is required for some outpatient surgical procedures. If proper pre-authorization is not obtained, services will not be covered.
	Physician/surgeon fees	30% coinsurance after deductible	Not covered	Pre-Authorization is required for some outpatient surgical procedures. If proper pre-authorization is not obtained, services will not be covered.
If you need immediate medical attention	Emergency room care	\$750 copay per visit	\$750 copay per visit	If services are obtained inside the service area from an out-of-network provider , the member may be billed for the balance between billed charges and Non-Participating Provider Reimbursement (NPPR) if payment is made at NPPR.
	Emergency medical transportation	30% coinsurance after deductible	30% coinsurance after deductible	
	Urgent care	\$100 copay per visit	\$100 copay per visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible	Not covered	Pre-Authorization is required for some hospital stays. If proper pre-authorization is not obtained, services will not be covered.
	Physician/surgeon fees	30% coinsurance after deductible	Not covered	Pre-Authorization is required for some hospital stays. If proper pre-authorization is not obtained, services will not be covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 copay per visit	Not covered	Pre-Authorization is required for some mental health, behavioral health, or substance abuse services. If proper pre-authorization is not obtained, services will not be covered.
	Inpatient services	30% coinsurance after deductible	Not covered	
If you are pregnant	Office visits	\$40 copay for initial visit	Not covered	Cost sharing does not apply to certain preventive services . Depending on the type of services, copayment , coinsurance , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% coinsurance after deductible	Not covered	
	Childbirth/delivery facility services	30% coinsurance after deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	30% coinsurance after deductible	Not covered	60 visits per year. Pre-Authorization may be required. If proper pre-authorization is not obtained, services will not be covered.
	Rehabilitation services	\$65 copay per visit	Not covered	Pre-Authorization may be required. If proper pre-authorization is not obtained, services will not be covered.
	Habilitation services	\$65 copay per visit	Not covered	Pre-Authorization may be required. If proper pre-authorization is not obtained, services will not be covered.
	Skilled nursing care	30% coinsurance after deductible	Not covered	25 days per year. Pre-Authorization may be required. If proper pre-authorization is not obtained, services will not be covered.
	Durable medical equipment	30% coinsurance after deductible	Not covered	Pre-Authorization may be required. If proper pre-authorization is not obtained, services will not be covered.
	Hospice services	30% coinsurance after deductible	Not covered	Pre-Authorization may be required. If proper pre-authorization is not obtained, services will not be covered.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Coverage limited to one exam per year.
	Children's glasses	No charge	Not covered	Coverage limited to one pair of glasses per year. Limited to \$250.00 allowance on frames per year.
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- | | | |
|-----------------------|--|-------------------------|
| • Acupuncture | • Infertility treatment | • Pediatric dental care |
| • Bariatric surgery | • Long-term care | • Private-duty nursing |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Routine foot care |
| • Dental care (Adult) | | • Weight loss programs |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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| • Chiropractic care | • Hearing aids | • Routine eye care (Adult) |
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Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the [plan](#) at 1-888-459-3366. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For questions about your rights, this notice, or assistance, you can contact the insurer at 1-888-459-3366; the Texas Department of Insurance at 1-800-252-3439; or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-607-0117.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$4,000
- [Specialist copayment](#) \$65
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$4,000
Copayments	\$120
Coinsurance	\$1,040
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,220

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$4,000
- [Specialist copayment](#) \$65
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$140
Copayments	\$2,020
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,220

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$4,000
- [Specialist copayment](#) \$65
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,420
Copayments	\$330
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,750