




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-Choice-bronze-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 <a href="#">deductible</a> ?	\$6,650/Individual or \$13,300/family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">participating providers</a> \$6,650 individual / \$13,300 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.vista360health.com">www.vista360health.com</a> or call 1-866-607-0117 for a list of <a href="#">participating providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes, for certain <a href="#">specialists</a> .	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see certain <a href="#">specialists</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	None
	<a href="#">Specialist</a> visit	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	<a href="#">Pre-Authorization</a> is required for some imaging services. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered.
	Imaging (CT/PET scans, MRIs)	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.vista360health.com">www.vista360health.com</a>	Preferred generic drugs	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> . Covers up to a 90-day supply (retail or mail order)	Not covered	<a href="#">Pre-Authorization</a> is required for some <a href="#">specialty</a> drugs. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered.
	Non-preferred generic drugs	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> . Covers up to a 90-day supply (retail or mail order)	Not covered	
	Preferred brand drugs	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> . Covers up to a 90-day supply (retail or mail order) supply by mail-order.	Not covered	
	Non-preferred brand drugs	0% <a href="#">coinsurance</a> after <a href="#">deductible</a> . Covers up to a 90-day supply (retail or mail order)	Not covered	
	<a href="#">Specialty</a> drugs	0% <a href="#">coinsurance</a> after	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)	
		<a href="#">deductible</a> . Covers up to a 30-day supply (retail or mail order)		<a href="#">Pre-Authorization</a> is required for some <a href="#">specialty</a> drugs. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	<a href="#">Pre-Authorization</a> is required for some outpatient surgical procedures. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered.
	Physician/surgeon fees	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	<a href="#">Pre-Authorization</a> is required for some outpatient surgical procedures. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered.
If you need immediate medical attention	<a href="#">Emergency room care</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	If services are obtained inside the service area from an <a href="#">out-of-network provider</a> , the member may be billed for the balance between billed charges and Non-Participating Provider Reimbursement (NPPR) if payment is made at NPPR.
	<a href="#">Emergency medical transportation</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
	<a href="#">Urgent care</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	<a href="#">Pre-Authorization</a> is required for some hospital stays. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered.
	Physician/surgeon fees	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	<a href="#">Pre-Authorization</a> is required for some hospital stays. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	<a href="#">Pre-Authorization</a> is required for some mental health, behavioral health, or substance abuse services. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered.
	Inpatient services	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	
If you are pregnant	Office visits	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	
	Childbirth/delivery facility services	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	60 visits per year. <a href="#">Pre-Authorization</a> may be required. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered.
	<a href="#">Rehabilitation services</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	<a href="#">Pre-Authorization</a> may be required. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered.
	<a href="#">Habilitation services</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	<a href="#">Pre-Authorization</a> may be required. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered.
	<a href="#">Skilled nursing care</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	25 days per year. <a href="#">Pre-Authorization</a> may be required. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered.
	<a href="#">Durable medical equipment</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	<a href="#">Pre-Authorization</a> may be required. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered.
	<a href="#">Hospice services</a>	0% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	<a href="#">Pre-Authorization</a> may be required. If proper <a href="#">pre-authorization</a> 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.)

- |                     |                |                            |
|---------------------|----------------|----------------------------|
| • 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](http://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](http://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](http://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](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,650
■ <a href="#">Specialist copayment</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%

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:

Cost Sharing	
Deductibles	\$6,650
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$6,710

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,650
■ <a href="#">Specialist copayment</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%

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:

Cost Sharing	
Deductibles	\$6,650
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$6,710

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,650
■ <a href="#">Specialist copayment</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%

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:

Cost Sharing	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900