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-0Ded-gold-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?	There is no deductible on this plan.	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. Maximum out of pocket of copayments will not exceed the lesser of the above stated out of pocket or 200% of your annual premium	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	$30 copay per visit	Not covered	None
	Specialist visit	$60 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)	25% coinsurance	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)	25% coinsurance	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	$10 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	$55 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)	
				Pre-Authorization is required for some specialty drugs. If proper pre-authorization is not obtained, services will not be covered.
	Non-preferred brand drugs	50% coinsurance Covers up to a 90-day supply (retail or mail order)	Not covered	
	Specialty drugs	50% coinsurance. 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)	25% coinsurance	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	25% coinsurance	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	25% coinsurance	25% coinsurance	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	$500 copay per use	25% coinsurance	
	Urgent care	$75 copay per visit		
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per day	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	25% coinsurance	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	$30 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	$500 copay per day	Not covered	
If you are pregnant	Office visits	$30 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	25% coinsurance	Not covered	
	Childbirth/delivery facility services	$500 copay per day	Not covered	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	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	$60 copay per visit	Not covered	Pre-Authorization may be required. If proper pre-authorization is not obtained, services will not be covered.
	Habilitation services	$60 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	$500 copay per day	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	25% coinsurance	Not covered	Pre-Authorization may be required. If proper pre-authorization is not obtained, services will not be covered.
	Hospice services	25% coinsurance	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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Pediatric dental care
- Private-duty nursing
- Routine foot care
- 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)

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 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	$0
Specialist copayment	$60
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$560
Coinsurance	$870
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,490

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

The plan's overall deductible	$0
Specialist copayment	$60
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,500
Coinsurance	$30
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,590

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

The plan's overall deductible	$0
Specialist copayment	$60
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$220
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,020

The plan would be responsible for the other costs of these EXAMPLE covered services.