

# Individual Solutions

Plan Name	Coinsurance Plans			
Benefits	C15-500	C15-1000	C20-2500	C30-5000
Primary Care Office Visit	\$15	\$15	\$20	\$30
Specialist Office Visit	\$30	\$30	\$40	\$50
Urgent Care	\$30	\$30	\$40	\$50
Emergency Room	\$100	\$100	\$100	\$100
Inpatient Hospital	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Outpatient Diagnostic Services (at a Hospital)	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Outpatient Diagnostic Services (at a Freestanding Facility)	\$30	\$30	\$40	\$50
Outpatient Surgery (at a Hospital)	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Outpatient Surgery (at an Ambulatory Surgical Center)	\$100	\$100	\$100	\$250
Preventive Dental & Vision	Included	Included	Included	Included
Deductible (hospital only)	\$500	\$1,000	\$2,500	\$5,000
Out-of-Pocket Maximum	\$1,500	\$1,500	\$2,000	\$5,000
Prescription Drug				
Tier One	\$10	\$10	\$20	\$30
Tier Two	\$20	\$20	\$35	\$45
Tier Three	\$40	\$40	\$50	\$60
Tier Four	20%	20%	20%	20%
Deductible	\$250	\$250	\$250	\$250
Maximum Benefit	\$1,200	\$1,200	\$1,200	\$1,200

Plans available as Open Access, no referrals needed.

Copays and coinsurance amounts apply to the out-of-pocket maximum for all benefits except pharmacy. Deductible does not apply towards Out-of-Pocket Maximum. Coinsurance is after the applicable deductible.

Optional maternity Rider available for all benefit plan options.

This is a brief summary description of benefits. Refer to plan documents for a complete list of covered services and limitations or exclusions.

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