VISTA Healthplans™

VISTA HEALTHPLAN OF SOUTH FLORIDA, INC.

Individual Health Benefits

Mark selected plan	□ **Focused Deductible IFD10 - 5000**	□ **Focused Deductible IFD30B - 5000**
HOSPITAL DEDUCTIBLE (applies to all inpatient & outpatient hospital services per contract year)	$5,000	$5,000
PHARMACY DEDUCTIBLE (per contract year)	$250	$250
PHYSICIAN SERVICES		
Primary Care Physician	$10 per visit	$30 per visit
- Primary Care Office Visits/Radiology, Lab, EKG's,	$10 per visit	$30 per visit
- Adult Wellness Visits/Exams - Health Education	$10 per visit	$30 per visit
Specialty Physician		
- Office Consultation/Visits/Services by a Specialist	$25 per visit	$50 per visit
- Allergy Testing Services	$25 per visit	$50 per visit
- Chiropractic Visits (20 self referrals per contract year)	$25 per visit	$50 per visit
- Podiatric Visits (12 self referrals per contract year)	$25 per visit	$50 per visit
- Dermatological Visits (5 self referrals per contract year - for office visits and minor surgical procedures)	$25 per visit	$50 per visit
Urgent Care Center Visit (Plan Centers)	$25 per visit	$50 per visit
Professional Facility – Related Services		
- Inpatient Consultation by a Specialist	After Hospital Deduct, No Charge for Physician's Services	After Hospital Deduct, No Charge for Physician's Services
- Inpatient Visit – Primary Care or Specialist		
- Inpatient Newborn Care – Primary Care or Specialist		
Injections		
- Immunizations – Primary Care or Specialist	$10 PCP/$25 Specialist per visit	$30 PCP/$50 Specialist per visit
- Therapeutic – Primary Care or Specialist	No Charge	No Charge
- Allergy/Immunotherapy – Primary Care or Specialist	$10 PCP/$25 Specialist per visit	$30 PCP/$50 Specialist per visit
Other Hospital Physician Services (Anesthesia Services, Inpatient Specialist Visits)	After Hospital Deduct, No Charge	After Hospital Deduct, No Charge
FAMILY PLANNING SERVICES		
- Voluntary Family Planning Counseling	Not Covered	Not Covered
- Infertility Diagnosis/Treatment	Not Covered	Not Covered
- Elective Sterilization	$250 Copay	$250 Copay
- at a Hospital	After Hospital Deduct, $250 Copay	After Hospital Deduct, $250 Copay
MATERNITY SERVICES (OPTIONAL RIDER)	**Optional Rider**	**Optional Rider**
(15 month Waiting Period on all Maternity Services)		
- Obstetrics; Pre-Natal	$25 Copay; One time	$50 Copay; One time
- Obstetrical; Hospital/Birthing Center	After Hospital Deduct, $1,000 Copay	After Hospital Deduct, $1,000 Copay
HOSPITAL SERVICES (PLAN HOSPITALS)		
- Inpatient Room and Board/Ancillary services to include: Medical, Surgery, Rehabilitation	After Hospital Deduct, $100 per day/$500 max. per admit (Unlimited days)	After Hospital Deduct, $500 per day/$2,500 max. per admit (Unlimited days)
- Diagnostic Services at a Hospital	After Hospital Deduct, $50 per visit	After Hospital Deduct, $100 per visit
- Diagnostic Services at a Freestanding Facility	$25 per visit	$50 per visit
- Outpatient Surgery at a Hospital	After Hospital Deduct, $100 Copay	After Hospital Deduct, $500 Copay
- Outpatient Surgery at an Ambulatory Surgery Center	$50 Copay	$250 Copay
Emergency Room and Related Services (Waived if Admitted)	$100 Copay	$100 Copay

Mark selected plan	□ **Focused Deductible IFD10 - 5000**	□ **Focused Deductible IFD30B - 5000**
SKILLED NURSING FACILITY – INPATIENT (PLAN SNF'S) (30 days per contract year)	$50 per day/$250 max. per admit	$250 per day/$1,250 max. per admit
HOSPICE FACILITIES (PLAN FACILITIES) - Inpatient Hospice Services - Outpatient Hospice Services - Home Hospice Services (210 days lifetime)	 No Charge No Charge No Charge	 No Charge No Charge No Charge
REHABILITATION SERVICES – OUTPATIENT - Outpatient Physical, Speech and Occupational Therapy (60 Visits per contract year combined for all therapies) - at a Hospital	 $25 per visit After Hospital Deduct, $25 per visit	 $50 per visit After Hospital Deduct, $50 per visit
OTHER MEDICAL SERVICES - Ambulance Services - Durable Medical Equipment - Home Health Services (60 visits per contract year) - Orthotics & Prosthetics	 $25 per trip No Charge No Charge No Charge	 $50 per trip No Charge No Charge No Charge
MENTAL HEALTH SERVICES - Inpatient Mental Health Services - Outpatient Mental Health Services	 Not Covered Not Covered	 Not Covered Not Covered
SUBSTANCE ABUSE SERVICES - Detoxification only (Up to 5 days per admission up to 2 admissions per contract year)	After Hospital Deduct, $100 per day per admission	After Hospital Deduct, $500 per day per admission
PRESCRIPTION DRUGS (includes contraceptives) (as outlined in Vista Healthplan of South Florida Formulary) **Pharmacy Deductible (applies to all prescription drugs)** - Generic Prescription Drugs/30 day supply - Brand Name Prescription Drugs/30 day supply (if generic not available) - Brand Name Prescription Drugs/30 day supply (if generic is available) - Prescription Drug Limit - Non-formulary Drugs (Note: Copays are per Prescription and per Refill)	 **$250** $10 Copay $20 Copay $20 plus difference in cost $1,200 max./cont. yr. $40 Copay 20% self injectables up to $250	 **$250** $30 Copay $45 Copay $45 plus difference in cost $1,200 max./cont. yr. $60 Copay 20% self injectables up to $250
INSULIN AND DIABETIC SUPPLIES Insulin and diabetic supplies count towards the prescription drug benefit limit each contract year. This benefit will continue to be covered at applicable copay levels after the $1,200 prescription drug benefit limit is reached. - insulin - diabetic supplies (test strips & lancets)	After Pharmacy Deduct, 1 formulary brand copay per prescription 1 formulary brand copay per month	After Pharmacy Deduct, 1 formulary brand copay per prescription 1 formulary brand copay per month
DENTAL SERVICES	Covered	Covered
VISION SERVICES	Covered	Covered
PRE-EXISTING WAITING PERIOD	24 months	24 months
MAXIMUM LIFETIME BENEFITS	Unlimited	Unlimited
COPAYMENT MAXIMUM (per contract year)	$1,500.00	$5,000.00