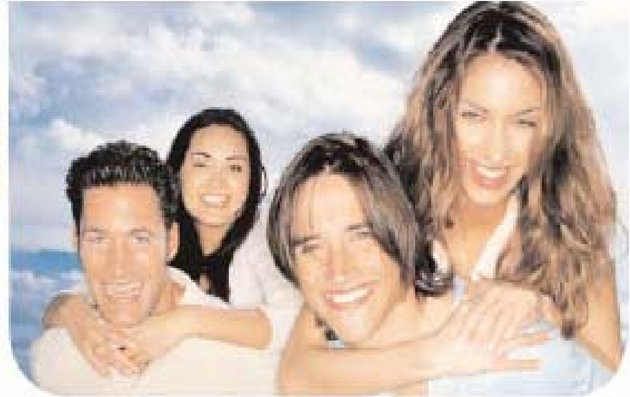

Individual Sales Guide

Individual Coinsurance Plans

VISTA Healthplans

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Extra Value in VISTA's products.

Coinsurance Plan Comparison

Coinsurance Focused Deductible
New Plans for Individuals

Highlights:

- Traditional HMO Benefits
- Only Hospital Services are subject to Hospital Deductible and Coinsurance
- Plans available as HMO (PCP referral required) or Open Access (self-referral)

Benefits	C15	C20	C30
PCP	$15	$20	$30
Specialist	$30	$40	$50
Hospital Deductible		$500	
		$1,000	
		$2,500	
		$5,000	
Inpatient/Outpatient Hospital Services		After Hospital Deductible, 20% Coinsurance	
Outpatient Freestanding Facility Services		Applicable Copays Only	
Urgent Care	$30	$40	$50
Emergency Room		$100	
Out-of-Pocket Max	$1,500	$2,000	$5,000
Prescription Benefits	$10/$20/$40/20%	$20/$35/$50/20%	$30/$45/$60/20%

For more information on these great savings plans or other Individual health benefit plans being offered, please contact your VISTA sales representative.

These plans have exclusions and limitations and terms under which the plans may be continued in force or discontinued. For cost and complete details of coverage, contact your VISTA sales representative.

VISTA HEALTHPLAN OF SOUTH FLORIDA, INC.

Individual Health Benefits

	COINSURANCE FOCUSED DEDUCTIBLE		
	C15 – 500	**C20 – 500**	**C30 – 500**
PHYSICIAN SERVICES			
Primary Care Physician Office Visits Specialist Office Visits *Office visit includes routine lab tests, diagnostic procedures and radiology, annual physical exams, well-child visits, well woman visits, hearing and vision screening, outpatient surgery, health education and counseling, and immunizations.*	$15 Copay $30 Copay	$20 Copay $40 Copay	$30 Copay $50 Copay
Non-surgical Spine and Back Visits (20 visits per contract year)	$30 Copay	$40 Copay	$50 Copay
Podiatry Visits (12 self-referrals per contract year)	$30 Copay	$40 Copay	$50 Copay
Dermatology Visits (5 self-referrals per contract year)	$30 Copay	$40 Copay	$50 Copay
INPATIENT HOSPITAL SERVICES – SUBJECT TO HOSPITAL DEDUCTIBLE			
Inpatient Hospital Facility and Physician Services *Facility and physician services include semi-private room and board, general nursing services, use of intensive care and specialty care units, x-rays, diagnostics/labs, operating and recovery rooms, prescription medications dispensed while confined, surgeon and assistant surgeon, anesthesiologist, specialist consultation and other physician visits while confined.*	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**
Inpatient Rehabilitation Services (30 days per contract year)	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**
OUTPATIENT SERVICES			
Outpatient Diagnostic Services at an Outpatient Diagnostic Center	$30 Copay	$40 Copay	$50 Copay
Outpatient Diagnostic Services at a Hospital	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**
Outpatient Surgery at an Ambulatory Surgical Center	$100 Copay	$100 Copay	$250 Copay
Outpatient Surgery at a Hospital	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**
Outpatient Physical, Speech and Occupational Therapy at a Freestanding Facility (60 visits per contract year, combined for all therapy types)	$30 Copay	$40 Copay	$50 Copay
Outpatient Physical, Speech and Occupational Therapy at a Hospital (60 visits per contract year, combined for all therapy types)	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**
EMERGENCY AND URGENT CARE SERVICES			
Hospital Emergency Room Visit (Waived if Admitted) Urgent Care Facility Visit Ambulance	$100 Copay $25 Copay $25 Copay	$100 Copay $40 Copay $40 Copay	$100 Copay $50 Copay $50 Copay
SKILLED NURSING, HOME HEALTH AND HOSPICE			
Skilled Nursing Care (30 days per contract year) Home Health Care (60 visits per contract year) Hospice Care (210 days lifetime)	$50 per days 1-5 No Copay No Copay	$100 per days 1-5 No Copay No Copay	$250 per days 1-5 No Copay No Copay

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	C15 – 500	C20 – 500	C30 – 500
OTHER MEDICAL SERVICES			
Durable Medical Equipment Orthotics and Prosthetics	No Copay No Copay	No Copay No Copay	No Copay No Copay
MENTAL HEALTH SERVICES			
Inpatient/Outpatient Mental Health Services	Not Covered	Not Covered	Not Covered
ALCOHOL AND SUBSTANCE ABUSE SERVICES			
Inpatient Detoxification (5 days per admission; 2 admissions per contract year)	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**
PRESCRIPTION DRUGS			
30 Day Supply at Participating Pharmacy **Pharmacy Deductible (applies to all prescription drugs)**	**$250**	**$250**	**$250**
Formulary Generic Prescription Drugs Formulary Brand Name Prescription Drugs Non-formulary Prescription Drugs Self-Injectables ($250 monthly out-of-pocket maximum)	**$10 Copay** **$20 Copay** **$40 Copay** **20%**	**$20 Copay** **$35 Copay** **$50 Copay** **20%**	**$30 Copay** **$45 Copay** **$60 Copay** **20%**
Pharmacy Maximum Benefit (per contract year)	$1,200	$1,200	$1,200
Insulin	**After Pharmacy Deductible, One Brand Copay per Prescription**	**After Pharmacy Deductible, One Brand Copay per Prescription**	**After Pharmacy Deductible, One Brand Copay per Prescription**
Diabetic supplies (test strips & lancets)	**After Pharmacy Deductible, One Brand Copay per Month**	**After Pharmacy Deductible, One Brand Copay per Month**	**After Pharmacy Deductible, One Brand Copay per Month**
MATERNITY SERVICES - OPTIONAL RIDER			
15 month Waiting Period on all Maternity Services Prenatal and Postnatal Care	One-time $30 Copay	One-time $40 Copay	One-time $50 Copay
Hospital/Birthing Center Maternity Care	$1000 Copay	$1000 Copay	$1000 Copay
DENTAL AND VISION CARE SERVICES			
PREVENTIVE DENTAL SERVICES	Included	Included	Included
VISION CARE SERVICES	Included	Included	Included
OUT-OF-POCKET MAXIMUMS			
HOSPITAL DEDUCTIBLE (per contract year) *Applies to inpatient/outpatient hospital services.*	**$500**	**$500**	**$500**
OUT-OF-POCKET MAXIMUM (per contract year) *Does not include hospital deductible or prescription drug copayments.*	$1,500	$2,000	$5,000
TOTAL OUT-OF-POCKET MAXIMUM (per contract year) *Includes deductible, coinsurance and copayments; excludes pharmacy deductible and prescription drugs copayments.*	$2,000	$2,500	$5,500
MAXIMUM LIFETIME BENEFIT	Unlimited	Unlimited	Unlimited
PRE-EXISTING WAITING PERIOD	24 months	24 months	24 months

VISTA HEALTHPLAN OF SOUTH FLORIDA, INC.

Individual Health Benefits

	COINSURANCE FOCUSED DEDUCTIBLE		
	C15 – 1000	**C20 – 1000**	**C30 – 1000**
PHYSICIAN SERVICES			
Primary Care Physician Office Visits Specialist Office Visits *Office visit includes routine lab tests, diagnostic procedures and radiology, annual physical exams, well-child visits, well woman visits, hearing and vision screening, outpatient surgery, health education and counseling, and immunizations.*	$15 Copay $30 Copay	$20 Copay $40 Copay	$30 Copay $50 Copay
Non-surgical Spine and Back Visits (20 visits per contract year)	$30 Copay	$40 Copay	$50 Copay
Podiatry Visits (12 self-referrals per contract year)	$30 Copay	$40 Copay	$50 Copay
Dermatology Visits (5 self-referrals per contract year)	$30 Copay	$40 Copay	$50 Copay
INPATIENT HOSPITAL SERVICES – SUBJECT TO HOSPITAL DEDUCTIBLE			
Inpatient Hospital Facility and Physician Services *Facility and physician services include semi-private room and board, general nursing services, use of intensive care and specialty care units, x-rays, diagnostics/labs, operating and recovery rooms, prescription medications dispensed while confined, surgeon and assistant surgeon, anesthesiologist, specialist consultation and other physician visits while confined.*	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**
Inpatient Rehabilitation Services (30 days per contract year)	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**
OUTPATIENT SERVICES			
Outpatient Diagnostics at an Outpatient Diagnostic Center	$30 Copay	$40 Copay	$50 Copay
Outpatient Diagnostics at a Hospital	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**
Outpatient Surgery at a Ambulatory Surgical Center	$100 Copay	$100 Copay	$250 Copay
Outpatient Surgery at a Hospital	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**
Outpatient Physical, Speech and Occupational Therapy at a Freestanding Facility (60 visits per contract year, combined for all therapy types)	$30 Copay	$40 Copay	$50 Copay
Outpatient Physical, Speech and Occupational Therapy at a Hospital (60 visits per contract year, combined for all therapy types)	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**
EMERGENCY AND URGENT CARE SERVICES			
Hospital Emergency Room Visit (Waived if Admitted) Urgent Care Facility Visit Ambulance	$100 Copay $25 Copay $25 Copay	$100 Copay $40 Copay $40 Copay	$100 Copay $50 Copay $50 Copay
SKILLED NURSING, HOME HEALTH AND HOSPICE			
Skilled Nursing Care (30 days per contract year) Home Health Care (60 visits per contract year) Hospice Care (210 days lifetime)	$50 per days 1-5 No Copay No Copay	$100 per days 1-5 No Copay No Copay	$250 per days 1-5 No Copay No Copay

	C15 – 1000	C20 – 1000	C30 – 1000
OTHER MEDICAL SERVICES			
Durable Medical Equipment Orthotics and Prosthetics	No Copay No Copay	No Copay No Copay	No Copay No Copay
MENTAL HEALTH SERVICES			
Inpatient/Outpatient Mental Health Services	Not Covered	Not Covered	Not Covered
ALCOHOL AND SUBSTANCE ABUSE SERVICES			
Inpatient Detoxification (5 days per admission; 2 admissions per contract year)	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**
PRESCRIPTION DRUGS			
30 Day Supply at Participating Pharmacy **Pharmacy Deductible (applies to all prescription drugs)** Formulary Generic Prescription Drugs Formulary Brand Name Prescription Drugs Non-formulary Prescription Drugs Self-Injectables ($250 monthly out-of-pocket maximum) Pharmacy Maximum Benefit (per contract year)	 **$250** **$10 Copay** **$20 Copay** **$40 Copay** **20%** $1,200	 **$250** **$20 Copay** **$35 Copay** **$50 Copay** **20%** $1,200	 **$250** **$30 Copay** **$45 Copay** **$60 Copay** **20%** $1,200
Insulin	**After Pharmacy Deductible, One Brand Copay per Prescription**	**After Pharmacy Deductible, One Brand Copay per Prescription**	**After Pharmacy Deductible, One Brand Copay per Prescription**
Diabetic supplies (test strips & lancets)	**After Pharmacy Deductible, One Brand Copay per Month**	**After Pharmacy Deductible, One Brand Copay per Month**	**After Pharmacy Deductible, One Brand Copay per Month**
MATERNITY SERVICES - OPTIONAL RIDER			
15 month Waiting Period on all Maternity Services Prenatal and Postnatal Care	 One-time $30 Copay	 One-time $40 Copay	 One-time $50 Copay
Hospital/Birthing Center Maternity Care	$1000 Copay	$1000 Copay	$1000 Copay
DENTAL AND VISION CARE SERVICES			
PREVENTIVE DENTAL SERVICES	Included	Included	Included
VISION CARE SERVICES	Included	Included	Included
OUT-OF-POCKET MAXIMUMS			
HOSPITAL DEDUCTIBLE (per contract year) *Applies to inpatient/outpatient hospital services.*	**$1,000**	**$1,000**	**$1,000**
OUT-OF-POCKET MAXIMUM (per contract year) *Does not include hospital deductible or prescription drug copayments.*	$1,500	$2,000	$5,000
TOTAL OUT-OF-POCKET MAXIMUM (per contract year) *Includes deductible, coinsurance and copayments; excludes pharmacy deductible and prescription drugs copayments.*	$2,500	$3,000	$6,000
MAXIMUM LIFETIME BENEFIT	Unlimited	Unlimited	Unlimited
PRE-EXISTING WAITING PERIOD	24 months	24 months	24 months

VISTA HEALTHPLAN OF SOUTH FLORIDA, INC.
Individual Health Benefits

	COINSURANCE FOCUSED DEDUCTIBLE		
	C15 – 2500	**C20 – 2500**	**C30 – 2500**
PHYSICIAN SERVICES			
Primary Care Physician Office Visits Specialist Office Visits *Office visit includes routine lab tests, diagnostic procedures and radiology, annual physical exams, well-child visits, well woman visits, hearing and vision screening, outpatient surgery, health education and counseling, and immunizations.*	$15 Copay $30 Copay	$20 Copay $40 Copay	$30 Copay $50 Copay
Non-surgical Spine and Back Visits (20 visits per contract year)	$30 Copay	$40 Copay	$50 Copay
Podiatry Visits (12 self-referrals per contract year)	$30 Copay	$40 Copay	$50 Copay
Dermatology Visits (5 self-referrals per contract year)	$30 Copay	$40 Copay	$50 Copay
INPATIENT HOSPITAL SERVICES – SUBJECT TO HOSPITAL DEDUCTIBLE			
Inpatient Hospital Facility and Physician Services *Facility and physician services include semi-private room and board, general nursing services, use of intensive care and specialty care units, x-rays, diagnostics/labs, operating and recovery rooms, prescription medications dispensed while confined, surgeon and assistant surgeon, anesthesiologist, specialist consultation and other physician visits while confined.*	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**
Inpatient Rehabilitation Services (30 days per contract year)	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**
OUTPATIENT SERVICES			
Outpatient Diagnostic Services at an Outpatient Diagnostic Center	$30 Copay	$40 Copay	$50 Copay
Outpatient Diagnostic Services at a Hospital	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**
Outpatient Surgery at an Ambulatory Surgical Center	$100 Copay	$100 Copay	$250 Copay
Outpatient Surgery at a Hospital	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**
Outpatient Physical, Speech and Occupational Therapy at a Freestanding Facility (60 visits per contract year, combined for all therapy types)	$30 Copay	$40 Copay	$50 Copay
Outpatient Physical, Speech and Occupational Therapy at a Hospital (60 visits per contract year, combined for all therapy types)	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**
EMERGENCY AND URGENT CARE SERVICES			
Hospital Emergency Room Visit (Waived if Admitted) Urgent Care Facility Visit Ambulance	$100 Copay $25 Copay $25 Copay	$100 Copay $40 Copay $40 Copay	$100 Copay $50 Copay $50 Copay
SKILLED NURSING, HOME HEALTH AND HOSPICE			
Skilled Nursing Care (30 days per contract year) Home Health Care (60 visits per contract year) Hospice Care (210 days lifetime)	$50 per days 1-5 No Copay No Copay	$100 per days 1-5 No Copay No Copay	$250 per days 1-5 No Copay No Copay

	C15 – 2500	C20 – 2500	C30 – 2500
OTHER MEDICAL SERVICES			
Durable Medical Equipment Orthotics and Prosthetics	No Copay No Copay	No Copay No Copay	No Copay No Copay
MENTAL HEALTH SERVICES			
Inpatient/Outpatient Mental Health Services	Not Covered	Not Covered	Not Covered
ALCOHOL AND SUBSTANCE ABUSE SERVICES			
Inpatient Detoxification (5 days per admission; 2 admissions per contract year)	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**
PRESCRIPTION DRUGS			
30 Day Supply at Participating Pharmacy **Pharmacy Deductible (applies to all prescription drugs)** Formulary Generic Prescription Drugs Formulary Brand Name Prescription Drugs Non-formulary Prescription Drugs Self-Injectables ($250 monthly out-of-pocket maximum) Pharmacy Maximum Benefit (per contract year)	 **$250** **$10 Copay** **$20 Copay** **$40 Copay** **20%** $1,200	 **$250** **$20 Copay** **$35 Copay** **$50 Copay** **20%** $1,200	 **$250** **$30 Copay** **$45 Copay** **$60 Copay** **20%** $1,200
Insulin	**After Pharmacy Deductible, One Brand Copay per Prescription**	**After Pharmacy Deductible, One Brand Copay per Prescription**	**After Pharmacy Deductible, One Brand Copay per Prescription**
Diabetic supplies (test strips & lancets)	**After Pharmacy Deductible, One Brand Copay per Month**	**After Pharmacy Deductible, One Brand Copay per Month**	**After Pharmacy Deductible, One Brand Copay per Month**
MATERNITY SERVICES - OPTIONAL RIDER			
15 month Waiting Period on all Maternity Services Prenatal and Postnatal Care	 One-time $30 Copay	 One-time $40 Copay	 One-time $50 Copay
Hospital/Birthing Center Maternity Care	$1000 Copay	$1000 Copay	$1000 Copay
DENTAL AND VISION CARE SERVICES			
PREVENTIVE DENTAL SERVICES	Included	Included	Included
VISION CARE SERVICES	Included	Included	Included
OUT-OF-POCKET MAXIMUMS			
HOSPITAL DEDUCTIBLE (per contract year) *Applies to inpatient/outpatient hospital services.*	**$2,500**	**$2,500**	**$2,500**
OUT-OF-POCKET MAXIMUM (per contract year) *Does not include hospital deductible or prescription drug copayments.*	$1,500	$2,000	$5,000
TOTAL OUT-OF-POCKET MAXIMUM (per contract year) *Includes deductible, coinsurance and copayments; excludes pharmacy deductible and prescription drugs copayments.*	$4,000	$4,500	$7,500
MAXIMUM LIFETIME BENEFIT	Unlimited	Unlimited	Unlimited
PRE-EXISTING WAITING PERIOD	24 months	24 months	24 months

VISTA HEALTHPLAN OF SOUTH FLORIDA, INC.

Individual Health Benefits

	COINSURANCE FOCUSED DEDUCTIBLE		
	C15 – 5000	**C20 – 5000**	**C30 – 5000**
PHYSICIAN SERVICES			
Primary Care Physician Office Visits Specialist Office Visits *Office visit includes routine lab tests, diagnostic procedures and radiology, annual physical exams, well-child visits, well woman visits, hearing and vision screening, outpatient surgery, health education and counseling, and immunizations.*	$15 Copay $30 Copay	$20 Copay $40 Copay	$30 Copay $50 Copay
Non-surgical Spine and Back Visits (20 visits per contract year)	$30 Copay	$40 Copay	$50 Copay
Podiatry Visits (12 self-referrals per contract year)	$30 Copay	$40 Copay	$50 Copay
Dermatology Visits (5 self-referrals per contract year)	$30 Copay	$40 Copay	$50 Copay
INPATIENT HOSPITAL SERVICES – SUBJECT TO HOSPITAL DEDUCTIBLE			
Inpatient Hospital Facility and Physician Services *Facility and physician services include semi-private room and board, general nursing services, use of intensive care and specialty care units, x-rays, diagnostics/labs, operating and recovery rooms, prescription medications dispensed while confined, surgeon and assistant surgeon, anesthesiologist, specialist consultation and other physician visits while confined.*	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**
Inpatient Rehabilitation Services (30 days per contract year)	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**
OUTPATIENT SERVICES			
Outpatient Diagnostic Services at an Outpatient Diagnostic Center	$30 Copay	$40 Copay	$50 Copay
Outpatient Diagnostic Services at a Hospital	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**
Outpatient Surgery at an Ambulatory Surgical Center	$100 Copay	$100 Copay	$250 Copay
Outpatient Surgery at a Hospital	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**
Outpatient Physical, Speech and Occupational Therapy at a Freestanding Facility (60 visits per contract year, combined for all therapy types)	$30 Copay	$40 Copay	$50 Copay
Outpatient Physical, Speech and Occupational Therapy at a Hospital (60 visits per contract year, combined for all therapy types)	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**
EMERGENCY AND URGENT CARE SERVICES			
Hospital Emergency Room Visit (Waived if Admitted) Urgent Care Facility Visit Ambulance	$100 Copay $25 Copay $25 Copay	$100 Copay $40 Copay $40 Copay	$100 Copay $50 Copay $50 Copay
SKILLED NURSING, HOME HEALTH AND HOSPICE			
Skilled Nursing Care (30 days per contract year) Home Health Care (60 visits per contract year) Hospice Care (210 days lifetime)	$50 per days 1-5 No Copay No Copay	$100 per days 1-5 No Copay No Copay	$250 per days 1-5 No Copay No Copay

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	C15 – 5000	C20 – 5000	C30 – 5000
OTHER MEDICAL SERVICES			
Durable Medical Equipment Orthotics and Prosthetics	No Copay No Copay	No Copay No Copay	No Copay No Copay
MENTAL HEALTH SERVICES			
Inpatient/Outpatient Mental Health Services	Not Covered	Not Covered	Not Covered
ALCOHOL AND SUBSTANCE ABUSE SERVICES			
Inpatient Detoxification (5 days per admission; 2 admissions per contract year)	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**	**20% Coinsurance; after Hospital Deductible**
PRESCRIPTION DRUGS			
30 Day Supply at Participating Pharmacy **Pharmacy Deductible (applies to all prescription drugs)** Formulary Generic Prescription Drugs Formulary Brand Name Prescription Drugs Non-formulary Prescription Drugs Self-Injectables ($250 monthly out-of-pocket maximum) Pharmacy Maximum Benefit (per contract year)	 **$250** **$10 Copay** **$20 Copay** **$40 Copay** **20%** $1,200	 **$250** **$20 Copay** **$35 Copay** **$50 Copay** **20%** $1,200	 **$250** **$30 Copay** **$45 Copay** **$60 Copay** **20%** $1,200
Insulin	**After Pharmacy Deductible, One Brand Copay per Prescription**	**After Pharmacy Deductible, One Brand Copay per Prescription**	**After Pharmacy Deductible, One Brand Copay per Prescription**
Diabetic supplies (test strips & lancets)	**After Pharmacy Deductible, One Brand Copay per Month**	**After Pharmacy Deductible, One Brand Copay per Month**	**After Pharmacy Deductible, One Brand Copay per Month**
MATERNITY SERVICES - OPTIONAL RIDER			
15 month Waiting Period on all Maternity Services Prenatal and Postnatal Care	 One-time $30 Copay	 One-time $40 Copay	 One-time $50 Copay
Hospital/Birthing Center Maternity Care	$1000 Copay	$1000 Copay	$1000 Copay
DENTAL AND VISION CARE SERVICES			
PREVENTIVE DENTAL SERVICES	Included	Included	Included
VISION CARE SERVICES	Included	Included	Included
OUT-OF-POCKET MAXIMUMS			
HOSPITAL DEDUCTIBLE (per contract year) *Applies to inpatient/outpatient hospital services.*	**$5,000**	**$5,000**	**$5,000**
OUT-OF-POCKET MAXIMUM (per contract year) *Does not include hospital deductible or prescription drug copayments.*	$1,500	$2,000	$5,000
TOTAL OUT-OF-POCKET MAXIMUM (per contract year) *Includes deductible, coinsurance and copayments; excludes pharmacy deductible and prescription drugs copayments.*	$6,500	$7,000	$10,000
MAXIMUM LIFETIME BENEFIT	Unlimited	Unlimited	Unlimited
PRE-EXISTING WAITING PERIOD	24 months	24 months	24 months

compbenefits VISION DENTAL

BENEFITS SCHEDULE

Vista Healthplan of South Florida, Inc.
Individual Dental Plan

These co-payments are the maximum fees that will be charged by the participating GENERAL DENTIST for the specified covered services.

DIAGNOSTIC

Code	Service	Member Pays
0120	Periodic oral evaluation	No Charge
0140	Limited oral evaluation-problem focused	No Charge
0150	Comprehensive oral evaluation	No Charge
0160	Detailed and extensive oral evaluation	No Charge
0180	Comprehensive periodontal evaluation	30
0460	Pulp vitality tests	No Charge
0470	Diagnostic casts	No Charge

X-RAYS

Code	Service	Member Pays
0220-0330	All necessary x-rays (once per year)	No Charge

PREVENTIVE CARE

Code	Service	Member Pays
1110	Prophylaxis—adult (1 per 6 months)	No Charge
1120	Prophylaxis—child (1 per 6 months)	No Charge
1110/20	Prophylaxis—child/adult (additional)	15
1203/04	Topical application of fluoride (1 per 12 months)	No Charge
1330	Oral hygiene instructions	No Charge
1351	Sealant—per tooth	10

RESTORATIVE (Fillings)

Code	Service	Member Pays
2140	Amalgam—one surface (primary or permanent)	10
2150	Amalgam—two surfaces (primary or permanent)	20
2160	Amalgam—three surfaces (primary or permanent)	30
2330	Resin-based composite—one surface, anterior	50
2331	Resin-based composite—two surfaces, anterior	70
2332	Resin-based composite—three surfaces, anterior	95
2520	Inlays—metallic, two surfaces+	210
2530	Inlay—metallic, three or more surfaces+	225
2940	Sedative filling	No Charge
2951	Pin retention (per tooth, in addition to restoration)	10
2961	Labial veneer (resin laminate) - laboratory	175

+ Gold additional

FIXED CROWN

Code	Service	Member Pays
2750+	Crown—porcelain fused to high noble metal	290
2751+	Crown—porcelain fused to base metal	220
2752+	Crown—porcelain fused to noble metal	245
2791+	Crown—full cast base metal	225
2910	Recement inlay, onlay or partial cov. restoration	No Charge
2930	Prefabricated stainless steel crown (primary)	50
2950	Core buildup (including any pins)	90
2954	Prefabricated post and core (in addition to crown)	75
6930	Recement fixed partial denture	20

+ Gold additional

*ENDODONTICS (Root Canal Therapy)

Code	Service	Member Pays
3220	Therapeutic pulpotomy (excluding restoration)	20
3310	Anterior root canal (excluding final restoration)	125
3320	Bicuspid root canal (excluding final restoration)	185
3330	Molar root canal (excluding final restoration)	280
3410	Apicoectomy/periradicular surgery-anterior	85

*PERIODONTICS (Gum Treatment)

Code	Service	Member Pays
4210	Gingivectomy or gingivoplasty (4+contiguous teeth, per quadrant)	160
4260	Osseous surgery (including flap entry/closure) (4+contiguous teeth, per quadrant)	250
4271	Free soft tissue graft procedure (inc. donor site surgery)	225
4341	Periodontal scaling and root planing (4+contiguous teeth, per quadrant)	65
4355	Full mouth debridement	35
4910	Periodontal maintenance	50

PROSTHETICS (Full & Partial Dentures)

Code	Service	Member Pays
5110/20	Complete upper or lower denture	240
5130/40	Immediate upper or lower denture	250
5211/12	Partial upper or lower denture-resin base (including clasps, rests and teeth)	105
5213/14	Partial upper or lower denture-cast metal framework (including clasps, rests and teeth)	325
5410/11	Adjust complete denture	7
5421/22	Adjust partial denture	7
5710/11	Rebase complete upper or lower denture	85
5720/21	Rebase complete upper or lower partial denture	85
5730/31	Reline complete upper or lower denture (chairside)	55
5740/41	Reline partial upper or lower denture (chairside)	55
5750/51	Reline complete upper or lower denture (laboratory)	85
5760/61	Reline partial upper or lower denture (laboratory)	85
5850/51	Tissue conditioning	35

REPAIRS TO PROSTHETICS (Full & Partial Dentures)

Code	Service	Member Pays
5510	Repair broken denture base (no teeth, including impression)	35
5640	Replace broken tooth, per tooth	40
5650	Add tooth to existing partial denture	18
5660	Add clasp to existing partial denture	50

*ORAL SURGERY

Code	Service	Member Pays
7111	Extraction, coronal remnants, deciduous tooth	No Charge
7140	Extraction, erupted tooth or exposed root	10
7210	Surgical removal of erupted tooth	35
7220	Removal of impacted tooth—soft tissue	45
7230	Removal of impacted tooth —partially bony	65
7240	Removal of impacted tooth —completely bony	95
7250	Surgical extraction of residual root	35
7310/20	Alveoloplasty (per quadrant)	70
7450	Cyst removal (up to 1.25 cm)	50
7472/73	Removal of torus	50
7510	Incision and drainage of abscess (intraoral soft tissue)	25

*ORTHODONTICS (Children up to age 19 only)

Code	Service	Member Pays
8070/80	Comprehensive orthodontic treatment of the transitional/adolescent dentition Up to 24 months of routine (full-banded) orthodontic treatment for Class I and Class II cases Initial consultation, including examination, x-rays, models, records	85
	Orthodontic treatment	2,100

With participating orthodontists only. Cases under treatment are eligible for discounts at the sole discretion of the participating orthodontist.

MISCELLANEOUS

Code	Service	Member Pays
9110	Palliative (emergency) treatment during office hours in addition to treatment charges	25
	after office hours in addition to treatment charges	35
9210	Local anesthesia	No Charge
9940	Occlusal guard, by report	55
9941	Fabrication of athletic mouthguard	175
9951	Occlusal adjustment (limited)	35
9952	Occlusal adjustment (complete)	160
9999	Broken appointment (more than 24 hour notice)	No Charge
9999	Broken appointment (less than 24 hour notice) per 15 min.	10

***The member charges listed are valid only when treatment is performed at a participating general dental office. If the services of a specialist are required, then the charge will be the specialist's usual and customary fee less discount of 20%. Any services not listed will be available at the dentist's usual and customary fees less discount of 20%.**

Not all participating dentists perform all listed procedures. Please consult your dentist prior to treatment.

CHOICE OF PROVIDERS

Plan benefits are available only through CompBenefits' Participating Dental Providers, located in Florida counties within the VISTA Service Area.
This dental plan does not cover services and supplies provided by a dentist who is not a CompBenefits Participating Dental Provider. Read the current Participating Dental Provider Directory for your area so you will know from which dentists dental care may be obtained in order to be covered under this plan.

Although the Participating Dental Provider Directory is a reasonably comprehensive listing of Participating dentists currently contracting with CompBenefits in your area, it is subject to change as new dentists contract with CompBenefits and some Participating dentist contracts end. The current participation status of any dentist can be obtained by calling the CompBenefits' Member Support Department at 1-800-848-3480.

COPAYMENTS

The copayment is your share of costs for Covered Services, usually paid to the dentist at the time care is rendered. Refer to the attached Copayment Schedule to determine the Copayments for dental services.

HOW TO SELECT A DENTAL PLAN

To enroll, simply fill out the VISTA Enrollment application. When you enroll, you must select a dentist for your entire family from our list of Participating Dental Providers for your area. Submit your Enrollment application to VISTA at the address listed on your VISTA Enrollment application. To change your dentist, simply select a new dentist from the CompBenefits Participating Dental Provider Directory and call the CompBenefits Member Support Department with your change.

HOW TO USE THE PLAN

When you go for your appointment with your dentist, present your membership card and the appropriate Copayment. That's all there is to it!

You will be responsible for paying the dentist any Copayment(s) (when applicable) and for any extras. All payments of claims will be made directly to the Participating Dental Provider.

TERM, COMMENCEMENT OF COVERAGE, RENEWAL AND TERMINATION PROVISIONS

The term of your coverage under this dental plan coincides with the term of your coverage under your health plan with VISTA. Your coverage under this dental plan will commence, renew and terminate consistent with the commencement, renewal and termination provisions set forth in the Member Welcome Kit for your health plan benefits with VISTA.

EXCLUSIONS AND LIMITATIONS

The following services and supplies are excluded from, or limited in, coverage under this dental plan, as specified. (Note: all charges related to, or as a follow-up to services and supplies that are specified as excluded or limited below, are likewise excluded:

Coverage limited to care rendered by a Participating Dental Provider. All Covered Services must be provided by a Participating Dental Provider in order to be covered under this dental plan.

- Services for injuries or conditions which are paid by Workers' Compensation or Employer's Liability Laws. Services which are provided without cost to the member by any municipality, county or other political subdivision.
- Services, which in the opinion of the attending dentist, are not necessary for the patient's dental health.
- Cosmetic, elective or aesthetic dentistry.
- Oral surgery requiring the setting of fractures or dislocations.
- Treatment of malignancies, cysts or neoplasm or congenital malformities.
- Any dental services performed in a hospital.
- Any procedure of implantation or experimental procedures.
- General anesthesia.
- Services that cannot be performed because of the general health of the patient.
- Cost of dental care which is covered under automobile, medical, no-fault or similar type insurance.
- After three years on the plan and five years following the last denture expense, the insured is eligible for replacement dentures. Lost, mislaid or stolen dentures are not eligible for replacement.
- Coverage will not be provided for any procedure begun prior to the member's effective date.
- If an eligible group member does not enroll in the dental plan at the time he or she first becomes eligible, and chooses to enroll at a later date, then the usual and customary fees for all dental work required at the initial screening, other than x-rays and prophylaxis will be the patient's responsibility.

VISTA HEALTHPLAN OF SOUTH FLORIDA, INC.
VISION BENEFIT ENDORSEMENT

VISION CARE, INC. / PRIMARY PLUS
HMO VISION PLAN
$19 EXAMINATION COPAYMENT

VISION IS VALUABLE

Your eyes are perhaps the most valuable of the five senses and require systematic, preventive care. Through a comprehensive network of providers, Vista Healthplan of South Florida provides vision plans to protect this valuable resource. Our benefits include a comprehensive vision examination, corrective lenses, frames and contact lenses. Vista Healthplan of South Florida and Primary Plus offers you extensive vision care benefits at affordable prices.

SIGNIFICANT ATTRIBUTES

There are numerous significant attributes to our Vision Plans. No long waiting periods for the claim forms and simple administration for the group. We take care of the payments to the providers and the laboratories directly. With our Vision Plans, you receive quality materials and quality service. It all adds up to superior vision care.

COVERED MEMBERS

The plan covers enrolled Vista Healthplan of South Florida Individual HMO members (benefit automatically included when you purchase one of our Medical HMO products) and Commercial Group HMO and Point of Service members (Optional Endorsement must be selected by your Employer). All you have to do is use a Participating Provider.

1 CHOICE OF PROVIDERS

Plan benefits are available only through **Primary Plus** Participating Vision Providers, located throughout Florida except Pasco, Hillsborough and Pinellas counties. This vision plan does **not** cover services and supplies provided by a provider who is not a Participating Vision Provider. Read the current Participating Vision Provider Directory for your area so you will know from which Participating Vision Providers vision care may be obtained in order to be covered under this plan.

Although the Participating Vision Provider Directory is a reasonably comprehensive listing of Participating Vision Providers currently contracting with **Primary Plus** in your area, it is subject to change as new providers contract with **Primary Plus** and as some Participating Vision Provider contracts end. To obtain a Vision Provider or determine the current participation status of any provider, contact the Primary Plus Customer Service Department at 1-800-393-2873.

2 VISION EXAMINATION

The primary purpose of your vision care plan is to provide for periodic professional vision examinations. These examinations are a complete analysis of the eyes and related structures to determine the presence of vision problems and other abnormalities. Prescriptions for eyewear will also be provided upon request. There are **Primary Plus** Providers conveniently located throughout Florida. Each service center is staffed with vision care professionals who are committed to provide plan services in accordance with high standards. With Participating Vision Providers, even if optional "extras" are selected, the member receives the advantage of a 20% discount from the Participating Provider's regular retail prices.

3 SERVICE INTERVALS

Eyeglasses Examination .... **12 months**
Lenses .... **12 months**
Frames .... **12 months**
Or
Contact Lenses................................. **12 months**
(Includes contact lens examination)

4 FRAMES AND LENSES

Our Participating Vision Providers offer a modern and extensive selection of frames from the Select Collection of Frames. Each Participating Vision Provider stocks a complete display supply of this Select Collection, thereby assuring a uniform selection of "covered" frame styles. Outside of the Selection collection of frames, members are eligible to receive a 20% discount off all other frame and lens styles within the participating provider optical.

5 CONTACT LENSES

The plan provides a variety of Contact Lens selections. All medically necessary contact lenses are covered in full. Discounted pricing applies for routine contact lenses as described on the attached copayment schedule.

6 COPAYMENTS

Your plan provides one routine examination every 12 months with a $19 examination copayment. Refer to the attached Copayment Schedule to determine the copayments for materials.

7 HOW TO SELECT A VISION PLAN

To enroll, simply fill out the VISTA-SFL Enrollment application and submit it to your Employee Benefit Representative, or directly through VISTA-SFL if you have Individual coverage.

8 HOW TO USE THE PLAN

When you are ready for your services, select a Participating Vision Provider from your **Primary Plus Plan** Directory, call for an appointment and identify yourself as a VISTA-SFL member. The provider's office will already have the appropriate Benefit Form and will be able to **contact Primary Plus** to verify your eligibility.

At the time of service, you will be responsible for paying the Participating Vision Provider any copayment(s) (when applicable) and for any extras. All payments of claims will be made directly to the participating Provider.

9 TERM, COMMENCEMENT OF COVERAGE, RENEWAL AND TERMINATION PROVISIONS

The term of your coverage under this vision plan coincides with the term of your coverage under your health plan with VISTA-SFL. Your coverage under this vision plan will commence, renew and terminate consistent with the commencement, renewal and termination provisions set forth in the Evidence of Coverage for your health plan with Vista Healthplan of South Florida.

10 DEFINITIONS

Anisometropia: Condition of unequal refractive state for the two eyes, one eye requiring a different lens correction than the other.

Blended Lenses: Bifocals which do not have a visible dividing line.

Coated Lenses: A substance which is added to a finished lens on one or both surfaces.

Covered Services: Vision services and Materials which are specified as being covered in the attached Benefit Schedule.

Keratoconus: A development of dystrophic deformity of the cornea in which it becomes cone shaped due to a thinning and stretching of the tissue in its central area.

Materials: Lenses, frames and contact lenses.

Medically Necessary (or Medical Necessity): Medically Necessary services are Covered Services which are necessary and appropriate for treatment of a Member's visual acuity according to professionally recognized standards of practice and which are consistent with VISTA-SFL's vision policies.

Attending Participating Vision Providers are exclusively responsible for making all vision determinations and treatment decisions. However, payment for Covered Services rendered will be conditioned on Primary Plus' subsequent review and determination as to consistency with professionally recognized standards of vision practice and Primary Plus' vision policies. The fact that a Participating Vision Provider may prescribe, order, recommend or approve a service or Material does not, in itself, make it Medically Necessary, or make it a Covered Service even though it is not specifically listed in this Supplemental Plan Contract or the Benefit Schedule as an exclusion or limitation.

Orthoptics: The teaching and training process for the improvement of visual perception and coordination of the two eyes for efficient and comfortable binocular lenses.

Oversized Lenses: Larger than standard (i.e., 61 millimeter) lens blanks to accommodate a prescription.

Participating Vision Provider: An optometrist, ophthalmologist or optician licensed to provide Covered Services who, or which, at the time care is rendered to a Member, has a contract in effect with **Primary Plus** to furnish care to Members. The names of Participating Vision Providers are set forth in Primary Plus' Participating Vision Provider Directory. The names of Participating Vision Providers and their locations and hours of practice may also be obtained by contacting Primary Plus' Customer Service Department. This vision plan does not guarantee the initial or continued availability of any particular Participating Vision Provider.

Photochromic Lenses: Lenses which change color with intensity of sunlight.

Professional Service: Examination, Material selection, fitting of eyeglasses or contact lenses, related adjustments, instructions, etc.

Progressive Lenses: Trifocals which do not have a visible dividing line.

Subnormal or Low Vision Aids: Devices (optical and non-optical) to assist those individuals who are partially sighted.

Tinted Lenses: Lenses which have additional substance added to produce constant tint (e.g., pink, green, gray, blue, etc.).

11 EXCLUSIONS AND LIMITATIONS

THE FOLLOWING SERVICES AND SUPPLIES ARE EXCLUDED FROM, OR LIMITED IN COVERAGE UNDER THIS VISION PLAN, AS SPECIFIED. (NOTE: ALL CHARGES RELATED TO, OR AS A FOLLOW-UP TO SERVICES AND SUPPLIES THAT ARE SPECIFIED AS EXCLUDED OR LIMITED BELOW, ARE LIKEWISE EXCLUDED):

Coverage is limited to the primary subscriber and family members enrolled in the VISTA-SFL medical plan. Coverage is also limited to care rendered by a Participating Vision Provider. All Covered Services must be provided by a Participating Vision Provider in order to be covered under this vision plan.

- **Extras and Non-Medically Necessary services and Materials.** This vision plan is designed to cover Medically Necessary visual needs rather than cosmetic desires. Charges for services and Materials that VISTA-SFL determines to be not Medically Necessary non-basic are excluded. Non-basic lens features include, special lens fabrication, coated lenses, tinted lenses, dyed lenses, laminated lenses, progressive lenses, blended lenses, oversize lenses, occupational lenses, and any other types of lenses or features VISTA-SFL determines to be non-basic or not Medically Necessary.
- **Medically Necessary contact lenses.** Coverage for prescriptions for contact lenses is subject to Medical Necessity, prior authorization by VISTA-SFL and all applicable exclusions and limitations. Generally, **full** coverage (exclusive of the indicated Copayment) for contact lenses will only be authorized (1) for contact lenses to correct extreme visual acuity problems that cannot be corrected with spectacle lenses, (2) following cataract surgery, (3) for Anisometropia, or (4) for Keratoconus. When covered, contact lenses are furnished at the same interval as prescription lenses are covered under this vision plan.
- **Medical or hospital.** Hospital and medical charges of any kind, vision services rendered in a hospital, and medical or surgical treatment of the eyes, are excluded.
- **Prescriptions from non-Participating Vision Providers.** Participating Vision Providers are not required to fill prescriptions from non-Participating Vision Providers and such prescriptions will not be covered under this vision plan.
- **Oversized lenses.** Required in a "Non-Select Collection" frame.
- **Blended and progressive lenses.** No line bifocals or lens styles other than those listed in the Copayment Schedule.
- **Loss or theft**. Replacement due to loss, theft or destruction is excluded, except when replacement is at the regular time intervals of coverage under this vision plan.
- **Orthoptics, vision training, etc.** Orthoptics and vision training and any associated testing, subnormal vision aids, plano (non-prescription) lenses are excluded.
- **No prescription change.** Lenses secured when there is no prescription change are excluded.
- **Second pair.** A second pair of glasses in lieu of bifocals are excluded.
- **Health, emotional or mental limitations.** Services that cannot be performed because of the general health, physical, emotional mental behavioral limitations of the patient are excluded.
- **Experimental.** Experimental services and supplies are excluded. Experimental services and supplies generally include any procedure, treatment, therapy, drug, biological product, facility, equipment, device or supply which has not been demonstrated to be safe, effective and efficacious for use in the treatment of the illness, injury or condition at issue as compared with the conventional means of treatment, or diagnosis. **VISTA-SFL**, in its sole discretion, shall determine whether such service or supply is safe, effective and efficacious for the injury or condition at issue according to the criteria set forth in the definition of "Experimental."

- **Governmental programs.** Charges for services or supplies for treatment of conditions where the Member is paid or receives reimbursement through a government agency or program and for which such care is available are excluded, unless otherwise provided by law.

- **No legal obligation to pay.** Services or supplies for which the Member has no legal obligation to pay, or for which no charge would be made if the Member was not eligible under this vision plan, are excluded.

- **Fraud.** If a Member makes a material false statement as to his or her health status on application materials, **VISTA-SFL** shall have no liability for the provision of coverage under this vision plan in connection with any condition for which information has been knowingly incorrectly stated.

- **Workers' Compensation, insurance and third party liability recoveries**. Services and supplies that are otherwise covered under this vision plan are excluded to the extent that a Member is paid from any source, including settlements and recoveries derived from Workers' Compensation, a liable third party, or from other insurance coverage (e.g. homeowners' insurance, underinsured and uninsured motorists insurance). Coverage for any condition caused by another person's negligence or intentional act or omission is excluded. This vision plan will, however, advance the benefits of this vision plan, subject to an automatic lien against the recovery.

- **Medical records.** Charges associated with copying or transferring vision records are excluded.

- **Mid-year vision plan changes**. Benefits under this vision plan that are subject to annual limitations will not be increased even when a Member becomes covered under two separate VISTA-SFL plan contracts during the same annual period.

- **Medications.** Prescription and non-prescription drugs and medications, topical, oral and injectable pharmaceutical agents are excluded.

- **Employment Examination.** Any eye examination required by an employer as a condition of employment.

- **Miscellaneous.** Clinical laboratory services, Low vision devices, Ocular prostheses, Treatment of tumors, Diagnostic imaging with exclusion of A-cans and B-Scans of the eye, photochromic lenses, frames costing more than the plan allowance, faceted lenses, lens materials other than regular plastic, orbit, corneal and skin graft tissue and any service or materials provided by any other vision care plan, or group benefit plan containing benefits for vision care are excluded.

Vista Healthplan of South Florida, Inc.
Vision Benefits

Schedule of Benefits

Benefits	**Copayment Amount**
Examination	$19.00
Eyeglasses	
Select Plan Frame	No Charge
Single Vision Lens	$20.00
Bifocal Lenses	$25.00
Trifocal Lenses	$30.00
Prescription Tint – Solid Brown/Gray/Green C	No Charge
Other upgrades are available at discounted pricing.	
Contact Lenses	
Medically Necessary Contact Lenses-Evaluation/Fitting	No Charge
Non-Medically Necessary Contact Lenses-Evaluation/Fitting	Not Covered*

** Primary Plus participating providers will charge a maximum of $45.00 to Vista Healthplan of South Florida, Inc. members.*

Hardware/Lenses	
Daily Wear Lenses: Bausch & Lomb, Biomedics	$10.00
Extended Wear Lenses: Bausch & Lomb, Biomedics	$15.00
Disposable Lenses (2 boxes) - All clear, spherical disposable lenses	$48.00*

** All other disposables (colored lenses, bifocal lenses, etc.) are available at a 20% discount from provider's usual and customary charge.*

Limitation: One vision examination and one pair of eyeglasses or medically necessary contact lenses allowed per member per contract year.

All eyewear is available at a 20% discount from the provider's usual and customary charge.

For provider locations in your area, please call Primary Plus:
1-800-393-2873

This Schedule of Benefits is effective as of the Effective Date of the Certificate of Coverage to which it is attached.

Individual Application Submission Requirements

ELIGIBLE AGES	REQUIREMENTS
6 months – 17 yrs	Child can apply alone
6 month – 4 yrs old	Must provide complete Pediatric Records inclusive of: • All updated Immunization Records • All Labs and All notes within the last 24 months
5 yrs – 49 yrs old	Completed Application
40 yrs – 49 yrs old	Females – Mammogram and Pelvic/Pap Smear results within the last 24 months
50 yrs – 64 ½ yrs old	Must provide complete Medical Records inclusive of: • All Labs and All notes for the last 24 month period • Mammogram and Pelvic/Pap Smear Exam (for woman 50+) • The following LABS must be current within 90 days: ◊ SMAC 26 Blood Test ◊ CBC (Hematology Studies) Blood Test ◊ HIV ◊ Urinalysis ◊ Blood Pressure and Pulse readings ◊ Height and Weight Measurements ◊ PSA (for men 50+ only)

Extra Value in VISTA's products.

Coinsurance Focused Deductible Plans

Q: What is a Coinsurance Focused Deductible plan?

A: *Focused Deductible refers to the Annual Hospital Deductible each individual member must satisfy in a contract year when utilizing inpatient or outpatient services at a hospital.*

Q: Does the Hospital deductible contribute toward the out-of-pocket maximum?

A: *No, the out-of-pocket maximum includes copayments and/or coinsurance amounts.*

Q: Does the Hospital Coinsurance contribute toward the out-of-pocket maximum?

A: *Yes, the Hospital Coinsurance and copayments contribute toward the out-of-pocket maximum.*

Q: How do Coinsurance Focused Deductible plan members know what they are responsible to pay the hospital?

A: *When a member utilizes hospital services, claims are processed based on the contracted rate between VISTA and the hospital. The member receives an Explanation of Benefits "EOB" which indicates the member responsibility, including any applicable deductible, copayment or coinsurance amounts. If the deductible is satisfied a copayment and/or coinsurance applies.*

Q: While satisfying the Hospital Deductible is a member responsible for billed charges?

A: *No, while satisfying the Hospital Deductible, Coinsurance Focused Deductible plan members receive the benefit of the "allowed amount" or contracted rate between VISTA and the hospital.*

Q: What is the difference between Focused Deductible and Coinsurance Focused Deductible?

A: *Focused Deductible and Coinsurance Focused Deductible plans have an Annual Hospital Deductible that applies only to inpatient or outpatient services at a hospital. After the deductible is satisfied, Focused Deductible plans have a copayment for services performed at a hospital. Coinsurance Focused Deductible plans have coinsurance for services performed at a hospital.*

Frequently Asked Questions (cont.)

Q: Do members of Coinsurance Focused Deductible plans need a referral to see a participating specialist?

A: *Coinsurance Focused Deductible plans are available as HMO and HMO Open Access. Members enrolled in the HMO Open Access plans are not required to obtain referrals for covered services.*

Q: Are members required to use freestanding facilities for outpatient services?

A: *No, members may utilize hospital facilities for outpatient services. However members are encouraged to use freestanding facilities whenever possible to take advantage of the lower out-of-pocket expenses. Services performed at hospitals are subject to the Hospital Deductible and copayments or coinsurance.*

Q: How can a member determine how much of the Hospital Deductible is satisfied?

A: *Each time a member receives an EOB, the year-to-date accumulation for deductible, coinsurance, copayments and out-of-pocket expenses are displayed. Members may also contact VISTA Customer Service for status of their deductible satisfaction during Customer Service hour.*

Q: How are commissions paid on this product?

A: *Please refer to your VISTA sales representative for detailed information on commission structures and bonus opportunities.*

Customer Service	(800) 441-5501
Pharmacy Services	(866) VISTA-RX / 847-8279
Interactive Voice Response (IVR)	(800) 977-6870
Web Services	www.vistahealthplan.com
Vision Benefits	(866) 847-8235
Dental Benefits	(800) 432-3376
Suggested Paramedical Services	
APPS Para Medical Services	(800) 635-9021
NMS Management Services	(800) 269-0502

Mailing Addresses	
Premium Payments	Vista Healthplan of South Florida, Inc. P.O. Box 30218 Tampa, FL 33630-3218
Claims	P.O. Box 45-9011 Sunrise, FL 33345

VISTA now offers more options and value than ever!

The V is for Value.

To keep our members happy and healthy, **VISTA** now offers added convenience and more value with new discounts for Individual plan members.

VISTA Better Living Program

VISTA members can now take a more active role in living a healthy lifestyle. Beginning January 1, 2007, the following VISTA Better Living Program enhancements, offered through Axia Health Management, are available to Individual plan members:

- 50% discount on membership fees at participating fitness clubs including *Curves*, *Fitness Solutions*, *Gold's Gym*, *Planet Fitness* and *World Gym*.
- QuitNet, a comprehensive online behavioral support program to help people quit smoking.
- My ePHIT, a customized online health and wellness program, with a telephone coaching feature, designed to engage individuals in activities promoting physical fitness, healthy eating habits and behavioral management.

MORE VALUE...

HEARx diagnostics, exams & products

HEARx offers the largest variety of hearing products to VISTA members at a 20% discount. In addition, members can also take advantage of a screening to Commercial members at no charge. Refer your clients to *www.hearusa.com* to find a convenient HEARx store location.

HealthwoRx virtual scans

HealthwoRx Scan Center, located in Pembroke Pines, now offers VISTA members up to a 15% discount on a new, non-invasive scanning technology using electron beam tomography (EBT). EBT scans are useful in the early detection of heart disease, cancer and other diseases and produce more precise images with less radiation than other screening methods. Members should call HealthwoRx at 954-442-0879 for more information.

Get Value. Get VISTA.

Only **VISTA** offers you this kind of **VALUE** in a health benefits plan.

For more information, call: 1-866-275-4773

Mon. – Fri. from 8:00 a.m. to 5:30 p.m. • **www.vistahealthplan.com**

Item # 1045(12/06)

Vista Healthplans' Offices

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1340 Concord Terrace
Sunrise, FL 33323
954-858-3000

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Hollywood, FL 33021
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