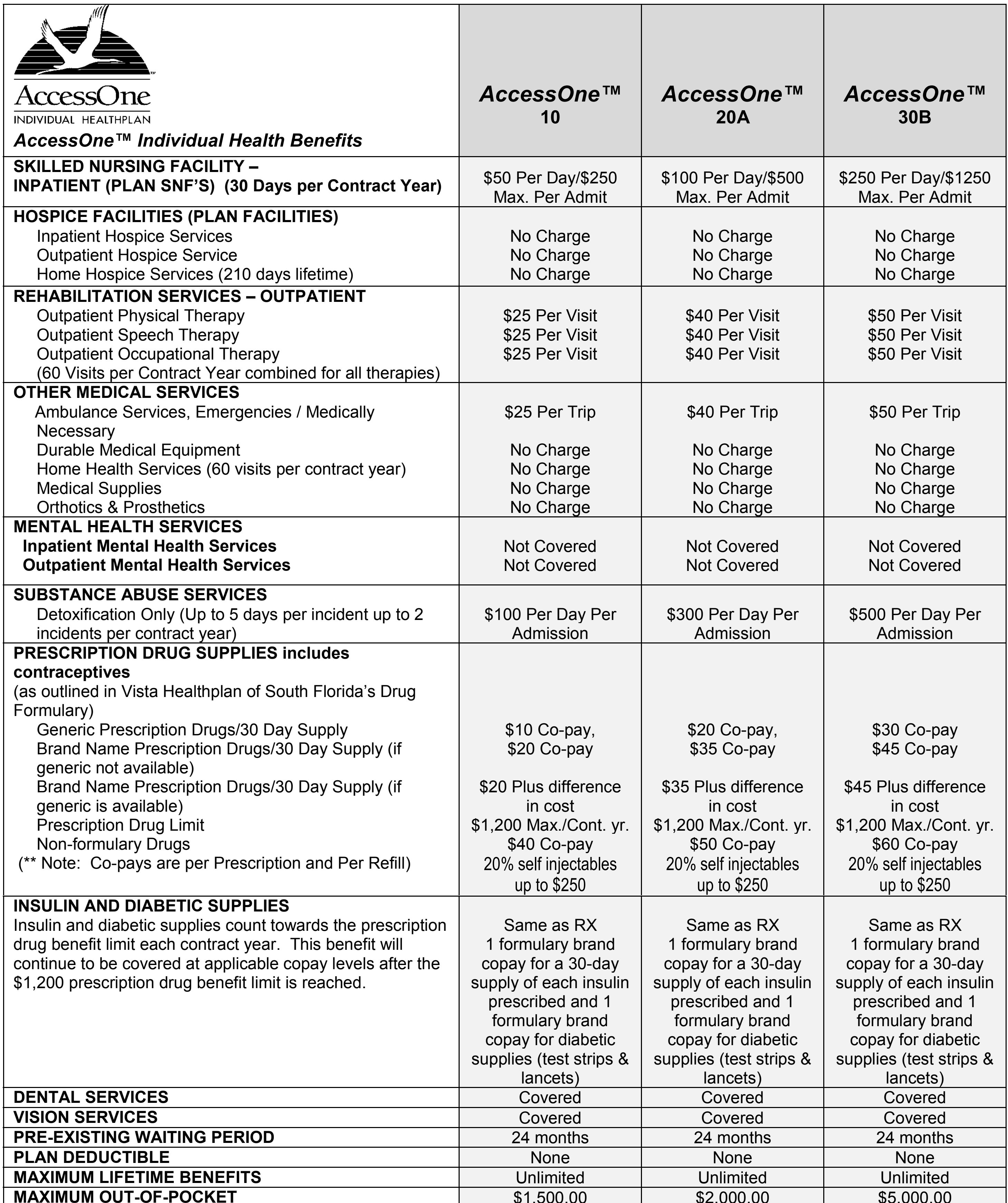
benefit summary

AccessOne™ INDIVIDUAL HMO

RESUMEN DE BENEFICIOS

PLAN HMO INDIVIDUAL ACCESSONE™

AccessOne™ Individual Health Benefits	**AccessOne™ 10**	**AccessOne™ 20A**	**AccessOne™ 30B**
PHYSICIAN SERVICES			
Primary Care Physician			
Primary Care Office Visits/Radiology, Lab, EKG's,	$10 Per Visit	$20 Per Visit	$30 Per Visit
Adult Wellness Visits/Exams - Health Education	$10 Per Visit	$20 Per Visit	$30 Per Visit
Home Visits As Necessary	$10 Per Visit	$20 Per Visit	$30 Per Visit
Specialty Physician			
Office Consultation/Visits/Services by a Specialist – Including, but not limited to Ophthalmology, ENT, Cardiology, Gastroenterology, Urology, Hematology, Oncology	$25 Per Visit	$40 Per Visit	$50 Per Visit
Allergy Testing Services	$25 Per Visit	$40 Per Visit	$50 Per Visit
Chiropractic Visits (20 self referrals per contract year)	$25 Per Visit	$40 Per Visit	$50 Per Visit
Podiatric Visits (12 self referrals per contract year)	$25 Per Visit	$40 Per Visit	$50 Per Visit
Dermatological Visits (5 self referrals per contract year - for office visits and minor surgical procedures)	$25 Per Visit	$40 Per Visit	$50 Per Visit
Urgent Care Center Visit (Plan Centers) (If Available)	$25 Per Visit	$40 Per Visit	$50 Per Visit
Professional Facility – Related Services Inpatient Consultation by a Specialist Inpatient Visit – Primary Care or Specialist Inpatient Newborn Care – Primary Care or Specialist Skilled Nursing Benefits – Primary Care or Specialist Emergency Room Visits/Diagnostic Services	No Charge For Physician's Services	No Charge For Physician's Services	No Charge For Physician's Services
Injections			
Immunizations – Primary Care or Specialist	$10 PCP/$25 Specialist Per Visit	$20 PCP/$40 Specialist Per Visit	$30 PCP/$50 Specialist Per Visit
Therapeutic – Primary Care or Specialist	No Charge	No Charge	No Charge
Allergy/Immunotherapy – Primary Care or Specialist	$10 PCP/$25 Specialist Per Visit	$20 PCP/$40 Specialist Per Visit	$30 PCP/$50 Specialist Per Visit
Other Hospital Physician Services (Anesthesia Services, Inpatient Specialist Visits)	No Charge	No Charge	No Charge
FAMILY PLANNING SERVICES			
Voluntary Family Planning Counseling	Not Covered	Not Covered	Not Covered
Infertility	Not Covered	Not Covered	Not Covered
Elective Sterilization – Inpatient/Outpatient	$250 Co-pay	$250 Co-pay	$250 Co-pay
MATERNITY SERVICES (OPTIONAL RIDER)	**Optional Rider**	**Optional Rider**	**Optional Rider**
Obstetrics; Pre-Natal	$25 Co-pay; One time 15 Mo. Waiting Period.	$40 Co-pay; One time 15 Mo. Waiting Period.	$50 Co-pay; One time 15 Mo. Waiting Period.
Obstetrical; Hospital/Birthing Center (15 month Waiting Period on all Maternity Services)	$1,000 Co-pay	$1,000 Co-pay	$1,000 Co-pay
HOSPITAL SERVICES (PLAN HOSPITALS)			
Inpatient Room and Board/Ancillary services to include: Medical, Surgery, Rehabilitation	$100 Per Day/$500 Max. Per Admit (Unlimited Days)	$200 Per Day/$1000 Max. Per Admit (Unlimited Days)	$500 Per Day/$2,500 Max. Per Admit (Unlimited Days)
Diagnostic Services at a Hospital	$50 Per Visit	$80 Per Visit	$100 Per Visit
Diagnostic Services at a Freestanding Facility	$25 Per Visit	$40 Per Visit	$50 Per Visit
Outpatient Surgery at a Hospital	$100 Co-pay	$200 Co-pay	$500 Co-pay
Outpatient Surgery at an Ambulatory Surgery Center	$50 Co-pay	$100 Co-pay	$250 Co-pay
Emergency Room and Related Services (Waived if Admitted)	$100 Co-pay	$100 Co-pay	$100 Co-pay



AccessOne INDIVIDUAL HEALTHPLAN *AccessOne™ Individual Health Benefits*	***AccessOne™*** **10**	***AccessOne™*** **20A**	***AccessOne™*** **30B**
SKILLED NURSING FACILITY – INPATIENT (PLAN SNF'S) (30 Days per Contract Year)	$50 Per Day/$250 Max. Per Admit	$100 Per Day/$500 Max. Per Admit	$250 Per Day/$1250 Max. Per Admit
HOSPICE FACILITIES (PLAN FACILITIES)			
Inpatient Hospice Services	No Charge	No Charge	No Charge
Outpatient Hospice Service	No Charge	No Charge	No Charge
Home Hospice Services (210 days lifetime)	No Charge	No Charge	No Charge
REHABILITATION SERVICES – OUTPATIENT			
Outpatient Physical Therapy	$25 Per Visit	$40 Per Visit	$50 Per Visit
Outpatient Speech Therapy	$25 Per Visit	$40 Per Visit	$50 Per Visit
Outpatient Occupational Therapy	$25 Per Visit	$40 Per Visit	$50 Per Visit
(60 Visits per Contract Year combined for all therapies)			
OTHER MEDICAL SERVICES			
Ambulance Services, Emergencies / Medically Necessary	$25 Per Trip	$40 Per Trip	$50 Per Trip
Durable Medical Equipment	No Charge	No Charge	No Charge
Home Health Services (60 visits per contract year)	No Charge	No Charge	No Charge
Medical Supplies	No Charge	No Charge	No Charge
Orthotics & Prosthetics	No Charge	No Charge	No Charge
MENTAL HEALTH SERVICES			
Inpatient Mental Health Services	Not Covered	Not Covered	Not Covered
Outpatient Mental Health Services	Not Covered	Not Covered	Not Covered
SUBSTANCE ABUSE SERVICES			
Detoxification Only (Up to 5 days per incident up to 2 incidents per contract year)	$100 Per Day Per Admission	$300 Per Day Per Admission	$500 Per Day Per Admission
PRESCRIPTION DRUG SUPPLIES includes contraceptives (as outlined in Vista Healthplan of South Florida's Drug Formulary)			
Generic Prescription Drugs/30 Day Supply	$10 Co-pay,	$20 Co-pay,	$30 Co-pay
Brand Name Prescription Drugs/30 Day Supply (if generic not available)	$20 Co-pay	$35 Co-pay	$45 Co-pay
Brand Name Prescription Drugs/30 Day Supply (if generic is available)	$20 Plus difference in cost	$35 Plus difference in cost	$45 Plus difference in cost
Prescription Drug Limit	$1,200 Max./Cont. yr.	$1,200 Max./Cont. yr.	$1,200 Max./Cont. yr.
Non-formulary Drugs	$40 Co-pay	$50 Co-pay	$60 Co-pay
(** Note: Co-pays are per Prescription and Per Refill)	20% self injectables up to $250	20% self injectables up to $250	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.	Same as RX 1 formulary brand copay for a 30-day supply of each insulin prescribed and 1 formulary brand copay for diabetic supplies (test strips & lancets)	Same as RX 1 formulary brand copay for a 30-day supply of each insulin prescribed and 1 formulary brand copay for diabetic supplies (test strips & lancets)	Same as RX 1 formulary brand copay for a 30-day supply of each insulin prescribed and 1 formulary brand copay for diabetic supplies (test strips & lancets)
DENTAL SERVICES	Covered	Covered	Covered
VISION SERVICES	Covered	Covered	Covered
PRE-EXISTING WAITING PERIOD	24 months	24 months	24 months
PLAN DEDUCTIBLE	None	None	None
MAXIMUM LIFETIME BENEFITS	Unlimited	Unlimited	Unlimited
MAXIMUM OUT-OF-POCKET	$1,500.00	$2,000.00	$5,000.00

Summary of Dental Benefits

Covered Services	Member Pays
Diagnostic	
All necessary X-rays (once per year)	No Charge
Oral exam/initial visit	No Charge
Oral exam/periodic	No Charge
Vitality test	No Charge
Oral cancer exam	No Charge
Diagnostic cast	No Charge
Preventive	
Cleaning (one every six months)	No Charge
Topical application of fluoride (annually)	No Charge
Additional cleanings	$15
Sealant (per tooth)	$10
Preventive dental instructions	No Charge
Restorative (filings)	
Sedative base	No Charge
Amalgam - one surface	$10
Amalgam - two surfaces	$20
Amalgam - three surfaces	$30
Composite - one surface	$16
Composite - two surfaces	$26
Composite - three surfaces	$34
Acid etch, add	$10
Inlays - two surfaces*	$210
Inlays - three surfaces*	$225
*Gold additional	
Bonding (light cured composite):	
Including acid etch:	
One surface	$50
Two surfaces	$70
Three surfaces	$95
Laminates per tooth	$175
Crown (Caps)	
Recement inlays	No charge
Temporary crown	No charge
Crown - porcelain fused to non-precious metal	$220
Crown - porcelain fused to semi-precious metal	$245
Crown - porcelain fused to precious mental	$290
Crown - full cast	$225
Core build-up with pin (in addition to above)	$90
Core with post (in addition to above)	$90
Crown - stainless steel (primary teeth)	$50
Connection over three, each	$30
Endodontics (Root Canal)	
Pulpotomy (excluding restoration)	$20
Single root canal filling (excluding final restoration)	$125
Bi-root canal filling (excluding final restoration)	$185
Tri-root canal filling (excluding final restoration)	$280
Apicoectomy	$85
Periodontics (Gum Treatment)	
Periodontal prophylaxis (after periosurgery)	$50
Examination, treatment plan	$30
Periodontal, root planning & curettage	$225
per quadrant	$65
Gingivectomy or Gingivoplasty (includes post surgical visit) - per quadrant	$160

Covered Services	Member Pays
Periodontics (Gum Treatment)--continued	
Osseous surgery (per quadrant)	$250
Free gingival graft (per procedure)	$225
Occlusal adjustment, single treatment	$35
Occlusal adjustment, complete treatment	$160
Night guard - soft	$55
Night guard - hard	$175
Gross scaling in presence of gingival inflammation	$35
Oral Surgery	
Extraction (Simple) each tooth	No charge
Post-operative treatment	No charge
Tori removal	$50
Cyst removal (less than 5 mm)	$50
Alveolectomy (per quadrant)	$70
Impaction (soft tissue)	$45
Multiple extraction 3 or more (each)	$10
Surgical extraction	$35
Surgical extraction of residual roots	$35
Impaction (partial bony)	$65
Impaction (complete bony)	$95
Incise and drain	$25
Orthodontics (Braces)--children up to age 19 only	
Initial consultation, including examination, x-rays models and records	$85
The maximum orthodontic fee for normal 24 month fully banded case will not exceed	$2,100
Prosthodontics	
Acrylic partial (upper or lower) each	$105
Complete upper	$240
Complete lower	$240
Immediate upper or lower	$250
Cast chrome partial - upper (unlimited clasps)	$325
Cast chrome partial - lower (unlimited clasps)	$325
Cosmetic denture, upper or lower	$350
Repair broken denture (no teeth, including impression)	$35
Add or replace tooth to denture with impression	$40
Each additional tooth	$15
Add or replace tooth to denture with no impression	$18
Soft liner (additional)	$85
Denture adjustment (old)	$7
Denture cleaning	No charge
Reline upper or lower partial or complete denture (office)	$55
Reline upper or lower partial or complete denture (lab)	$85
Add clasp to existing denture/partial	$50
Soft tissue conditioner	$35
Miscellaneous	
Appointment cancellation (more than 24 hour notice)	No charge
Appointment cancellation (less than 24-hour notice) for each 15 minute unit	$10
Local anesthetic	No charge
Temporary filling	No charge
Emergency treatment (during regular office hours in addition to treatment charges)	$25
Emergency treatment (after regular office hours in addition to treatment charges)	$35

The member charges listed are valid only when treatment is performed at a participating general dental office. If the service 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%.

For more information regarding Dental Services and Providers, please call 1-800-848-3480.

V I S I O N   B E N E F I T S   C O P A Y M E N T   S C H E D U L E

BENEFITS	COPAYMENT AMOUNT
A. EXAMINATION	$19.00
B. EYEGLASSES	
Select Plan Frame	No Charge
Single Vision Lens	$20.00
Bifocal Lenses	$25.00
Trifocal Lenses	$30.00
Prescription Tint - Solid Brown C, Solid Gray C or Solid Green C	No Charge
Other upgrades are available at discounted pricing.	
C. CONTACT LENSES	
Medically Necessary Contact Lenses	
Evaluation / Fitting:	Covered in full
Non-Medically Necessary Contact Lenses	
Evaluation / Fitting:	Not Covered, however, Primary Plus Participating Providers will charge a maximum of $45.00 to Vista-SFL 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.

All eyewear outside Select Plan, daily wear and extended wear contact lenses are available at a 25% discount from the provider's usual and customary charge.

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

This Rider will be effective as of the Effective Date of the Certificate to which it is attached.
VISTA HEALTHPLAN OF SOUTH FLORIDA