



VISTA HEALTHPLAN OF SOUTH FLORIDA, INC.
Individual Health Benefits

	Focused Deductible IFD10 - 1000	Focused Deductible IFD10 - 2500	Focused Deductible IFD10 - 5000
HOSPITAL DEDUCTIBLE (applies to all inpatient & outpatient hospital services) PHARMACY DEDUCTIBLE	\$1,000 \$250	\$2,500 \$250	\$5,000 \$250
PHYSICIAN SERVICES Primary Care Physician - Primary Care Office Visits/Radiology, Lab, EKG's, - Adult Wellness Visits/Exams - Health Education	\$10 Per Visit \$10 Per Visit \$10 Per Visit	\$10 Per Visit \$10 Per Visit \$10 Per Visit	\$10 Per Visit \$10 Per Visit \$10 Per Visit
Specialty Physician - Office Consultation/Visits/Services by a Specialist	\$25 Per Visit	\$25 Per Visit	\$25 Per Visit
- Allergy Testing Services	\$25 Per Visit	\$25 Per Visit	\$25 Per Visit
- Chiropractic Visits (20 self referrals per contract year)	\$25 Per Visit	\$25 Per Visit	\$25 Per Visit
- Podiatric Visits (12 self referrals per contract year)	\$25 Per Visit	\$25 Per Visit	\$25 Per Visit
- Dermatological Visits (5 self referrals per contract year - for office visits and minor surgical procedures)	\$25 Per Visit	\$25 Per Visit	\$25 Per Visit
Urgent Care Center Visit (Plan Centers)	\$25 Per Visit	\$25 Per Visit	\$25 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	After Hospital Deduct, No Charge For Physician's Services	After Hospital Deduct, No Charge For Physician's Services	After Hospital Deduct, No Charge For Physician's Services
Injections - Immunizations – Primary Care or Specialist - Therapeutic – Primary Care or Specialist - Allergy/Immunotherapy – Primary Care or Specialist	\$10 PCP/\$25 Specialist Per Visit No Charge \$10 PCP/\$25 Specialist Per Visit	\$10 PCP/\$25 Specialist Per Visit No Charge \$10 PCP/\$25 Specialist Per Visit	\$10 PCP/\$25 Specialist Per Visit No Charge \$10 PCP/\$25 Specialist Per Visit
Other Hospital Physician Services (Anesthesia Services, Inpatient Specialist Visits)	After Hospital Deduct, No Charge	After Hospital Deduct, No Charge	After Hospital Deduct, No Charge
FAMILY PLANNING SERVICES - Voluntary Family Planning Counseling - Infertility - Elective Sterilization - at a Hospital	Not Covered Not Covered \$250 Copay After Hospital Deduct, \$250 Copay	Not Covered Not Covered \$250 Copay After Hospital Deduct, \$250 Copay	Not Covered Not Covered \$250 Copay After Hospital Deduct, \$250 Copay
MATERNITY SERVICES (OPTIONAL RIDER) (15 month Waiting Period on all Maternity Services) - Obstetrics; Pre-Natal - Obstetrical; Hospital/Birthing Center	Optional Rider \$25 Copay; One time After Hospital Deduct, \$1,000 Copay	Optional Rider \$25 Copay; One time After Hospital Deduct, \$1,000 Copay	Optional Rider \$25 Copay; One time After Hospital Deduct, \$1,000 Copay
HOSPITAL SERVICES (PLAN HOSPITALS) - Inpatient Room and Board/Ancillary services to include: Medical, Surgery, Rehabilitation - Diagnostic Services at a Hospital - Diagnostic Services at a Freestanding Facility - Outpatient Surgery at a Hospital - Outpatient Surgery at an Ambulatory Surgery Center	After Hospital Deduct, \$100 Per Day/\$500 Max. Per Admit (Unlimited Days) After Hospital Deduct, \$50 Per Visit \$25 Per Visit After Hospital Deduct, \$100 Copay \$50 Copay	After Hospital Deduct, \$100 Per Day/\$500 Max. Per Admit (Unlimited Days) After Hospital Deduct, \$50 Per Visit \$25 Per Visit After Hospital Deduct, \$100 Copay \$50 Copay	After Hospital Deduct, \$100 Per Day/\$500 Max. Per Admit (Unlimited Days) After Hospital Deduct, \$50 Per Visit \$25 Per Visit After Hospital Deduct, \$100 Copay \$50 Copay

	Focused Deductible IFD10 - 1000	Focused Deductible IFD10 - 2500	Focused Deductible IFD10 - 5000
Emergency Room and Related Services (Waived if Admitted)	\$100 Copay	\$100 Copay	\$100 Copay
SKILLED NURSING FACILITY – INPATIENT (PLAN SNF’S) (30 days per contract year)	\$50 Per Day/\$250 Max. Per Admit	\$50 Per Day/\$250 Max. Per Admit	\$50 Per Day/\$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	No Charge No Charge No Charge
REHABILITATION SERVICES – OUTPATIENT - Outpatient Physical Therapy - Outpatient Speech Therapy - Outpatient Occupational Therapy (60 Visits per contract year combined for all therapies)	\$25 Per Visit \$25 Per Visit \$25 Per Visit	\$25 Per Visit \$25 Per Visit \$25 Per Visit	\$25 Per Visit \$25 Per Visit \$25 Per Visit
OTHER MEDICAL SERVICES - Ambulance Services - Durable Medical Equipment - Home Health Services (60 visits per contract year) - Medical Supplies - Orthotics & Prosthetics	\$25 Per Trip No Charge No Charge No Charge No Charge	\$25 Per Trip No Charge No Charge No Charge No Charge	\$25 Per Trip No Charge 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	Not Covered Not Covered
SUBSTANCE ABUSE SERVICES - Detoxification Only (Up to 5 days per incident up to 2 incidents per contract year)	After Hospital Deduct, \$100 Per Day per Admission	After Hospital Deduct, \$100 Per Day per Admission	After Hospital Deduct, \$100 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 \$10 Copay \$20 Copay \$20 Plus difference in cost \$1,200 Max./Cont. yr. \$40 Copay 20% self injectables up to \$250	\$250 \$10 Copay \$20 Copay \$20 Plus difference in cost \$1,200 Max./Cont. yr. \$40 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	After Pharmacy Deduct, 1 formulary brand copay per prescription 1 formulary brand copay per month
DENTAL SERVICES	Covered	Covered	Covered
VISION SERVICES	Covered	Covered	Covered
PRE-EXISTING WAITING PERIOD	24 months	24 months	24 months
MAXIMUM LIFETIME BENEFITS	Unlimited	Unlimited	Unlimited
COPAYMENT MAXIMUM	\$1,500.00	\$1,500.00	\$1,500.00