VISTA SOUTH FLORIDA ***Individual Health Benefits***	***Preferred Choice*** *"Plan F" FI/FN* *FI – Prescription covered* *FN – Prescription not covered*	***Select Choice*** *"Plan C" C2*	***Excel Choice*** *"Plan E" ED/EN* *ED – Dental covered* *EN – Dental not covered*
PHYSICIAN SERVICES			
Primary Care Physician			
Primary Care Office Visits/Radiology, Lab, EKG's,	$10 Per Visit	$15 Per Visit	$10 Per Visit
Adult Wellness Visits/Exams - Health Education	$10 Per Visit	$15 Per Visit	$10 Per Visit
Home Visits As Necessary	$10 Per Visit	$15 Per Visit	$10 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	$25 Per Visit	$10 Per Visit
Allergy Testing Services	$25 Per Visit	$25 Per Visit	$10 Per Visit
Chiropractic Visits (12 self referrals per contract year)	$25 Per Visit	$25 Per Visit	$10 Per Visit
Podiatric Visits (12 self referrals per contract year)	$25 Per Visit	$25 Per Visit	$10 Per Visit
Dermatological Visits (5 self referrals per contract year - for office visits and minor surgical procedures)	$25 Per Visit	$25 Per Visit	$10 Per Visit
Urgent Care Center Visit (Plan Centers) (If Available)	$25 Per Visit	$15 Per Visit	$10 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	$15 Per Visit	$10 Per Visit
Therapeutic – Primary Care or Specialist	No Charge	No Charge	No Charge
Allergy/Immunotherapy – Primary Care or Specialist	$10 PCP/$25Specialist Per Visit	$15 Per Visit	$10 Per Visit
Other Professional Services			
Anesthesia Services	No Charge	No Charge	No Charge
Minor and Major Surgery Services	No Charge	No Charge	No Charge
Oral Surgery Services with Limitations	No Charge	No Charge	No Charge
FAMILY PLANNING SERVICES			
Voluntary Family Planning Counseling	$25 Per Visit	$25 Per Visit	$10 Per Visit
Infertility	Not Covered	Not Covered	Not Covered
Elective Sterilization – Inpatient/Outpatient	$200 Co-pay	$200 Co-pay	$200 Co-pay
MATERNITY SERVICES			
Obstetrics; Pre-Natal/OB Radiology/Post-Natal	$25 Per Visit, 15 Mo. Waiting Period.	$25 Per Visit, 15 Mo. Waiting Period.	Not Covered
Obstetrical; Hospital/Birthing Center (15 month Waiting Period on all Maternity Services)	$650 Co-pay, 15 Mo. Waiting Period	$850 Co-pay, 15 Mo. Waiting Period	Not Covered
HOSPITAL SERVICES (PLAN HOSPITALS)			
Inpatient Room and Board/Ancillary services to include: Medical, Surgery, Rehabilitation	$50 Per Day/$250 Max. Per Admit (Unlimited Days)	$150 Per Day/$750 Max. Per Admit (Unlimited Days)	$100 Per Day/$500 Max. Per Admit (Unlimited Days)
Outpatient Services including, but not limited to: Diagnostic Radiology, Laboratory, Neurology Ambulatory Surgery, Renal Dialysis Radiation Therapy	$25 Per Visit	$25 Per Visit	$25 Per Visit
Emergency Room and Related Services (Waived if Admitted)	$75 Co-pay	$100 Co-pay	$100 Co-pay
SKILLED NURSING FACILITY – INPATIENT (PLAN SNF'S) (100 Days per Contract Year)	No Charge	No Charge	No Charge

VISTA SOUTH FLORIDA ***Individual Health Benefits***	***Preferred Choice*** *"Plan F" FI/FN* *FI – Prescription covered* *FN – Prescription not covered*	***Select Choice*** *"Plan C" C2*	***Excel Choice*** *"Plan E" ED/EN* *ED – Dental covered* *EN – Dental not covered*
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	No Charge	No Charge	No Charge
REHABILITATION SERVICES – OUTPATIENT			
Outpatient Physical Therapy	No Charge	No Charge	No Charge
Outpatient Speech Therapy	No Charge	No Charge	No Charge
Outpatient Occupational Therapy	No Charge	No Charge	No Charge
(24 Visits per Contract Year per Therapy)			
OTHER MEDICAL SERVICES			
Ambulance Services, Emergencies/Medically Necessary	No Charge	No Charge	No Charge
Durable Medical Equipment	No Charge	No Charge	No Charge
Home Health Services (up to 4 hours per visit)	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
Inpatient Hospital Psychiatric			
Room & Board/Ancillary			
Inpatient Psychiatric Visits by Physician			
Inpatient Psychiatric Consultation by Physician			
Outpatient Mental Health Services:	Not Covered	Not Covered	Not Covered
Outpatient Psychiatric Evaluation			
Outpatient Psychiatric Therapy – Individual			
Outpatient Psychiatric Therapy – Group			
SUBSTANCE ABUSE SERVICES			
Detoxification Only (Up to 5 days per incident up to 2 incidents per contract year)	No Charge	No Charge	No Charge
PRESCRIPTION DRUG SUPPLIES			
(as outlined in Vista Healthplan of South Florida's Drug Formulary)	Plan FN (RX Not Covered) Plan FI (Inclusive)	(Inclusive)	(Inclusive)
Generic Prescription Drugs/34 Day Supply	$5 Co-pay,	$5 Co-pay	$10 Co-pay,
Brand Name Prescription Drugs/34 Day Supply (if generic not available)	$15 Co-pay	$15 Co-pay	$20 Co-pay
Brand Name Prescription Drugs/34 Day Supply (if generic is available)	$15 Plus difference in cost	$15 Plus difference in cost	$20 Plus difference in cost
Oral Contraceptives	Not Covered	Not Covered	$20 Co-pay
Prescription Drug Limit	$1,200 Max./Cont. yr.	$1,200 Max./Cont. yr.	$1,200 Max./Cont. yr.
Non-formulary Drugs	$35 Co-pay	$35 Co-pay	$40 Co-pay
(** Note: Co-pays are per Prescription and Per Refill)			
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. **Note: Insulin and diabetic supplies are the only prescription drugs covered under Plan FN.**	Same as RX 1 copay for a 34-day supply of insulin and 1 copay for diabetic supplies (test strips & lancets)	Same as RX 1 copay for a 34-day supply of insulin and 1 copay for diabetic supplies (test strips & lancets)	Same as RX 1 copay for a 34-day supply of insulin and 1 copay for diabetic supplies (test strips & lancets)
DENTAL SERVICES			
Preventative/Routine Dental Care (See Summary of Dental Benefits)	Inclusive	Inclusive	(Optional)
VISION SERVICES			
Eye Examination, Eyeglasses or Contact Lenses (See Summary of Vision Benefits)	Inclusive	Inclusive	Inclusive
PRE-EXISITNG 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	$1,500.00	$1,500.00

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.

NON-COVERED MEMBERS

All Commercial Group HMO and Point of Service members who have not selected the vision plan endorsement will receive significant discounts through our participating provider network.

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 25% 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 25% 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, opthamologist 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. N**o 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 entitled to care or 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 realizes a recovery 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.

C O P A Y M E N T S C H E D U L E

VISION BENEFITS

SEE PAGE 1, SECTION 3 FOR LIMITATIONS ON SERVICE INTERVALS

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

VISTA
SOUTH FLORIDA

DENTAL CARE IS VALUABLE

HMO DENTAL CARE ENDORSEMENT

COVERED MEMBERS

The plan covers members enrolled in the following Vista Healthplan of South Florida:

- Individual HMO Plans C and F at no additional premium;
- Individual HMO Plan E as an optional rider ; and
- Commercial Group HMO and Point of Service plans as an optional rider selected by your Employer

All you have to do is use a Participating Dental Provider.

1 CHOICE OF PROVIDERS

Plan benefits are available only through a network of dentists administered by Oral Health Services, Inc. (OHS), a prepaid limited health services organization licensed under Chapter 636, Florida Statutes. Participating Dental Providers are located in all Florida counties within Vista-SFL's HMO Service Area. This dental plan does not cover services and supplies provided by a dentist who is not an OHS 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 OHS in your area, it is subject to change as new dentists contract with OHS and some Participating dentist contracts end. The current participation status of any dentist can be obtained by calling the OHS Customer Service Department at 1-800-848-3480.

2 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.

3 HOW TO SELECT A DENTAL PLAN

To enroll, simply fill out the Vista-SFL 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-SFL at the address listed on the enrollment application. To change your dentist, simply select a new dentist from the OHS Participating Dental Provider Directory and call the OHS Customer Service Department with your change.

4 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.

5 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-SFL Your coverage under this dental plan will commence, renew and terminate consistent with the commencement, renewal and termination provisions set forth in the Member Handbook for your health plan with Vista Healthlan of South Florida.

6 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 under Workman's 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 in 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.

7 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 per quadrant	$225 $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.

Medical Exclusions and Limitations

Except as otherwise specified in your Schedule of Benefits, exclusions from coverage are as follows:

Abortion: Elective abortions (termination of pregnancy) performed at any time during a pregnancy; or services in connection with the pregnancy of eligible children; unless medically necessary as defined by the Plan; includes all related services.

Accidents / Injuries: Health care services resulting from accidental bodily injuries arising out of a motor vehicle accident, watercraft accident, aircraft accident, or any type of accident on public transportation, wherein the Member is covered under any type of insurance, private or public, regardless if the Member sues a third party for liability.

Ambulance: Ambulance services which are not medically necessary.

Amniocentesis: Amniocentesis, except when medically required to determine a genetic disorder.

Artificial aids; corrective appliances (such as braces); hearing aids; and home monitoring devices unless otherwise amended.

Athletic Event-Related: Care and treatment for injuries sustained by a Member in the course of any athletic event, or while training for such athletic event, for which the Member is to receive remuneration in cash or in kind.

Avocation or Hobby Related Activities: Care or treatment for injuries/conditions directly related to a Member's avocation/hobby that is considered to be one of high risk; including but not limited to sky-diving, operating on an all-terrain vehicle, para-sailing, bungee-jumping, scub-a-diving, operating small aircraft.

Blood/Blood Products: Whole blood, blood plasma, and blood products such as clotting factors, which are replaced.

Complications: Resulting from non-covered services, including the diagnosis or treatment of any condition which arises as a complication of a non-covered service, including but not limited to services rendered for cosmetic purposes including ear or any other body piercing, gastric bypasses, gastric stapling, breast reductions and breast implants. However, Complications of Pregnancy are covered the same as any other illness for all plans.

Contraceptives, including:

1. Diaphragms, contraceptive foams, abortifacients (i.e., medications to induce abortions) and menstrual induction medications.

2. Insertion or removal of implantable medications and devices (e.g., pain control, Norplant and other contraceptive medications and devices), drug infusion pumps and release devices.

Cosmetic Surgery: Cosmetic surgery (plastic and reconstructive), and any other service and supply to improve the Member's appearance or perception, but is not expected to significantly restore, normal bodily functions, including, but not limited to, mammary reduction or augmentation, face lifts, varicose veins, correction of baldness, gastric bypass, gastric stapling and related procedures for the treatment of obesity; includes the diagnosis or treatment which arises as a complication of a non-covered cosmetic surgery. Cosmetic implantations are excluded except when they are incident to a Medically Necessary mastectomy.

Cosmetic - Other Non-Surgical Services: Including but not limited to, ear or any other body piercing and any complications derived as a result of such service.

Counseling: Marriage or relationship counseling, services or adoption agencies, pastoral counseling, family counseling, social, occupational, religious, or other social maladjustment's; chronic behavior disorders; codependency; impulse control disorders, organic disorders, learning disabilities, hyperkenetic syndromes. This exclusion includes any prescription medications prescribed for treatment associated with any of the above conditions.

Court-Ordered Services: Court ordered care or treatment, unless otherwise covered by the Health Plan.

Criminal Activities:

1. Care and treatment incurred in connection with injuries which occurred during a crime committed by a Member or which the Member tries to commit including, without limitation, treatment and care for any injuries sustained when the Member's blood alcohol content is in excess of the legal limit whether or not the Member is charged with or convicted of any criminal offenses.

2. Care and treatment for injuries sustained while the Member is under the influence of any illegal or illicit drug, or any controlled or legend drug or substance if the drug or substance is not then subject to a valid prescription issued in the name of the Member by a Plan Physician and being administered to treat a current episode of illness.

Custodial Care: Custodial care, including any service or supply of a custodial nature primarily intended to assist the Member in the activities of daily living. This includes rest home facilities, nursing homes, skilled nursing facilities, home health aids (sitters), home mothers, domestic maid services and respite care.

Dental Care and all Dental Services: Dental Care means treatment on or to the teeth; extraction of teeth; treatment of dental abscess or granuloma; treatment of gingival tissues other than for tumors, dental examinations; and conventional or surgical orthodontics or orthognathics. Certain plans cover dental care services, as set out in the Dental Care Endorsement. These Dental Services are available only as a part of the Dental Endorsement and not provided as a part of your medical benefit. See your Schedule of Benefits and Contract to determine the availability of the separate Dental benefit. For certain plans not providing dental care services, optional dental care can be purchased at an additional premium at the time of enrollment or at renewal.

Dietary Regimens: Dietary regimens, treatments, food, food substitutes or vitamins.

Experimental Procedures: Procedures determined by the U.S. Food and Drug Administration, the American Medical Association or Health Plan's Medical Director to be experimental or investigational. The following are not included in this exclusion: (a) bone marrow transplants not considered as experimental or investigational by the American Medical Association or ADA or bone marrow transplants when the particular use of the bone marrow transplant procedure is determined to be accepted within the appropriate oncological specialty and not experimental in accordance with Section 627.4236, Florida Statutes; and (b) a drug which is not approved by the U.S. Food and Drug Administration for a particular indication is not considered to be experimental if that drug is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature in accordance with Section 641.4239, Florida Statutes.

Foot Care-Routine: Routine foot care, including any service or supply in connection with foot care in the absence of a circulatory condition; including, but not limited to, treatment of bunions, flat feet, fallen arches, and chronic foot strain, removal of warts, corns, or calluses, or trimming of toenails, unless determined by the Health Plan to be Medically Necessary.

Hearing Aids: Hearing aids (external and implantable), and services related to the fitting or provision of hearing aids, including tinnitus maskers.

Hearing enhancement services: Including but not limited to Cochlear implants.

Hypnotism or hypnotic anesthesia.

Infertility treatment, etc.

1. Services and supplies for the purpose of diagnosing the cause of infertility, including examinations, diagnostic surgical services and related hospital or facility costs in connection with such surgery, are excluded.

2. Treatment for infertility, including Pergonal (or other like drug) therapy, artificial insemination or plastic repair of the Fallopian tubes, is excluded.

3. All charges incurred for in vitro fertilization, any procedure involving combining ovum and sperm outside of the body, embryo transfers, and any services and supplies related to donor sperm or sperm preservation for artificial insemination, are excluded.

4. Services and supplies in connection with the reversal of voluntary sterilization are excluded.

5. All charges incurred by a surrogate mother whose services were contracted by or on behalf of the Subscriber, spouse or dependent. All charges incurred by the newborn of a surrogate mother are also excluded unless the newborn is enrolled under its own Vista Healthplan of South Florida AccessOne plan. See "Newborn" section.

Illegal Actions: Treatment of a condition resulting from participating in any act which would constitute a riot or rebellion, or commission of a crime punishable as a felony; includes care and treatment incurred in connection with injuries suffered in a fight in which the Member is the Aggressor or while the member is under the use of an illegal substance.

Illegal Occupation: Treatment of a condition resulting from engaging in an illegal occupation.

Immediate Relatives and Self Imposed Treatment: Charges for physicians' services imposed by an immediate relative or member of the subscriber's household, even if the bill or claim is submitted by another individual or by an entity such as a partnership or a professional corporation, are excluded from coverage. This exclusion also precludes a member that is also a physician from treating himself and submitting claims to the Plan for such coverage.

For the purpose of this exclusion, "Immediate Relative" means any of the following:

1. Husband or wife
2. Natural or adoptive parent, child or sibling
3. Stepparent, stepchild, stepbrother or stepsister
4. Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law or sister-in-law
5. Grandparent or grandchild
6. Spouse of grandparent or grandchild

Immunizations for the purpose of travel. Refer to exclusion for Physical Examination for additional exclusions.

Medical care or surgery not prescribed and recommended by a Physician; and complications resulting from such surgery or medical care.

Mental and Nervous Disorders and related prescription drugs.

Military-Related: Military service-related medical care, for which the Member is legally entitled to service from military or government facilities and for which facilities are reasonably accessible.

Not Medically Necessary: Services or supplies not medically necessary, as determined by the Health Plan.

Obesity Treatment: Also refer to Cosmetic Surgery for other related exclusions and limitations.

Obstetrical Care: Pre-Natal and post-natal obstetric care, unless otherwise covered and provided in the Schedule of Benefits.

Organ Donor: All medical and hospital services or an organ donor or prospective donor with the exception of bone marrow transplants.

Organ Harvesting: The harvesting and processing of organs or transplant.

Organ transplants except as provided under the covered services provisions.

Orthomolecular therapy, including nutrients, vitamins, and food supplements.

Personal comfort, hygiene or convenience items, including services and supplies deemed to be not Medically Necessary by the Plan and not directly related to the care of the Subscriber, including, but not limited to, beauty and barber services, radio and television, guest meals and accommodations, telephone charges, take-home supplies, massages, travel expenses other than Medically Necessary ambulance services that are specifically provided for under the Covered Services section.

Physical examinations specifically for obtaining or continuing employment or required for education, insurance, government licensing or premarital purposes, and immunizations for purposes of travel.

Radial Keratotomy: Radial keratotomies, LASIK, myopic keratomileusis, and any surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.

Self-Inflicted/Suicide: Treatment for a condition resulting from intentionally self-inflicted injuries, suicide or attempted suicide, without regard to the mental state of the Member.

Sexual Reassignment: Sexual reassignment, reproduction or modification services; including hormone therapy, intersex surgery, sexual deviations and disorders, psychosexual dysfunctions, testicular prosthesis, genetic tests to determine paternity or sex of a child; or, the insertion of a penile prosthesis, except when necessary in the treatment of organic impotencies resulting from a medical disease.

Smoking Cessation: Smoking cessation programs, including any service or supply to eliminate or reduce the dependency on or addiction to tobacco; including, but not limited to, nicotine withdrawal programs and Nicorette gum or patch.

State/Local Requirements: Care for conditions that State or local law requires to be treated in a public facility.

Specific therapies and treatments as follows: hypnotherapy; biofeedback; acupuncture; sleep therapy (including diagnosis and treatment); behavioral training; sex therapy; and hair analysis, unless used as a diagnostic tool for heavy metal poisoning.

Sterilization-Reversals: Reversal of voluntary, surgically-induced sterility, including the reversal of tubal ligations and vasectomies and complications thereof.

Substance Abuse and related prescription drugs: This contract provides coverage for Detoxification services only.

Surrogate Costs: Refer to Infertility Treatment exclusion.

Temporomandibular Joint Syndrome (TMJ): Treatment for or prevention of TMJ unless under accepted medical standards, treatment is medically necessary to treat conditions caused by congenital or developmental deformity, disease, or injury.

Transportation Services: Transportation Services that are non-emergency transportation between institutional care facilities, or to and from the Member's residence.

Vision Services: Corrective lenses and eyeglasses, and the professional fee for fitting same. Certain plans cover vision services, as set out in the Vision Benefit Endorsement. See the appropriate Schedule of Benefits to determine the benefits and limitations unique to the plan variation you are enrolled in.

Vocational rehabilitation.

War-Related Treatment: Treatment of a condition resulting, from war or an act of war, whether declared or not.

Weight Control/Loss: Weight control and weight loss programs; including, but not limited to food supplements, appetite suppressants, dietary regimens or treatments, exercise programs or equipment, gastric stapling, gastric bypass, liposuction and related procedures for the treatment of obesity, surgical or invasive treatment including gastric balloon, or reversal thereof, including treatment of the complications resulting from surgical treatment of obesity; regardless of associated medical or psychological conditions.

Work-Related Treatment: Care and treatment for any injury, illness, or condition which arises out of, or in the course of, any occupation for wage or for-profit, any injury, illness, or condition for which the Member is entitled to receive benefits under any Workers' Compensation policy law, employer's liability policy, or any similar policy.

Prescription Drug Exclusions and Limitations

Refer to the Prescription Drug Endorsement for specific coverage information, exclusions and limitations. Prescription drugs related to non-covered medical services are also excluded from coverage, including but not limited to Mental and Nervous Disorders.

Mental and Nervous Disorders

Services for Mental and Nervous Disorders are excluded from coverage.

Alcoholism and Drug Dependency

Services for Alcoholism and Drug Dependency are excluded from coverage except for detoxification. Refer to your Schedule of Benefits for benefit limitations.

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SOUTH FLORIDA

QUESTIONS?

If you have questions about your AccessOne's Individual Health Plan, call

1-800-441-5501

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