

Vista Healthplan of South Florida

<http://www.vistahealthplan.com>

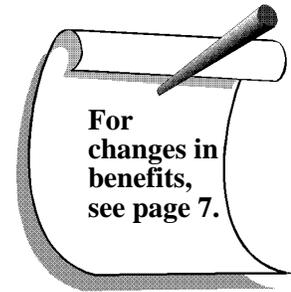


2007

A Health Maintenance Organization

Serving: South Florida (Broward, Miami-Dade and Palm Beach counties)

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 6 for requirements.



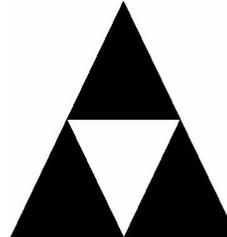
Important Special Notice for All Current Enrollees Concerning the Prescription Drug Benefits

Our coverage for high technology and self administered medication has changed. We cover these medications under Tier 4. You will pay 20% of the negotiated rate for Tier 4 medication up to the out-of-pocket maximum of \$100 per member per month. The annual out-of-pocket maximum is \$1,200 per member. Please read your brochure carefully so that you are aware of important benefit changes.

Enrollment code for this Plan:

5E1 High Option – Self Only

5E2 High Option – Self and Family



Accredited by

Accreditation Association
for Ambulatory Health Care, Inc.

This Plan has a three-year accreditation from Accreditation Association for Ambulatory Health Care, Inc. (AAAHC). See the 2006 Guide for more information on accreditation.

Authorized for distribution by the:



**United States
Office of Personnel Management**
Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

**Important Notice from Vista Healthplan of South Florida About
Our Prescription Drug Coverage and Medicare**

OPM has determined that the Vista Healthplan of South Florida prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and will coordinate benefits with Medicare.

Remember: If you are an annuitant and you terminate your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You may also have to wait until the next open enrollment period to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of Vista Healthplan of South Florida, Inc. under our contract (CS 2715) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Vista Healthplan of South Florida, Inc. administrative offices is:

Vista Healthplan of South Florida, Inc.
1340 Concord Terrace
Sunrise Florida 33323

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2007, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2007, and changes are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means Vista Healthplan of South Florida, Inc.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) forms that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 1-800-441-5501 and explain the situation.

If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC20415-1100

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That’s about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
 - Exactly what will you be doing?
 - About how long will it take?
 - What will happen after surgery
 - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications you are taking.

Visit these Web sites for more information about patient safety.

- www.ahrq.gov/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1 Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us. How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments.

Preventive care services

Preventive care services are generally paid as first dollar coverage or after a small deductible or copayment. First dollar coverage may be limited to a maximum dollar amount each year.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive care services.

Your rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Vista Healthplan of South Florida, Inc. is a for-profit entity and has been operational since 1984.
- Vista Healthplan of South Florida received a three-year accreditation from the Accreditation Association for Ambulatory Health Care, Inc.
- Vista Healthplan of South Florida, Inc., is licensed by the Florida Financial Services Commission.

If you want more information about us, call 1-800-441-5501, or write to Customer Service, Vista Healthplan of South Florida, Inc., 1340 Concord Terrace, Sunrise, Florida 33323. You may also contact us by fax at 954-846-8873 or visit our Web site at www.vistahealthplan.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area covers South Florida – Broward, Miami-Dade and Palm Beach counties.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. Reciprocity arrangements do not exist in any other Vista Healthplan of South Florida, Inc. networks. If you or a family member moves, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2 How we change for 2007

Do not rely on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to this Plan

- Your share of the non-Postal premium will decrease by 9.3% for Self Only or 9.3% for Self and Family. See Back Cover.
- We have reduced the Primary Care Physician office visit copay from \$20 to \$15. See Section 5 Benefits.
- Your facility copay for outpatient surgical procedures in a hospital setting has increased from \$50 to \$100, after you have satisfied an annual deductible of \$250 for hospital services. See page 28.
- We have added a 4th tier to the prescription drug benefits and you must pay 20% coinsurance up to the \$100 out-of-pocket maximum per member per month for drugs that fall into this tier. The annual out-of-pocket maximum is \$1,200 for Tier 4 medication per member. See Section 5(f) Prescription Drug Benefits for information.

Section 3 How you get care

Identification cards	<p>We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.</p> <p>If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-441-5501 or write to us at Vista Healthplan of South Florida, Attn: Customer Service, 1340 Concord Terrace, Sunrise, Florida 33323. You may also request replacement cards through our Web site at www.vistahealthplan.com.</p>
Where you get covered care	<p>You get care from “Plan providers” and “Plan facilities.” You will only pay copayments and deductibles.</p>
<ul style="list-style-type: none">• Plan providers	<p>Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.</p> <p>We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.</p>
<ul style="list-style-type: none">• Plan facilities	<p>Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site.</p>
What you must do to get covered care	<p>It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. Call us at 1-800-441-5501 or visit our website at www.vistahealthplan.com to select a primary care physician.</p>
<ul style="list-style-type: none">• Primary care	<p>Your primary care physician can be a family practitioner, general practitioner, internist or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.</p> <p>If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.</p>
<ul style="list-style-type: none">• Specialty care	<p>Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see:</p> <ul style="list-style-type: none">• <i>Gynecologists and Obstetricians</i>• <i>Podiatrists</i>• <i>Chiropractor</i>• <i>Dermatologists (up to 5 visits per year)</i>• <i>Mental Health / Substance Abuse providers</i>• <i>Optometrists (for annual eye exam)</i> <p>Here are some other things you should know about specialty care:</p>

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
 - Reduce our service area and you enroll in another FEHB Plan,

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

• **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

• **If you are hospitalized when your enrollment begins**

If you are in the hospital when your enrollment in our Plan begins, call our Customer Service Department immediately at 1-800-441-5501. If you are new to the FEHB Program, we will arrange for you to receive care and reimburse you for your covered expenses while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

Services requiring our prior approval

Your primary care physician has authority to refer you for most consultative services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process “Prior Approval”. Your physician must obtain prior approval for the following services:

- Ambulance transport (non-emergent)
- Air ambulance
- Ambulatory surgery
- Bariatric surgery
- Colonoscopy / endoscopy
- Cosmetic surgery
- DME customized
- Enhanced external counter pulsation
- Hospice care
- Hospital admission
- Hospital outpatient services (All) including outpatient diagnostics
- Hyperbaric treatments
- Infertility assessment and treatment
- Lab work (outpatient) not done through Quest
- Non-participating provider referrals
- Oral surgery
- Out-of-area service (non-emergent)
- Pain management in a facility
- PET scan
- Prosthetics / braces / orthotics
- Rehabilitation facility – inpatient admission
- Rehabilitation therapy (PT, OT, ST)
- Skilled nursing facility admission
- Sclerotherapy for varicose veins
- Tier 4 high technology and self-administered drugs
- Transplant evaluations
- Transplants
- Wound care center
- Wound care

Your participating primary care physician will contact the Prior Authorization Unit for you. You may wish to call your physician’s office to make sure this has been done.

Section 4 Your costs for covered services

This is what you will pay out-of-pocket for covered care.

Copayments

A member's share of costs for covered services, usually paid to the attending or contracting provider at the time the care is rendered. When a copayment is expressed as a percentage, the copayment is based on a percentage of the applicable negotiated rate.

Example of a fixed copayment: When you see your primary care physician, you pay a copayment of \$15 per office visit and when you go in the hospital, you pay \$150 per day for the first 3 days after the \$250 annual calendar year deductible per member has been met.

Example of a percentage based copayment: Under the prescription drug benefits, you pay 20% of the negotiated rate for Tier 4 prescription drugs up to no more than the \$100 per month out-of-pocket maximum per member.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying for them. Each person must satisfy a \$250 calendar year deductible for all services provided in a hospital setting. There is no limit to the number of deductibles under Self and Family enrollment. This deductible does not apply to emergency room services.

Coinsurance

We do not have coinsurance.

Your catastrophic protection out-of-pocket maximum

After your copayments total \$1,500 per Self only or \$3,000 per Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for prescription drugs do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for them.

You have a separate out-of-pocket maximum for Tier 4 covered prescription medication. The monthly out-of-pocket maximum is \$100 per person. The annual out-of-pocket maximum is \$1,200 per person per calendar year. After you have satisfied the monthly out-of-pocket, you no longer have to pay anything additional for covered Tier 4 drugs during that month. After you reach the annual out-of-pocket maximum, you no longer pay anything additional during that year for Tier 4 covered medication.

Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.

Section 5 Benefits

We describe our benefits package in Section 5. Please read the important things you should keep in mind at the beginning of each subsection. Also, read the General Exclusions in Section 6 because they apply to the benefits in the following subsections. See page 7 for how our benefits changed this year. Page 59 is a benefits summary of the coverage. To obtain claim forms, claims filing advice, or more information about our benefits, you may contact us at 1-800-441-5501 or visit our web site at www.vistahealthplan.com.

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Protection against catastrophic costs (annual out-of-pocket maximum):Some costs do not count toward this protection	58

**Section 5(a) Medical services and supplies
provided by physicians and other health care professionals**

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Each member must satisfy a calendar year deductible of \$250 for all services billed by a hospital except emergency services. Facility copayments also apply to surgical services that appear in this section but are performed in an ambulatory surgical center or in the outpatient department of a hospital.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOUR PHYSICIAN MUST GET PRIOR APPROVAL OF CERTAIN SERVICES.** Please refer to the prior approval information shown in Section 3 to be sure which services require preauthorization.

Benefit Description	You pay After the calendar year deductible...
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>	
Diagnostic and treatment services	
High Option	
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office 	\$15 per office visit to your primary care physician or \$30 per office visit to a specialist
Professional services of physicians <ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility • Office medical consultations 	Nothing
<ul style="list-style-type: none"> • Second surgical opinion 	Nothing if performed by a Plan physician or 40% of usual and customary charges if performed by a non-Plan physician.
<ul style="list-style-type: none"> • In an urgent care center 	\$30 per urgent care center visit
At home	\$15 per visit from your primary care physician or \$30 per visit from a specialist
Lab, X-ray and other diagnostic tests	
High Option	
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI 	\$15 per office visit to your primary care physician or \$30 per office visit to a specialist Nothing when performed at a participating freestanding laboratory or radiology center Note: These services are subject to the annual deductible when performed in a hospital. See Section 5(c).

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay After the calendar year deductible...
Lab, X-ray and other diagnostic tests (cont.)	High Option
<ul style="list-style-type: none"> • Ultrasound • Electrocardiogram and EEG 	<p>\$15 per office visit to your primary care physician or \$30 per office visit to a specialist</p> <p>Nothing when performed at a participating freestanding laboratory or radiology center</p> <p>Note: These services are subject to the annual deductible when performed in a hospital. See Section 5(c).</p>
Preventive care, adult	High Option
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening , including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 	<p>\$15 per office visit to your primary care physician or \$30 per office visit to a specialist</p> <p>Nothing for laboratory tests performed at a participating freestanding laboratory</p> <p>Note: The \$250 annual deductible applies to services performed in a hospital. Facility copayments also apply to surgical procedures performed in a free-standing surgery center or hospital. See Section 5(c) for more information.</p>
<ul style="list-style-type: none"> • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older 	<p>\$15 per office visit to your primary care physician or \$30 per office visit to a specialist</p> <p>Nothing for laboratory tests performed at a participating freestanding laboratory</p>
<ul style="list-style-type: none"> • Routine pap test • Routine Chlamydia screening <p>Note: You do not have a separate office visit copay for a pap test performed during your routine annual exam.</p>	<p>\$15 per office visit to your primary care physician or \$30 per office visit to a specialist</p>
<p>Routine mammogram – covered for women age 35 and older, as follows:</p> <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 49, one every two years or more frequently based upon a physician’s recommendations • At age 50 and older, one every year 	<p>Nothing</p> <p>Note: These services are subject to the annual deductible when performed in a hospital. See Section 5(c).</p>
<p>Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):</p> <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older 	<p>Nothing</p>

Benefit Description	You pay After the calendar year deductible...
Preventive care, adult (cont.)	High Option
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</i>
Preventive care, children	High Option
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	Nothing
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: • Eye exams through age 17 to determine the need for vision correction • Hearing exams through age 17 to determine the need for hearing correction • Examinations done on the day of immunizations (up to age 22) 	Nothing
Maternity care	High Option
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care and Postnatal care • Delivery <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 28 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. <p>We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).</p>	<p>\$15 per office visit to your primary care physician or \$30 per office visit to a specialist</p> <p>Nothing for physician delivery services</p> <p>Note: We waive the physician office visit copay for routine maternity care after your initial visit to confirm pregnancy.</p> <p>Note: The annual deductible and inpatient or outpatient hospital copay will apply to hospital services. Refer to Section 5(c) for information on facility copayments.</p>
<i>Not covered: Routine sonograms to determine fetal age, size or sex.</i>	<i>All charges.</i>

Benefit Description	You pay After the calendar year deductible...
Family planning	High Option
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Surgically implanted contraceptive s • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p> <ul style="list-style-type: none"> • Voluntary sterilization (e.g., tubal ligation or vasectomy) <p>Note: See Surgical procedures Section 5 (b) for information.</p>	<p>\$15 per office visit to your primary care physician or \$30 per office visit to a specialist</p> <p>\$200 copayment</p> <p>Note: We will apply the \$250 annual deductible per person and the appropriate facility copay to surgical procedures performed in an ambulatory surgery center or hospital. See Section 5(c) for information on the facility charges.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling</i> 	<p><i>All charges.</i></p>
Infertility services	High Option
<p>Diagnosis and treatment of infertility such as:</p> <p>Artificial insemination:</p> <ul style="list-style-type: none"> • intravaginal insemination (IVI) • intracervical insemination (ICI) • intrauterine insemination (IUI) 	<p>\$15 per office visit to your primary care physician or \$30 per visit to a specialist</p>
<p>Not covered:</p> <p>Assisted reproductive technology (ART) procedures, such as:</p> <ul style="list-style-type: none"> • in vitro fertilization • embryo transfer, gamete intra-fallopian transfer (GIFT) • Zygote intra-fallopian transfer (ZIFT) <p>Services and supplies related to ART procedures</p> <ul style="list-style-type: none"> • Drugs to treat infertility • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<p><i>All charges.</i></p>

Benefit Description	You pay After the calendar year deductible...
Allergy care	High Option
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections • Allergy serum 	<p>\$15 per office visit to your primary care physician or \$30 per office visit to a specialist</p> <p>Nothing</p>
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges.</i>
Treatment therapies	High Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 25.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy <p>Note: We cover growth hormone therapy under Tier 4 of the prescription drug benefits. Please see page 35. You pay 20% of the negotiated rate for all Tier 4 medication. We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>\$15 per office visit to your primary care physician or \$30 per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Chelation therapy</i> • <i>Any furniture, plumbing, electrical or other fixtures to perform dialysis at home.</i> 	<i>All charges.</i>
Physical and occupational therapies	High Option
<p>60 visits per calendar year; no less than 2 consecutive months of therapy for each condition for each of the following services:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p>	<p>\$30 per office visit</p> <p>Nothing per visit during covered inpatient admission</p> <p>Note: The annual deductible and facility copayments apply to services billed by a hospital.</p>

Physical and occupational therapies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Physical and occupational therapies (cont.)	High Option
<p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 100 sessions.</p>	<p>\$30 per office visit</p> <p>Nothing per visit during covered inpatient admission</p> <p>Note: The annual deductible and facility copayments apply to services billed by a hospital.</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • <i>Exercise programs</i> • <i>Pulmonary rehabilitation</i> 	<p><i>All charges.</i></p>
Speech therapy	High Option
<p>60 visits per calendar year; no less than 2 consecutive months of therapy for each condition.</p>	<p>\$30 per office visit</p> <p>Nothing per visit during covered inpatient admission.</p> <p>Note: The annual deductible and facility copayments apply to services billed by a hospital.</p>
Hearing services (testing, treatment, and supplies)	High Option
<ul style="list-style-type: none"> • Hearing diagnostic and treatment services for disease and/or medical conditions • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17, which include; (see <i>Preventive care, children</i>) 	<p>\$15 per office visit to your primary care physician or \$30 per visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>All other hearing testing</i> 	<p><i>All charges.</i></p>
Vision services (testing, treatment, and supplies)	High Option
<ul style="list-style-type: none"> • Annual eye refractions, including written lens prescription Note: See Preventive care, children for eye exam to determine the need for vision correction through age 18. 	<p>\$19 per office visit at a participating optometrist or \$30 per office visit to a specialist</p>
<p>Eyeglasses (one pair each calendar year from the VISTA South Florida Standard collection at a participating provider)</p> <ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Standard Select Plan Frames (preselected collection) 	<p>\$20 per office visit to a specialist</p> <p>Nothing</p>
<ul style="list-style-type: none"> • Single vision lenses • Bifocal lenses 	<p>\$20</p> <p>\$25</p>

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay After the calendar year deductible...
Vision services (testing, treatment, and supplies) (cont.)	High Option
<ul style="list-style-type: none"> • Trifocal lenses Contact Lenses <ul style="list-style-type: none"> • Medically necessary contact lenses (evaluation and fitting) in lieu of eyeglasses • Daily wear contact lenses (Bausch & Lomb, Biomedics) • Extended wear contact lenses (Bausch & Lomb) • Disposable lenses (2 boxes of all clear spherical lens) • All eyewear (including contact lenses) outside of the Standard Select plan (preselected collection) • Eye exam to determine the need for vision correction for children through age 18 (see Preventive care, children) 	\$30 Nothing \$10 \$15 \$48 Retail cost minus 25% discount \$15 per office visit to your Primary Care Physician or \$30 per office visit to a specialist
Not covered: <ul style="list-style-type: none"> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> 	<i>All charges.</i>
Foot care	High Option
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	\$15 per office visit to your primary care physician or \$30 per visit to a specialist
Not covered: <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<i>All charges.</i>
Orthopedic and prosthetic devices	High Option
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices , such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. See note below. 	Nothing

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible...
Orthopedic and prosthetic devices (cont.)	
<ul style="list-style-type: none"> • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See Section 5(b) for coverage of the surgery to insert the device. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Prosthetic replacements provided less than 3 years after the last one we covered</i> • <i>Penile Implants</i> • <i>Wigs</i> 	<i>All charges</i>
Durable medical equipment (DME)	
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen; • Dialysis equipment; • Hospital beds; • Wheelchairs (standard model necessary to meet your needs); • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps. <p>Note: Call us at 1-800-441-5501 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Motorized wheelchairs unless medically necessary to meet the minimum functional requirements of the member 	<i>All charges.</i>

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible...
Durable medical equipment (DME) (cont.)	High Option
<ul style="list-style-type: none"> • More than one device for the same body part or more than one piece of equipment that serves the same function • Spare or alternate use devices • Adjust, repair or maintenance of devices which are worn or damaged as a result of abuse • Replacement of lost devices • Exercise equipment and bicycles • Elevators and chair lifts, plus home and automobile modifications • <i>Air conditioners, humidifiers, dehumidifiers, air purifiers, pillows, whirlpools, spas, jacuzzis, and saunas</i> • <i>Any equipment that does not serve a medical purpose</i> 	<i>All charges.</i>
Home health services	High Option
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. <p>Note: See Section 5(a) Diagnostic and Treatment Services for the amount you pay for physician visits in the home.</p> <ul style="list-style-type: none"> • Services include oxygen therapy, intravenous therapy and medications. 	Nothing
<p>Not covered:</p> <ul style="list-style-type: none"> • Nursing care requested by, or for the convenience of, the patient or the patient's family; • <i>Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> 	<i>All charges.</i>

Benefit Description	You pay After the calendar year deductible...
Chiropractic	High Option
<ul style="list-style-type: none"> • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	\$30 per office visit
<i>Not covered: All services and deemed medically necessary.</i>	<i>All Charges.</i>
Alternative treatments	High Option
Biofeedback – limited to the treatment of migraine and muscle contraction headaches	\$30 per office visit
<p>Not covered:</p> <ul style="list-style-type: none"> • Naturopathic services • Hypnotherapy • <i>Biofeedback, except as shown above</i> • <i>Acupuncture</i> 	<i>All charges.</i>
Educational classes and programs	High Option
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Smoking cessation – one smoking cessation program per member per calendar year • Diabetes self management • Disease management programs 	Nothing

Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The calendar year deductible is \$250 per person for all services provided in a hospital setting except emergency services.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. We will also apply a facility copay to surgical services that appear in this section but are performed in an ambulatory surgical center or in the outpatient department of a hospital. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible...
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>	
Surgical procedures	High Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Insertion of internal prosthetic devices . See 5(a) – Orthopedic and prosthetic devices for device coverage information • Treatment of burns <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>\$15 per office visit to your primary care physician or \$30 per visit to a specialist</p> <p>Nothing for the physician’s charge for surgery</p> <p>Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The \$250 annual deductible applies to all services billed by a hospital.</p>
<ul style="list-style-type: none"> • Voluntary sterilization (e.g., tubal ligation, vasectomy) 	<p>\$200 copayment</p>

Benefit Description	You pay After the calendar year deductible...
Surgical procedures (cont.)	High Option
<ul style="list-style-type: none"> Surgical treatment of morbid obesity (bariatric surgery) <p>Note: You must satisfy all of the following criteria in order for us to consider the surgery:</p> <ul style="list-style-type: none"> Body mass Index (BMI) of 40 or more or a BMI of 35 if co-morbidities exist; 18 years old or have documentation of completion of Bone Growth; Failed attempted weight loss under the direction of MD or Presurgical weight loss regime; Pre-operative psychological evaluation. <p>Note: Bariatric surgery requires our prior approval. See <i>Services requiring our prior approval</i> on page 10.</p>	<p>Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The \$250 annual deductible applies to all services billed by a hospital.</p> <p>\$15 per office visit to your primary care physician or \$30 per visit to a specialist</p> <p>Nothing for the physician's charge for surgery</p> <p>Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The \$250 annual deductible applies to all services billed by a hospital.</p>
<p>Not covered:</p> <ul style="list-style-type: none"> <i>Reversal of voluntary sterilization</i> <i>Routine treatment of conditions of the foot; see Foot care</i> 	<p><i>All Charges.</i></p>
Reconstructive surgery	High Option
<ul style="list-style-type: none"> Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. Surgery to correct a functional defect. Surgery to correct a condition caused by injury or illness, if: <ul style="list-style-type: none"> the condition produced a major effect on the member's appearance and the condition can reasonably be expected to be corrected by such surgery All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> surgery to produce a symmetrical appearance of breasts; treatment of any physical complications, such as lymphedemas; breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) 	<p>\$15 per office visit to your primary care physician or \$30 per visit to a specialist</p> <p>Nothing for the physician's charge for surgery</p> <p>Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The \$250 annual deductible applies to all services billed by a hospital.</p>

Benefit Description	You pay After the calendar year deductible...
Reconstructive surgery (cont.)	High Option
<p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>\$15 per office visit to your primary care physician or \$30 per visit to a specialist</p> <p>Nothing for the physician's charge for surgery</p> <p>Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The \$250 annual deductible applies to all services billed by a hospital.</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All Charges.</i></p>
Oral and maxillofacial surgery	High Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	<p>\$15 per office visit to your primary care physician or \$30 per visit to a specialist</p> <p>Nothing for the physician's charge for surgery</p> <p>Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The \$250 annual deductible applies to all services billed by a hospital.</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<p><i>All charges.</i></p>
Organ/tissue transplants	High Option
<p>Solid organ transplants limited to:</p> <p>Cornea</p> <p>Heart</p> <p>Heart/lung</p> <p>Kidney</p> <p>Liver</p> <p>Pancreas</p>	<p>\$15 per office visit to your primary care physician or \$30 per visit to a specialist</p> <p>Nothing for the physician's charge for surgery</p> <p>Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The \$250 annual deductible applies to all services billed by a hospital.</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	High Option
Kidney/Pancreas Lung: Single/double Intestinal transplants <ul style="list-style-type: none"> • Small intestine • Small intestine with the liver • Small intestine with multiple organs, such as the liver, stomach, and pancreas 	\$15 per office visit to your primary care physician or \$30 per visit to a specialist Nothing for the physician's charge for surgery Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The \$250 annual deductible applies to all services billed by a hospital.
Blood or marrow stem cell transplants limited to the stages of the following diagnoses (medical necessity is considered satisfied if a patient meets the staging description). Allogeneic transplants for <ul style="list-style-type: none"> • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Chronic myelogenous leukemia • Severe combined immunodeficiency • Severe or very severe aplastic anemia Autologous transplants for <ul style="list-style-type: none"> • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced neuroblastoma • Advanced non-Hodgkin's lymphoma Autologous tandem transplants for <ul style="list-style-type: none"> • recurrent germ cell tumors (including testicular cancer) 	\$15 per office visit to your primary care physician or \$30 per visit to a specialist Nothing for the physician's charge for surgery Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The \$250 annual deductible applies to all services billed by a hospital.
Blood or marrow stem cell transplants limited to the following conditions: Allogeneic transplants for <ul style="list-style-type: none"> • Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) Autologous transplants for <ul style="list-style-type: none"> • Multiple myeloma • Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors • Breast cancer 	\$15 per office visit to your primary care physician or \$30 per visit to a specialist Nothing for the physician's charge for surgery Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The \$250 annual deductible applies to all services billed by a hospital.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none"> • Epithelial ovarian cancer 	<p>\$15 per office visit to your primary care physician or \$30 per visit to a specialist</p> <p>Nothing for the physician's charge for surgery</p> <p>Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The \$250 annual deductible applies to all services billed by a hospital.</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • <i>Implants of artificial organs</i> • <i>Transplants not specifically listed as covered</i> 	<p><i>All Charges</i></p>
Anesthesia	High Option
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center 	<p>Nothing</p> <p>Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The \$250 annual deductible applies to all services billed by a hospital.</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Office 	<p>\$15 per office visit to your primary care physician or \$30 per visit to a specialist</p> <p>Note: See Section 5(c) for information on the applicable facility copayment and annual deductible. The \$250 annual deductible applies to all services billed by a hospital.</p>

Section 5(c) Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- All services provided in a hospital setting are subject to a \$250 annual calendar deductible per member. You also owe the applicable facility copayment as indicated.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Note: The calendar year deductible applies only when we say below: “(calendar year deductible applies)”.	
Inpatient hospital	High Option
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	\$150 per day for the first three (3) days per admission, after you have satisfied a \$250 calendar year deductible
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Administration of blood and blood products • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	Nothing after the inpatient hospital admission copay and \$250 annual calendar year deductible
Not covered: <ul style="list-style-type: none"> • Custodial care 	<i>All Charges</i>

Inpatient hospital - continued on next page

Benefit Description	You pay
Hospice care	
<p>Hospice care: up to 210 days per lifetime</p> <p>The Plan covers supportive and palliative care for a terminally ill member. Coverage is provided in the home or a hospice facility. Services include inpatient, outpatient care and family counseling; these services are provided under the direction of a Plan physician who certifies that the patient is in terminal stages of illness, with a life expectancy of approximately six months or less.</p>	Nothing
<p><i>Not covered: Independent nursing, homemaker services</i></p>	<p><i>All Charges.</i></p>
Ambulance	
<ul style="list-style-type: none"> • Local professional ambulance service when medically appropriate • Air Ambulance limited to situation where ground transportation is not medically appropriate – prior plan authorization required. <p>Note: See 5(c) for non-emergency service.</p>	Nothing

Section 5(d) Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We do not have a calendar year deductible for emergency services.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

If you are in an emergency situation, please call your primary doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours unless it is not reasonably possible to do so. It is your responsibility to ensure that the Plan has been notified timely.

If you need to be hospitalized, the Plan must be notified within 48 hours or the first working day following your admission, unless it is not reasonably possible to notify the Plan in that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with ambulance charges covered in full.

Emergencies within our service area: Benefits are available for care from non-Plan provider in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Emergencies outside our service area: Benefits are available for any medically necessary service that is immediately required because of injury because of injury of unforeseen illness.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan in that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefit Description	You pay After the calendar year deductible...
Emergency within our service area	High Option
<ul style="list-style-type: none"> Emergency care at a doctor’s office 	\$15 per visit to primary care physician / \$30 per visit to specialist
<ul style="list-style-type: none"> Emergency care at an urgent care center 	\$30 per visit
<ul style="list-style-type: none"> Emergency care as an outpatient or inpatient at a hospital, including doctors’ services <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	\$100 per visit (waived if admitted)
<i>Not covered: Elective care or non-emergency care</i>	<i>All Charges.</i>
Emergency outside our service area	High Option
<ul style="list-style-type: none"> Emergency care at a doctor’s office 	\$15 per visit to PCP / \$30 per visit to Specialist
Emergency care at an urgent care center	\$30 per visit
Emergency care as an outpatient at a hospital, including doctors’ services Note: We waive the ER copay if you are admitted to the hospital.	\$100 per hospital emergency room visit (waived if admitted)
<p>Not covered:</p> <ul style="list-style-type: none"> Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All Charges.</i>
Ambulance	High Option
<ul style="list-style-type: none"> Professional ambulance service when medically appropriate. Air Ambulance limited to situation where ground transportation is not medically appropriate – prior plan authorization required. <p>Note: See 5(c) for non-emergency service.</p>	Nothing

Section 5(e) Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- All services provided in a hospital setting are subject to a \$250 deductible per member per year. Daily copayments for inpatient hospital admissions and other the facility charges may also apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible...
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>	
Mental health and substance abuse benefits	High Option
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$15 per office visit to your primary care physician and \$30 per office visit to a specialist</p>
<ul style="list-style-type: none"> • Diagnostic laboratory tests • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>\$15 per office visit to your primary care physician and \$30 per office visit to a specialist</p> <p>Nothing when performed at a participating free-standing laboratory center</p> <p>After the \$250 annual deductible, nothing for services performed and billed by a hospital</p> <p>\$150 per day for the first three (3) days per admission, after you have satisfied a \$250 calendar year deductible</p>
<p>Not covered: Services we have not approved.</p>	<p><i>All Charges.</i></p>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible...
Mental health and substance abuse benefits (cont.)	High Option
<i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i>	<i>All Charges.</i>

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:

Prior to seeking mental health and substance abuse treatment, you must call Psych/Care at 1-800-221-5487. Psych/Care is a managed behavioral health care firm with over 500 providers in our service area. You do not need a referral from your primary care physician or authorization from us. A Psych/Care provider will evaluate you and develop a treatment plan.

Once the treatment plan has been approved, you must follow it. If you need inpatient care, your Psych/Care provider will arrange it for you. Call Psych/Care for a list of participating providers in your area.

Limitation

We may limit your benefits if you do not obtain a treatment plan.

Section 5(f) Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Certain drugs require prior authorization from us. Your physician must obtain our prior authorization for certain drugs and all Tier IV high technology and self-administered drugs.
- We do not have a calendar year deductible for prescription drugs.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a participating pharmacy. Please see the complete listing of participating pharmacies in our provider directory.
- **We use a formulary.** The formulary is a list of medications, both brand and generic, that we approve as covered medication. Plan pharmacies dispense prescription medication to our members based on our formulary list. However, we cover non-formulary drugs prescribed by a Plan doctor. You must pay a higher copay for non-formulary drugs. Our formulary has 4 tiers of prescription drug coverage. Tier 1 includes low cost generic formulary drugs. Tier 2 includes brand name formulary drugs. Tier 3 includes high cost, mostly brand name non-formulary drugs that usually have generic or brand name alternatives in Tiers 1 or 2. Tier 4 includes high technology and self-administered drugs, including growth hormone. Tier 4 drugs require our prior authorization. If you'd like a copy of our formulary, please call 1-800-441-5501.
- **Plan pharmacies will dispense a generic when a generic is available and substitution is allowed by law unless your physician specifically requires a name brand drug.** When generic substitution is medically appropriate but you insist on the name brand drug, you will pay the difference in price between the name brand drug and generic drug in addition to the applicable name brand formulary or non-formulary copay.
- **These are the dispensing limitations.** You may obtain a 30-day supply at a Plan pharmacy or a 90-day supply via mail order. Mail order is available for maintenance medications only. A 90-day vacation supply may also be obtained from a Plan pharmacy once a year. Plan pharmacies will not dispense refills in excess of the number specified by the physician or refill medication more than 12 months after the original date of the prescription. You may obtain a refill up to 6 days before your prescription runs out. A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand drug. When your physician requires a name brand drug, the physician must specify "Dispense as Written" on the prescription or you will have to pay the difference in cost between the name brand drug and the generic.
- **Prior authorization process for medication other than self-injectable drugs.** Our prescription drug formulary is based on the principles of providing and promoting safe, efficacious and cost-effective medications for our members. In order to monitor drug therapy duplication, abuse, misuse, and interactions, we administer a prior authorization (PA) requirement for certain drugs. Our prior authorization program operates in the following manner.

We provide our participating physicians with a list of medications that require our prior authorization before they can be dispensed by a Plan pharmacy. Your Plan physician must complete and submit a PA form to VISTA to begin the authorization process. If you try to fill the prescription at a pharmacy and we have not authorized the medication, the pharmacist will advise you that your physician must obtain prior authorization for the medication before it can be dispensed. Your physician should call 1-866-VISTA-RX (1-866-847-8279) to obtain a PA form and must complete and fax it to 954-858-3386. If PA is urgent and you need the medication immediately, the physician can call the Rx phone number and speak to a VISTA clinical pharmacist during office hours. After office hours, pharmacies can call VISTA's round-the-clock Pharmacy Benefit Manager at 1-800-Rx-Argus to obtain an authorization for a one-time 7-day supply of a non-formulary medication.

- **Prior authorization process for self-injectable drugs.** The prior approval process for requesting self-injectable medication is very similar to PA for other medication. The only difference is that the prescription must be filled by a Specialty Pharmacy. The physician completes a request form and faxes it to the Specialty Pharmacy and the specialty pharmacy forwards it to VISTA’s Pharmacy Department for approval. If you have any questions about the prior authorization process, please contact 1-800-441-5501.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you – and us – less than a name brand prescription.
- **When you do have to file a claim.** There are no claims to file when you use a Plan pharmacy or our mail order program. If you have an emergency while outside our service area, and you fill a prescription at a non-Plan pharmacy, you must submit a claim for reimbursement. We will reimburse up to the amount we would have paid if you had used a plan pharmacy.
- **If you are a military reservist called to active duty or are a member requiring a supply of medication during a national emergency,** call us at 1-866-847-8279 for assistance with obtaining your medication.

Benefit Description	You pay After the calendar year deductible...
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Covered medications and supplies	High Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Disposable needles and syringes for the administration of covered medications • Diabetic supplies, including insulin syringes, needles, glucose test tablets, test strips, and solution • Drugs for sexual dysfunction • Contraceptive drugs and devices <p>Note: Drugs for sexual dysfunctions have special dispensing limits and guidelines. Please contact us for details. These drugs are not available under our mail-order program.</p> <ul style="list-style-type: none"> • High technology and select self-injectable specialty pharmacy medications including but not limited to: Amevive; Apokyn; Aranesp; Copegus; Enbrel; EpiPen Auto-injector; Epogen; Forteo; Fuzeon; glucagon; Humira; Pegasus; Raptiva; Somatropin; Ventavis; and Xolair. 	<p>Retail Pharmacy (up to 30-day supply per prescription unit or refill):</p> <p>\$20 Tier 1 generic formulary; \$40 Tier 2 name brand formulary; and \$60 Tier 3 non-formulary</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name or non-formulary copay.</p> <p>Plan’s Mail-Order Pharmacy (up to a 90-day supply of maintenance medication):</p> <p>\$60 Tier 1 generic formulary; \$120 Tier 2 name brand formulary; and \$180 Tier 3 non-formulary</p> <p>Retail Pharmacy (up to a 30-day supply)</p> <p>Tier 4 – 20% of negotiated rate up to \$100 per prescription per member per month</p> <p>Note: These drugs require prior authorization and are not available from our mail-order pharmacy.</p>

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies (cont.)	High Option
<p>Note: Tier 4 drugs require our prior authorization. The list above is not all inclusive and subject to change as we periodically review and update the list of medications. Please contact us to verify if your drug is on Tier 4. These drugs have specific characteristics such as: usually injectable; high in cost; and require special handling and special training to use.</p> <ul style="list-style-type: none"> • Drugs for smoking cessation (combined with all smoking cessation services) 	<p>Retail Pharmacy (up to a 30-day supply)</p> <p>Tier 4 – 20% of negotiated rate up to \$100 per prescription per member per month</p> <p>Note: These drugs require prior authorization and are not available from our mail-order pharmacy.</p> <p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs for the treatment of infertility</i> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines</i> • <i>Drugs given to you while you are a patient in a hospital, skilled nursing facility, convalescent hospital, hospice or other facility where drugs are ordinarily provided by the facility to its patients.</i> • <i>Refills in excess of the number specified by the physician or refills dispensed more than 12 months after the original date of the prescription</i> • <i>Drugs provided to you by this Plan, but which are lost, stolen, or destroyed</i> • <i>Drugs for the treatment of obesity, unless medically necessary for the treatment of morbid obesity</i> 	<p><i>All Charges.</i></p>

Section 5(g) Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Services for deaf and hearing impaired	<p>If you are hearing or speech impaired and use a telephone device for the deaf, you may call 1-888-444-7352 Monday through Friday from 8 a.m. to 6 p.m.</p>
High risk pregnancies	<p>Vista Healthplan of South Florida offers a dedicated OB Case Management unit, coordinating and monitoring all phases of care through the member's pregnancy.</p>
Centers of excellence for transplants	<p>Vista Healthplan of South Florida utilizes the Special Risk International (SRI) Network for transplants. SRI centers are utilized on a case by case basis. SRI has centers of excellence nationwide for various transplants.</p>
Worksite wellness programs	<p>Vista Healthplan of South Florida offers screenings, health fairs and seminars that encourage appropriate immunizations, examinations and public awareness for members and their families. The following screenings are available to members: Colds & Flu, Depression, Diabetes, High Blood Pressure, Lowering Cholesterol, Men's Health, Pregnancy & STD Protection, Physical Fitness, Smoking Cessation, Stress Management, Women's Health, Weight Management and Vision Health.</p>
Case Management programs and services	<p>Vista Healthplan of South Florida offers members state-of-the-art Case Management programs and services as an important dimension of care, helping you and your doctor make sure you have all the support you need under these circumstances. These programs include: Complex Care, Discharge Planning, Obstetrical Care, Pediatric Care, Transplant Care and Ventilator Program.</p>
Disease State Management (DSM) programs	<p>Vista Healthplan of South Florida offers members with certain chronic diseases can find additional assistance through our DSM programs. The following DSM programs are currently available for members: Asthma, Diabetes and Congestive Heart Failure.</p>

Section 5(h) Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay
Accidental injury benefit	High Option
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	\$30 per office visit

Dental benefits

We have no other dental benefits.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums.

Over-the-Counter Value Added Benefit

VISTA offers more value for your healthcare dollars by offering \$120 on over-the-counter products, such as cough medicine, bandages, sunscreen and much more. Limited to a \$10 value per subscriber per month. Choose from over 160 items ordered completely through the mail at no additional cost to you.

VISTA Better Living Fitness Program

The VISTA Better Living Program is designed to empower individuals to take a more active role in their personal health. VISTA members can choose a healthier lifestyle through VISTA's partnership with Axia Health Management.

- **Free Fitness Club Membership**

- Members receive a free basic membership at participating fitness clubs, including over 500 clubs across Florida. Membership provides access to amenities and services offered at selected center.

- **My ePHIT®**

- Members receive access to My ePHIT®, an online and telephone coaching health and wellness program designed to engage individuals in activities promoting physical fitness, healthy eating habits and behavioral management.

- **QuitNet®**

- Members receive access to QuitNet® Comprehensive, an online behavioral support program to help people quit smoking.

LASIK Surgery services at Preferred Rates

Direct access to affordable vision correction is available for plan members* who are nearsighted or have astigmatism and wear glasses or contacts. The LASIK procedure is performed at substantially reduced fees by a contracted network of participating board certified ophthalmologists experienced in LASIK.

Expanded Dental Care***

- Available to all enrolled members.

- Additional premiums of \$116.40 Employee only, \$221.28 Employee +1, and \$301.68 Employee + family. These premiums are annual premiums.

- Application required.

- Most diagnostic and preventive services provided at no charge when received from participating general dentists. Other services including restorative care, endodontics, periodontics, prosthodontics, oral surgery, as provided by participating general dentists, are offered at copayments listed in the separate plan description. When you receive services from a participating specialist, you will receive a 25% discount off of their charges.

VISTA Better Living CAM Program

With the VISTA Better Living Complementary Alternative Medicine Program, you and covered family members have access to receive discounts of up to 30% for various alternative therapies through American WholeHealth Network (AWHN) of practitioners. Call American WholeHealth's customer service department at 1-877-438-0416.

Medicare Advantage

VISTA offers Medicare Advantage plans to individuals who live in Miami-Dade, Broward, and Palm Beach counties and are entitled to Medicare Part A and enrolled in Medicare Part B. VISTA's Medicare Advantage plans have all the benefits of Original Medicare plus additional benefits that Original Medicare does not offer including prescription drugs, hearing and vision screenings, routine foot care, dental services and over-the-counter vitamins. VISTA's Medicare Advantage plans also offer a value added fitness club incentive. Benefits, premiums and copayments vary by county. If you are Medicare eligible, you may enroll in a VISTA Medicare Advantage plan at any time during the year. For more information call 1-800-826-1013 Monday through Friday from 9 a.m to 5 p.m. or TDD 1-888-444-7352 if you are hearing or speech impaired.

*** Employee wishing to enroll in Expanded Dental plan must enroll with Vista Healthplan of South Florida HMO plan.

Section 6 General exclusions – things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies you receive without charge while in active military service; or
- Services provided to you without charge or that would normally be provided without charge if you were not covered under this Plan or under any other insurance, and care rendered by your immediate family members.

Section 7 Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copay, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 1-800-441-5501.

When you must file a claim – such as for services you received outside the Plan’s service area – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member’s name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to:

Vista Healthplan of South Florida, Inc.
Attn: FEHB Claims Department
P.O. Box 459011
Sunrise, Florida 33345-9011

Prescription drugs

You do not file claims when you use Plan pharmacies or the plan’s mail order service to fill your prescriptions. You use your identification card and pay the appropriate copay. If you fill a prescription at a non-Plan pharmacy in an emergency, you must submit a Pharmacy Reimbursement Form for reimbursement. Include your itemized prescription receipt from the pharmacy along with your cash register receipt showing the amount you paid and explain why you filled the prescription at a non-Plan pharmacy. Pharmacy Reimbursement forms may be obtained by calling our Customer Service Department at 1-800-441-5501.

Submit your reimbursement form to:

Vista Healthplan of South Florida, Inc.
PO Box 459011
Sunrise, FL 33345-9011

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond.

Section 8 The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3.

1

Ask us in writing to reconsider our initial decision. You must:

a) Write to us within 6 months from the date of our decision; and

b) Send your request to us at:
Vista Healthplan of South Florida
Grievance and Appeal
1340 Concord Terrace
Sunrise, Florida 33323

c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

2

We have 30 days from the date we receive your request to:

a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or

b) Write to you and maintain our denial - go to step 4; or

c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

3

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

4

If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group x, 1900 E Street, NW, Washington, DC 20415-xxxx.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5

OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-441-5501 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9 Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under any other health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age or older;
- Some people with disabilities under 65 years of age; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.

Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

• Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It’s easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 1-800-441-5501 or see our Web site at www.vistahealthplan.com.

We waive some costs if the Original Medicare Plan is your primary payer – We will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by physicians and other health care professionals.

We do not waive any costs if the Original Medicare Plan is your primary payer.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)** When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you?	The primary payer for the individual with Medicare is?	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
5) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓ *	
B. When you or a covered family member?		
1) Have Medicare solely based on end stage renal disease (ESRD) and • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you?		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10 Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 11.
Contracting Medical Group (CMG)	A partnership, corporation, association, Independent Practice Association, medical group or other legal entity which has entered in a service arrangement (or arrangements), with licensed physicians or other health care providers, a majority or all of whom are licensed to practice medicine, and which has a written agreement with us to arrange for the provision of covered services to our members.
Copayment	A copayment is a fixed amount of money or a percentage of the negotiated rate that you pay when you receive covered services. See page 11.
Covered services	Medically necessary medical, surgical, hospital, and other services or supplies rendered by Contracting Providers, and Emergency Services and Care and supplies provided by non-Contracting Providers, which are specified as being covered in this brochure.
Custodial care	Services to support and generally maintain the patient's condition, provide for the patient's comfort or ensure the manageability of the patient. Custodial care that lasts 90 days or more is sometimes known as Long Term Care.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 11.
Experimental or investigational service	Services, supplies, drugs and procedures, which have not demonstrated to be safe, effective, medically appropriate for use in the treatment of illness or injury. Also include service supplies, drugs and procedures that are determined to be the subject of clinical trial.
Group health coverage	Services which are necessary and appropriate for the treatment of an illness or injury according to professionally recognized standards of practice and are consistent with Vista Healthplan of South Florida, Inc. medical policies.
Medical necessity	Services which are necessary and appropriate for the treatment of an illness or injury according to professionally recognized standards of practice and are consistent with Vista Healthplan of South Florida, Inc. medical policies.
Negotiated Rate	The rate of compensation for a particular covered service, payable on a fee-for-service or per diem basis, which Vista Healthplan of South Florida pays to the Contracting Provider providing the covered service, or where the provider is paid by the CMG, the rate paid to the provider by the CMG.
Primary Care Physician (PCP)	Any contracting physician who has the responsibility for providing initial and primary care to Members, maintaining the continuity of patient care, initiating referral for specialist care, and who is listed in the current Contracting Provider Directory for your area as a PCP.
Prior Authorization	The requirement that a Member's attending physician requests approval of coverage from us prior to the member obtaining certain Covered Services.
Us/We	Us and We refer to Vista Healthplan of South Florida.

Usual and Customary

The usual charge is that price normally charged, for a given service or supply, by a health care provider to the provider's private patients. A charge is customary when it is within the range of usual prices charged by health care providers of similar training and experience, for the same service or supply within the same specific and limited geographic area, as determined by us through a professional review process.

You

You refers to the enrollee and each covered family member.

Section 11 FEHB Facts

Coverage information

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2007 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2006 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

When FEHB coverage ends

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

Upon divorce

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

Converting to individual coverage

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12 Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB Program.

Second, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Third, the new **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, offers a variety of dental plans and vision plans to anyone who is eligible to enroll in the Federal Employees Health Benefits Program. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents. Premiums are on an enrollee-pays-all basis

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program (FLTCIP)**?

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses.

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum annual election of \$5,000.

- **Health Care FSA (HCFSA)** – Pays for eligible health care expenses for you and your dependents which are not covered or reimbursed by FEHBP coverage or other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed, by FEHBP or FEDVIP coverage or other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

What expenses can I pay with an FSAFEDS account?

For the HCFSA and LEX HCFSA – Health plan copayments, deductibles, over-the-counter medications and products, sunscreen, eyeglasses, contacts, other vision and dental expenses (but not insurance premiums).

For the LEX HCFSA – Dental and vision care expenses (but not insurance premiums)

For the DCFSA – daycare expenses (including summer camp) for your child(ren) under age 13, dependent care expenses for dependents unable to care for themselves

AND MUCH MORE! Visit www.FSAFEDS.com

Who is eligible to enroll?

Most Federal employees in the Executive branch and many in non-Executive branch agencies are eligible. For specifics on eligibility, visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., EST. TTY: 1-800-952-0450.

When can I enroll?

If you wish to participate, you must make an election to enroll each year by visiting www.FSAFEDS.com or calling the number above during the FEHB Open Season or within 60 days of employment (for new employees).

Even if you enrolled for 2006, you must make a new election to continue participating in 2007. Enrollment DOES NOT carry over from year to year.

Who is SHPS?

SHPS is the Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is BENEFEDS?

BENEFEDS is the name of the voluntary benefits portal hired by OPM to work with the FSAFEDS Program to set up payroll deductions for FSAFEDS allotments.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

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Summary of benefits for the High Option of Vista Healthplan of South Florida, Inc. - 2007

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the \$250 calendar year deductible.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$15 primary care; \$30 specialist	14
Services provided by a hospital:*		
• Inpatient	\$150 per admission copay for the first 3 days after \$250 annual calendar year deductible has been met.	28
• Outpatient	\$50 copay per outpatient surgery when performed at a freestanding participating facility. \$100 copay at a participating hospital after \$250 annual calendar year deductible has been met.	29
Emergency benefits:		
• In-area	\$30 per urgent care center visit or \$100 per hospital emergency room visit	31
Mental health and substance abuse treatment:*	Regular cost sharing	33
Prescription drugs:		35
• Retail pharmacy (up to 30-day supply)	\$20 Tier 1 generic formulary/ \$40 Tier 2 brand name formulary / \$60 Tier 3 non-formulary / 20% Tier 4 specialty drugs	
• Mail order (90-day supply)	Three times the retail pharmacy copay for Tier 1, Tier 2, and Tier 3 medications	
Dental care: Accidental injury coverage only	No benefit.	39
Vision care:	\$19 copay for eye exam and various copays/ discounts on frames and lenses	19
Annual eye refraction and other vision care services		
Special features:	Flexible benefits option; Services for deaf and hearing impaired, High risk pregnancies, Centers of excellence for transplants, Case Management programs and Disease State Management programs	38

Protection against catastrophic costs (annual out-of-pocket maximum):	\$1,500/Self Only enrollment or \$3,000/Family enrollment for medical care and	11
Some costs do not count toward this protection	\$1,200 per person for Tier 4 prescription medication	

2007 Rate Information for Vista Healthplan of South Florida, Inc.

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable FEHB Guide.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	5E1	\$ 94.07	\$ 31.35	\$203.81	\$ 67.93	\$111.31	\$ 14.11
High Option Self and Family	5E2	\$258.73	\$ 86.24	\$560.58	\$186.86	\$306.16	\$ 38.81