



# STATE OF FLORIDA HEALTH INVESTOR HEALTH PLAN

## EFFECTIVE 1/1/10

<b>DEDUCTIBLES AND BENEFIT LIMITS</b>	<b>COVERED PERSON'S FINANCIAL RESPONSIBILITY</b>
<b>Health Savings Account (HSA)</b> –Employer contribution for active employees only	\$500 – Individual \$1,000 – Family
<b>Annual Deductible</b> – Aggregate family deductible	\$1,250 – Individual \$2,500 – Family
Coinsurance	20%
Coinsurance Maximum	\$3,000 – Individual \$6,000 – Family
Lifetime Maximum	Unlimited
<b>INPATIENT CARE</b>	
Inpatient hospital care for illness, injury or maternity, Newborn care, Semi-private room and Misc. Hospital Services, Intensive Care Unit or Similar Unit,	20% coinsurance
Pre-Admission testing	
In-Hospital Physician's Services	20% coinsurance
Newborn Nursery Care (when infant has been pre-enrolled)	20% coinsurance
<b>OUTPATIENT CARE</b>	
Primary Care Provider Office Visit	20% coinsurance
Specialist Office Visit	20% coinsurance
Surgical Care in Outpatient Provider facility	20% coinsurance
Rehabilitation (limited to an aggregate of 60 visit per incident)	20% coinsurance
Non-Surgical Back Treatment (Chiropractic Visit)	20% coinsurance
<b>PREVENTIVE MEDICAL CARE</b>	
Well-Baby Care	\$0
Annual Physical	\$0
Annual Well Woman's Assessment when performed by your PCP	\$0
Annual Well Woman's Assessment when performed by a Specialist	\$0
<b>EMERGENCY / URGENT CARE SERVICES</b>	
Hospital Emergency Room – Contract Facility	20% coinsurance
Hospital Emergency Room – Non-Contract Facility	20% coinsurance
Ambulance Services	20% coinsurance
Non-scheduled Urgent Care at FHCP Affiliated Urgent Care Center	20% coinsurance
Nonscheduled MD Office Visit	20% coinsurance

**COVERED PERSON'S  
FINANCIAL  
RESPONSIBILITY**

**DEDUCTIBLES AND BENEFIT LIMITS**

**MENTAL AND NERVOUS DISORDERS**

Outpatient Visits	20% coinsurance
Inpatient	20% coinsurance

**ALCOHOL AND DRUG ABUSE TREATMENT**

Outpatient Visits	20% coinsurance
Inpatient	20% coinsurance

**SKILLED NURSING FACILITY**

Limited to 60 days per calendar year. Skilled criteria must be met.	20% coinsurance
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**OTHER COVERED SERVICES**

Autism Spectrum Disorder (limited to \$36,000 annually and may not exceed \$200,000 total benefits)	20% coinsurance
Home Health Care	20% coinsurance
Durable Medical Equipment and Supplies	20% coinsurance
Orthotics / Prosthetics	20% coinsurance
Radiation Therapy	20% coinsurance

**FORMULARY PRESCRIPTION DRUGS (including insulin) – Up to a 30 day supply**

FHCP/Walgreen Generic	30% (after deductible)
FHCP/Walgreen Preferred Brand Name	30% (after deductible)
FHCP/Walgreen Non-Preferred Brand Name	50% (after deductible)

**FORMULARY SELF-INJECTABLES (excluding insulin) – Up to a 30 day supply**

FHCP Generic	30% (after deductible)
FHCP Preferred Brand Name	30% (after deductible)
FHCP Non-Preferred Brand Name	50% (after deductible)

**FORMULARY PRESCRIPTION DRUGS / MAIL ORDER (including insulin) – Up to a 90 day supply**

FHCP Generic	30% (after deductible)
FHCP Preferred Brand Name	30% (after deductible)
FHCP Non-Preferred Brand Name	50% (after deductible)