

STATE OF FLORIDA HEALTH INVESTOR HEALTH PLAN EFFECTIVE 1/1/11

**For Further Information Call Your Account Executive at FHCP Marketing Department
at 386.676.7110 or 1.800.232.0578**

DEDUCTIBLES AND BENEFIT LIMITS	COVERED PERSON'S FINANCIAL RESPONSIBILITY
Health Savings Account (HSA) –Employer contribution for active employees only	\$500 – Individual \$1,000 – Family
Annual Deductible – Aggregate family deductible	\$1,250 – Individual \$2,500 – Family
Coinsurance	20%
Coinsurance Maximum	\$3,000 – Individual \$6,000 – Family
Lifetime Maximum	Unlimited
INPATIENT CARE	
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
OUTPATIENT CARE	
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
Lab Tests	Covered in Full
PREVENTIVE MEDICAL CARE - Services covered only during well visit and only as appropriate for gender, age, ethnicity, medical condition, and as recommended by standardized national guidelines	
Well-Baby Care & Child Health Supervision Visits	Covered In Full
Annual Adult Physical Health Screening	Covered in Full
Annual Well Woman's Assessment	Covered in Full
Other Preventive Services (includes screening mammogram, screening colonoscopy, and immunizations)	Covered in Full
EMERGENCY / URGENT CARE SERVICES	
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)