

STATE OF FLORIDA BENEFITS SCHEDULE

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

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, Pre-Admission testing	\$250 per Admission
In-Hospital Physician's Services	Covered in Full
Newborn Nursery Care (when infant has been pre-enrolled)	Covered in Full

OUTPATIENT CARE

Primary Care Provider Office Visit	\$20 copay/visit
Specialist Office Visit	\$40 copay/visit
Surgical Care in Outpatient Provider facility	None
Rehabilitation (limited to an aggregate of 60 visit per incident)	\$25 copay/visit
Non-Surgical Back Treatment (Chiropractic Visit)	\$25 copay/visit
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	\$100 copay/visit (waived if admitted)
Hospital Emergency Room – Non-Contract Facility	\$100 copay/visit
Ambulance Services	Covered in Full
Non-scheduled Urgent Care at FHCP Affiliated Urgent Care Center	\$25 copay/visit
Nonscheduled MD Office Visit	\$25 Copay/visit

MENTAL AND NERVOUS DISORDERS

Outpatient Visits	\$25 copay/visit
Inpatient	\$250 per Admission

ALCOHOL AND DRUG ABUSE TREATMENT

Outpatient Visits	\$25 copay/visit
Inpatient	\$250 per Admission

SKILLED NURSING FACILITY

Limited to 60 days per calendar year. Skilled criteria must be met.	Covered in Full
---	-----------------

OTHER COVERED SERVICES

Autism Spectrum Disorder (limited to \$36,000 annually and may not exceed \$200,000 total benefits)	\$25 copay/visit
Home Health Care	Covered in Full
Durable Medical Equipment and Supplies	Covered in Full
Orthotics / Prosthetics	Covered in Full
Radiation Therapy	Covered in Full

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

FHCP/Walgreen Generic	\$7
FHCP/Walgreen Preferred Brand Name	\$30
FHCP/Walgreen Non-Preferred Brand Name	\$50

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

FHCP Generic	\$7
FHCP Preferred Brand Name	\$30
FHCP Non-Preferred Brand Name	\$50

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

FHCP Generic	\$14
FHCP Preferred Brand Name	\$60
FHCP Non-Preferred Brand Name	\$100