

# Schedule of Benefits

Lake County BOCC	BlueCare HMO <i>Amount Member Pays</i>
<b>Out-of-Pocket Maximum</b> <i>All Copays including Rx Copays accumulate to the Out of Pocket Maximum. Per Individual / Per Family</i>	
In-Network	\$2,000 / \$4,000
Out-of-Network	Not Covered
<b>Lifetime Maximum (LTM)</b>	\$2,000,000
<b>Office Services</b>	
<b>Office visits</b>	
In-Network Family Physician/PCP	\$20
In-Network Specialist	\$35
Out-of-Network	Not Covered
<b>Diagnostic Services</b>	
<i>Radiology, laboratory, pathology, approved machine testing (e.g., electrocardiogram [EKG]).</i>	
In-Network Family Physician/PCP	\$0 Lab & X-ray; \$20 Diagnostic Testing
In-Network Specialist	\$0 Lab & X-ray; \$35 Diagnostic Testing
Out-of-Network	Not Covered
<b>Maternity</b> (due at initial visit only)	
In-Network Specialist	\$20
Out-of-Network	Not Covered
<b>Allergy Injections</b>	
In-Network	\$0
Out-of-Network	Not Covered
<b>Hospital/Surgical</b>	
<b>Ambulatory Surgical Center</b>	
In-Network	\$200
Out-of-Network	Not Covered
<b>Inpatient Hospital Facility Services</b> (per admit) <i>Maximum \$1,000 per admission</i>	
In-Network	\$200/day for days 1-5
Out-of-Network	Not Covered
<b>Outpatient Hospital Facility Services</b> (per visit)	
In-Network	\$200
Out-of-Network	Not Covered
<b>Preventive Care</b>	
<b>Adult Wellness Annual Benefit Maximum</b>	
	Unlimited
<b>Routine Adult Physical Exams and Immunizations</b>	
In-Network Family Physician/PCP*	\$20
In-Network Specialist	\$35
Out-of-Network	Not Covered
<b>Mammograms</b>	
<i>Member cost; in- and out-of-network</i>	
	\$0
<b>Well Woman Exam</b> (e.g., Annual GYN)	
In-Network Family Physician/PCP*	\$20
In-Network Specialist	\$35
Out-of-Network	Not Covered
<b>Well Child</b>	
In-Network Family Physician/PCP*	\$0
In-Network Specialist	\$35
Out-of-Network	Not Covered
<b>Prescription Drugs</b>	
<b>Retail (31 days)</b>	
Generic/Preferred Brand/Non-Preferred/	\$15 / \$25 / \$40
<b>Mail Order (90 days)</b>	
Generic/Preferred Brand/Non-Preferred	\$30 / \$50 / \$80
<b>Emergency Medical Care</b>	
<b>Urgent Care Centers</b>	
In-Network	\$30
Out-of-Network	Not Covered
<b>Emergency Room Facility Services</b> (per visit; waived if admitted)	
In-Network	\$100
Out-of-Network	\$100



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<b>Ambulance</b> Ground/Air & Water per day max In-Network Out-of-Network	No Maximum \$0 \$0
<b>Outpatient Diagnostic Services</b>	
<b>Diagnostic Lab &amp; X-ray at a Free Standing Facility</b> In-Network <b>Out-of-Network</b>	\$15 Not Covered
<b>Advanced Imaging Services at a Hosp or Free Standing Facility</b> (MRI, CT, Endoscopy, stress tests) In-Network Out-of-Network	\$200 Not Covered
<b>Independent Clinical Lab</b> In-Network Out-of-Network	\$0 Not Covered
<b>Mental Health and Substance Abuse</b>	
<b>Mental Health</b> – Calendar Year Max (CYM) Inpatient Hospital Facility Services (per admit) In-Network Out-of-Network Outpatient Office Visit (20 visits CYM) In-Network Family Physician/PCP In-Network Specialist Out-of-Network	30 days/20 visits \$200 copay per day up to \$1,000 per admission Not Covered Not Applicable \$25 Copay Not Covered
<b>Substance Dependency Care &amp; Treatment (LTM)</b> <i>Detox Only</i> Inpatient Hospital Facility Services (per admit) In-Network Out-of-Network <b>Outpatient Office Visit</b> (20 visits CYM) In-Network Family Physician/PCP In-Network Specialist Out-of-Network	\$200 copay per day up to \$1,000 per admission Not Covered Not Applicable \$15 Not Covered
<b>Other Provider Services</b>	
<b>Provider Services at Hospital and ER</b> In-Network Out-of-Network	\$0 Not Covered
<b>Radiology, Pathology, Anesthesiology Provider Services at an Ambulatory Surgical Center</b> In-Network Out-of-Network	\$0 Not Covered
<b>Home Health Care (CYM)</b> In-Network Out-of-Network	40 Visits \$0 Not Covered
<b>Spinal Manipulations (CYM)</b> In-Network Out-of-Network	\$500 or 18 visits \$0 copay Not Covered
<b>Outpatient Rehab</b> 62 consecutive days per condition (Massage, Occupational, Speech, Physical Therapies) In-Network Out-of-Network	\$20 Not Covered
<b>Skilled Nursing Facility (CYM)</b> In-Network Out-of-Network	90 days \$0 Not Covered
<b>Hospice (LTM)</b> In-Network Out-of-Network	Unlimited \$0 Not Covered
<b>Durable Medical Equipment, Prosthetics and Orthotics</b> In-Network Out-of-Network	\$0 Not Covered

**This is not an insurance contract or Benefit Booklet.** The above Benefit Summary is only a partial description of the many benefits and services covered by Blue Cross and Blue Shield of Florida, Inc., an independent licensee of the Blue Cross and Blue Shield Association. For a complete description of benefits and exclusions, please see Blue Cross and Blue Shield of Florida's Benefit Booklet and Schedule of Benefits; their terms prevail.

