Schedule of Benefits for 10-1-2014 thru 9-30-15

Lake County Board of County Commissioners #64550

The Lake County Board of County Commissioners believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueChoice 730 PPO	BlueCare 15 HMO
Deductible (DED) (Per Person/Family Agg)		
In-Network	$750 / $2,250	Not Applicable
Out-of-Network	Combined w/In-Ntwk	
Coinsurance (Member Responsibility)		
In-Network	20%	Not Applicable
Out-of-Network	40%	
Out of Pocket Maximum (Per Person/Family Agg)	Includes only Coins; Excludes Rx	Includes all Copays (including Rx)
In-Network	$2,000 / $6,000	$2,000 / $4,000
Out-of-Network	Combined w/In-Ntwk	Not Applicable
Lifetime Maximum	No Maximum	No Maximum
PROFESSIONAL PROVIDER SERVICES		
Allergy Injections (for testing, see place of service)		
In-Network Family Physician	$0	$0
In-Network Specialist	$0	$0
Out-of-Network	DED + 40%	Not Covered
E-Office Visit Services		
In-Network Family Physician	$20	$20
In-Network Specialist	$35	$35
Out-of-Network	DED + 40%	Not Covered
Office Services		
In-Network Family Physician	$20	$20
In-Network Specialist	$35	$35
Out-of-Network	DED + 40%	Not Covered
Provider Services at Hospital and ER		
In-Network Family Physician	DED + 20%	$0
In-Network Specialist	DED + 20%	$0
Out-of-Network	DED + 40%	Not Covered
Provider Services at Other Locations		
In-Network Family Physician	DED + 20%	$0
In-Network Specialist	DED + 20%	$0
Out-of-Network	DED + 40%	Not Covered
Radiology, Pathology and Anesthesiology Provider Services at Hospital or Ambulatory Surgical Center		
In-Network Specialist	DED + 20%	$0
Out-of-Network	DED + 40%	Not Covered
PREVENTIVE CARE		
Adult Wellness Office Services		
In-Network Family Physician	$20	$20
In-Network Specialist	$35	$35
Out-of-Network	40% (No DED)	Not Covered
Colonoscopies (Routine) With diagnosis, subject to applicable deductible, coinsurance or copays based on location of service.		
In-Network	$0	$0
Out-of-Network	40% (No DED)	Not Covered
Mammograms (Routine and Diagnostic)		
In-Network	$0	$0
Out-of-Network	$0	Not Covered
Well Child Office Visits (No BPM)**		
In-Network Family Physician	$0	$0
In-Network Specialist	$0	$0
Out-of-Network	40% (No DED)	Not Covered

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueChoice 730 PPO	BlueCare 15 HMO
EMERGENCY/URGENT/CONVENIENT CARE		
Ambulance	No Maximum (per day)	No Maximum (per day)
In-Network	DED + 20%	$0
Out-of-Network	In-Ntwk DED + 20%	$0
Convenient Care Centers (CCC)		
In-Network	$15	$20
Out-of-Network	DED + 40%	Not Covered
Emergency Room Facility Services (also see Professional Provider Services)		
In-Network	$50	$100
Out-of-Network	$50	$100
Urgent Care Centers (UCC)		
In-Network	$20	$30
Out-of-Network	DED + 40%	Not Covered
FACILITY SERVICES - HOSP/SURG/ICL/IDTF Unless otherwise noted, physician services are in addition to facility services. See Professional Provider Services.		
Ambulatory Surgical Center		
In-Network	DED + 20%	$200
Out-of-Network	DED + 40%	Not Covered
Independent Clinical Lab		
In-Network (Quest Labs)	20% (No DED)	$0
Out-of-Network	40% (No DED)	Not Covered
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)		
In-Network - Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine)	$35	$0
In-Network - Other Diagnostic Services (e.g. X-ray)	$35	$15
Out-of-Network	DED + 40%	Not Covered
Inpatient Hospital (per admit)		
In-Network	DED + 20%	$200 per Day up to $1,000
Out-of-Network	DED + 40%	Not Covered
Outpatient Hospital (per visit)		
In-Network	DED + 20%	$200
Out-of-Network	DED + 40%	Not Covered
Therapy at Outpatient Hospital		
In-Network	DED + 20%	$20
Out-of-Network	DED + 40%	Not Covered
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Hospitalization		
In-Network	DED + 20%	$200 per Day up to $1,000
Out-of-Network	DED + 40%	Not Covered
Outpatient Hospitalization (per visit)		
In-Network	DED + 20%	$200
Out-of-Network	DED + 40%	Not Covered
Provider Services at Hospital and ER		
In-Network Family Physician or Specialist	$0	$0
Out-of-Network Provider	$0	$0 at ER Not Covered at Hospital
Physician Office Visit		
In-Network Family Physician or Specialist	$20 / $35	$20 / $35
Out-of-Network Provider	DED + 40%	Not Covered
Emergency Room Facility Services (per visit)		
In-Network	$50	$100
Out-of-Network	$50	$100
Provider Services at Locations other than Hospital and ER		
In-Network Family Physician	DED + 20%	$0
In-Network Specialist	DED + 20%	$0
Out-of-Network Provider	DED + 40%	Not Covered
OTHER SPECIAL SERVICES AND LOCATIONS		
Advanced Imaging Services in Physician's Office		
In-Network Family Physician	$20	$0
In-Network Specialist	$35	$0
Out-of-Network	DED + 40%	Not Covered
Birthing Center		
In-Network	DED + 20%	$0
Out-of-Network	DED + 40%	Not Covered

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueChoice 730 PPO	BlueCare 15 HMO
Diabetic Equipment and Supplies*		
In-Network	DED + 20%	$0
Out-of-Network	DED + 40%	Not Covered
Home Health Care BPM	30 Visits	40 Visits
In-Network	DED + 20%	$0
Out-of-Network	DED + 40%	Not Covered
Hospice LTM	No Maximum	No Maximum
In-Network	DED + 20%	$0
Out-of-Network	DED + 40%	Not Covered
Outpatient Therapy BPM (Combined Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies)	60 Visits	No Maximum. Auth Req for Therapy
In-Network	DED + 20%	$20
Out-of-Network	DED + 40%	Not Covered
Spinal Manipulations BPM	26 Spinal Manipulations	26 Spinal Manipulations
In-Network	DED + 20%	$35
Out-of-Network	DED + 40%	Not Covered
Skilled Nursing Facility BPM	90 days	90 days
In-Network	DED + 20%	$0
Out-of-Network	DED + 40%	Not Covered
PRESCRIPTION DRUGS		
In-Network		
Retail (30 days)		
Generic/Preferred Brand/Non-Preferred	$15 / $25 / $40	$15 / $25 / $40
Mail Order (90 days)		
Generic/Preferred Brand/Non-Preferred	$30 / $50 / $80	$30 / $50 / $80

* Diabetic Supplies (lancets, strips, etc.) are covered under the Rx benefit and the Medical benefit (DME). Diabetic Equipment (insulin pumps, tubing) are always covered under the medical benefit.

** BPM means **B**enefit **P**eriod (calendar year) **M**aximum and runs from Jan 1 – Dec 31

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.