

## Schedule of Benefits for 10-1-2013 thru 9-30-14

### 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](http://www.healthreform.gov).

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



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

<b>COST SHARING</b> Maximums shown are Per Benefit Period (BPM) unless noted	<b>BlueChoice</b> 730 PPO	<b>BlueCare</b> 15 HMO
<b>Diabetic Equipment and Supplies*</b> In-Network Out-of-Network	DED + 20% DED + 40%	\$0 Not Covered
<b>Durable Medical Equipment, Prosthetics, Orthotics BPM</b> In-Network Out-of-Network	Enteral Formulas:\$2,500 All Other: No Maximum DED + 20% DED + 40%	Enteral Formulas:\$2,500 All Other: No Maximum \$0 Not Covered
<b>Home Health Care BPM</b> In-Network Out-of-Network	30 Visits DED + 20% DED + 40%	40 Visits \$0 Not Covered
<b>Hospice LTM</b> In-Network Out-of-Network	No Maximum DED + 20% DED + 40%	No Maximum \$0 Not Covered
<b>Outpatient Therapy BPM</b> (Combined Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies) In-Network Out-of-Network	60 Visits DED + 20% DED + 40%	No Maximum. Auth Req for Therapy \$20 Not Covered
<b>Spinal Manipulations BPM</b> In-Network Out-of-Network	26 Spinal Manipulations DED + 20% DED + 40%	\$35 Not Covered
<b>Skilled Nursing Facility BPM</b> In-Network Out-of-Network	90 days DED + 20% DED + 40%	90 days \$0 Not Covered
<b>PRESCRIPTION DRUGS</b>		
<b>In-Network Retail (30 days)</b> Generic/Preferred Brand/Non-Preferred	\$15 / \$25 / \$40	\$15 / \$25 / \$40
<b>Mail Order (90 days)</b> 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.