

Summary of Benefits for 10-1-2016 through 9-30-17

Lake County Board of County Commissioners 64550



COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueChoice PPO	BlueCare 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)		
In-Network	\$3,000 / \$6,000	\$3,000 / \$6,000
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	\$45	\$45
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	\$0	\$0
In-Network Specialist	\$0	\$0
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		
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

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EMERGENCY/URGENT/CONVENIENT CARE		
Ambulance In-Network Out-of-Network	DED + 20% In-Ntwk DED + 20%	\$0 \$0 May be balance billed
Convenient Care Centers (CCC) In-Network Out-of-Network	\$20 DED + 40%	\$20 Not Covered
Emergency Room Facility Services (also see Professional Provider Services) In-Network Out-of-Network	\$250 \$250	\$250 \$250
Urgent Care Centers (UCC) In-Network Out-of-Network	\$50 DED + \$50	\$50 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 Out-of-Network	DED + 20% DED + 40%	\$200 Not Covered
Independent Clinical Lab In-Network (Quest Labs) Out-of-Network	20% (No DED) 40% (No DED)	\$20 Not Covered
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services) In-Network - Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine) In-Network - Other Diagnostic Services (e.g. X-ray) Out-of-Network	\$75 \$50 DED + 40%	\$75 \$50 Not Covered
Inpatient Hospital (per admit) In-Network Out-of-Network	DED + 20% \$300 Copay + DED + 40%	\$300 per Day up to \$1,200 Not Covered
Outpatient Hospital (per visit) In-Network Out-of-Network	DED + 20% DED + 40%	\$300 Not Covered
Therapy at Outpatient Hospital In-Network Out-of-Network	DED + 20% DED + 40%	\$20 Not Covered
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Hospitalization In-Network Out-of-Network	DED + 20% DED + 40%	\$150 per Day up to \$750 Not Covered
Outpatient Hospitalization (per visit) In-Network Out-of-Network	DED + 20% DED + 40%	\$200 Not Covered
Provider Services at Hospital and ER In-Network Family Physician or Specialist Out-of-Network Provider	\$0 \$0	\$0 Not Covered
Physician Office Visit In-Network Family Physician or Specialist Out-of-Network Provider	\$20 / \$35 40%	\$20 / \$35 Not Covered
Emergency Room Facility Services (per visit) In-Network Out-of-Network	\$50 \$50	\$100 \$100
Provider Services at Locations other than Hospital and ER In-Network Family Physician In-Network Specialist Out-of-Network Provider	\$45 \$45 DED + 40%	\$0 \$0 Not Covered
OTHER SPECIAL SERVICES AND LOCATIONS		
Advanced Imaging Services in Physician's Office In-Network Family Physician In-Network Specialist Out-of-Network	\$75 \$75 DED + 40%	\$75 \$75 Not Covered
Birthing Center In-Network Out-of-Network	DED + 20% DED + 40%	\$0 Not Covered



COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueChoice PPO	BlueCare HMO
Medical Equipment and Supplies via CareCentrix		
Diabetic Equipment and Supplies*		
In-Network	DED + 20%	\$0
Out-of-Network	DED + 40%	Not Covered
All Other Durable Medical Equipment and Supplies		
In-Network	DED + 20%	\$50
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	30 Visits
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	45 days
In-Network	DED + 20%	\$100 per day / \$500 max
Out-of-Network	DED + 40%	Not Covered
PRESCRIPTION DRUGS		
In-Network		
Retail (30 days)		
Generic/Preferred Brand/Non-Preferred/Specialty	\$15 / \$40 / \$55 / \$100	\$15 / \$40 / \$55 / \$100
Mail Order (90 days)		
Generic/Preferred Brand/Non-Preferred/Specialty	\$30 / \$80 / \$110 / NA	\$30 / \$80 / \$110 / NA

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

** BPM means **B**enefit **P**eriod (calendar year) **M**aximum and will align with the plan year effective 10/1/16. On 10/1/16 deductible and out of pocket accumulators will reset and will now align with your October Open Enrollment Period.

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.

