2017 Pasco County School Board Plan Comparison

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueCare Premium HMO	BlueCare Basic HMO	BlueOptions Standard PPO
Deductible (DED) (Per Person/Family Agg)			
In-Network	$0	$2000/$6000	$250/$750
Out-of-Network	Not Covered	Not Covered	$1000/$3000
Hospital Per Admission Deductible (PAD)			
In-Network	$0	$100	$0
Coinsurance (Member Responsibility)			
In-Network	$0	20%	20%
Out-of-Network	Not Covered	Not Covered	40%
Out of Pocket Maximum (Per Person/Family Agg) (Includes DED/Coins./Copays,)			
In-Network	$3000/$9000	$5500/$11000	$3000/$6000
Out-of-Network	Not Covered	Not Covered	$6000/$12000
Lifetime Maximum	Unlimited	Unlimited	Unlimited
PROFESSIONAL PROVIDER SERVICES			
Allergy Injections			
In-Network Family Physician	$20	$10	$20
In-Network Specialist	$20	$10	$20
Out-of-Network	Not Covered	Not Covered	DED + 40%
E-Office Visit Services			
In-Network Family Physician	$30	$10	$10
In-Network Specialist	$50	$10	$10
Out-of-Network	Not Covered	Not Covered	DED + 40%
Office Services			
In-Network Family Physician	$30	$35	$30
In-Network Specialist	$50	$65	$50
Out-of-Network	Not Covered	Not Covered	DED + 40%
Provider Services at Hospital and ER			
In-Network Family Physician	$0	DED + 20%	$50
In-Network Specialist	$0	DED + 20%	$50
Out-of-Network	Not Covered	Not Covered	$50
Provider Services at Other Locations			
In-Network Family Physician	$0	$35	$30
In-Network Specialist	$0	$65	$50
Out-of-Network	Not Covered	Not Covered	DED + 40%
Radiology, Pathology and Anesthesiology Provider Services at Ambulatory Surgical Center			
In-Network Specialist	$0	$65	$50
Out-of-Network	Not Covered	Not Covered	$50
PREVENTIVE CARE			
Adult Wellness Office Services			
In-Network Family Physician	$0	$0	$0
In-Network Specialist	$0	$0	$0
Out-of-Network	Not Covered	Not Covered	40% Coinsurance
Colonoscopies (Routine/Diagnostic) (Age criteria applies: Routine 50+, High Risk, N/A)			
In-Network	$0	$0	$0
Out-of-Network	$0	$0	$0

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Mammograms (Routine and Diagnostic)			
In-Network	$0	$0	$0
Out-of-Network	Not Covered	Not Covered	$0
Well Child Office Visits (No BPM)			
In-Network Family Physician	$0	$0	$0
In-Network Specialist	$0	$0	$0
Out-of-Network	Not Covered	Not Covered	40% Coinsurance
EMERGENCY/URGENT/CONVENIENT CARE			
Ambulance Maximum			
In-Network	$100	DED + 20%	DED + 20%
Out-of-Network	$100	DED + 20%	DED + 20%
Convenient Care Centers (CCC) (Par Take Care Health Clinics inside Walgreens Rx)			
In-Network	$30	$35	$30
Out-of-Network	Not Covered	Not Covered	DED + 40%
Emergency Room Facility Services (per visit) (Copayment waived if admitted) (also see Professional Provider Services)			
In-Network	$200	$300	$100
Out-of-Network	$200	$300	$100
Urgent Care Centers (UCC)			
In-Network	$50	$70	$50
Out-of-Network	Not Covered	Not Covered	DED + $50
FACILITY SERVICES - HOSP/SURG/ICL/IDTF Unless otherwise noted, physician services are in addition to facility services. See Professional Provider Services.			
Ambulatory Surgical Center (ASC)			
In-Network	$400	$250	$200
Out-of-Network	Not Covered	Not Covered	DED + 40%
Independent Clinical Lab (Par Lab is Quest Diagnostics)			
In-Network	$0	$0	$0
Out-of-Network	Not Covered	Not Covered	DED + 40%
Independent Diagnostic Testing Facility (IDTF) - X-rays and AIS (Includes Physician Services)			
In-Network - Advanced Imaging Services (AIS) (I.E., MRI's, CT Scans, Nuclear Medicine)	$50	$300	$200
In-Network - Other Diagnostic Services	$0	$50	$50
Out-of-Network	Not Covered	Not Covered	DED + 40%
Inpatient Hospital (per admit)			
In-Network	$500 per day $2500 max	$100 + DED + 20%	DED + 20%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Outpatient Hospital (per visit) (Surgical or Non-Surgical Svcs., i.e., lab work/ Dx Testing)			
In-Network	$500	DED + 20%	$300
Out-of-Network	Not Covered	Not Covered	DED + 40%
Therapy at Outpatient Hospital			
In-Network	$50	$65	$50
Out-of-Network	Not Covered	Not Covered	DED + 40%

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OTHER SPECIAL SERVICES AND LOCATIONS			
Advanced Imaging Services in Physician's Office			
In-Network Family Physician	$30	$300	$200
In-Network Specialist	$50	$300	$200
Out-of-Network	Not Covered	Not Covered	DED + 40%
Birthing Center			
In-Network	$0	DED + 20%	DED + 20%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Diabetic Equipment and Supplies* (Coordinated via Par Vendor, CareCentrix)			
In-Network	$0	$0	DED + 20%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Durable Medical Equipment, Prosthetics, Orthotics (Par Vendor, CareCentrix)			
In-Network	$0/$500 Motorized Wheelchair	$0/$500 Motorized Wheelchair	DED + 20%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Home Health Care BPM (Coordinated via Par Vendor, CareCentrix)		20 visits per BP	20 visits per BP
In-Network	$0	$0	DED + 20%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Hospice			
In-Network	$0	DED + 20%	DED + 20%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Outpatient Therapy and Spinal Manipulations BPM	62 lifetime visits per BP	35 visits per BP	35 visits per BP
Outpatient Rehab Therapy Center			
In-Network	$30	$65	$30
Out-of-Network	Not Covered	Not Covered	DED + 40%
Outpatient Hospital Facility Services (per visit)			
In-Network	$50	$65	$50
Out-of-Network	Not Covered	Not Covered	DED + 40%
Skilled Nursing Facility BPM	60 visits per BP	60 visits per BP	60 visits per BP
In-Network	$0	DED + 20%	DED + 20%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Medical Pharmacy (Physician Administered)			
In-Network Monthly Out of Pocket Max**	$0	$200	$0
In-Network Provider	$0	20%	$0
Out-of-Network Provider	Not Covered	Not Covered	DED + 40%

* Diabetic Supplies (lancets, strips, etc.) are covered under the Rx benefit except when the group carves out pharmacy. When pharmacy is carved out, they are available through DME. Diabetic Equipment (insulin pumps, tubing) are always covered under the medical benefit.

** (1) Medical Pharmacy Monthly OOP Max includes the drug cost share and applies to the health plan OOP Max. (2) Physician Services are in addition to drug costs (separate cost share applies). (3) Separate drug cost share does not apply to allergy injections or immunizations; only office cost share applies.

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.