2022 Pasco County School Board Plan Comparison

Cost Sharing Maximums shown are Per Benefit Period (BPM) unless noted	HMO Basic BlueCare	HMO Premium BlueCare	PPO Standard BlueOptions
Deductible (DED) (Per Person/Family Agg)			
In-Network	$2,000/$6,000	$2,000/$6,000	$2,000/$6,000
Out-of-Network	Not Covered	Not Covered	$4,000/$12,000
Hospital Per Admission Deductible (PAD)			
In-Network	$100	$0	$0
Coinsurance (Member Responsibility)			
In-Network	20%	0%	20%
Out-of-Network	Not Covered	Not Covered	40%
Out of Pocket Maximum (Per Person/Family Agg) (Includes DED/Coins./Copays)			
In-Network	$5,500/$11,000	$5,500/$11,000	$5,500/$11,000
Out-of-Network	Not Covered	Not Covered	$8,250/$16,500
Lifetime Maximum	Unlimited	Unlimited	Unlimited
PROFESSIONAL PROVIDER SERVICES			
Allergy Injections			
In-Network Family Physician	$10	$20	$20
In-Network Specialist	$10	$20	$20
Out-of-Network	Not Covered	Not Covered	DED + 40%
Virtual Visit Services			
In-Network Family Physician	$0	$30	$10
In-Network Specialist **(In-Network Behavioral Health Provider Virtual Visit - $35 copay)**	$65	$50	$45
Out-of-Network	Not Covered	Not Covered	DED + 40%
Office Services			
In-Network Family Physician	$35	$30	$30
In-Network Specialist (Chiropractor office visit)	$65	$50	$50
Out-of-Network	Not Covered	Not Covered	DED + 40%
Provider Services at Hospital and ER			
In-Network Family Physician	DED + 20%	$0	$50
In-Network Specialist	DED + 20%	$0	$50
Out-of-Network	INN DED + 20%	$0	$50
Provider Services at Other Locations			
In-Network Family Physician	$35	$0	$30
In-Network Specialist	$65	$0	$50
Out-of-Network	Not Covered	Not Covered	DED + 40%
Radiology, Pathology and Anesthesiology Provider Services at Ambulatory Surgical Center			
In-Network Specialist	$65	$0	$50
Out-of-Network	$65	$0	$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 (*May be subject to balance billing by the out of network provider.)	Not Covered	Not Covered	*40% Coinsurance

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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 Services (Air, Ground, water)			
In-Network	DED + 20%	$100	DED + 20%
Out-of-Network	DED + 20%	$100	INN DED + 20%
Convenient Care Centers (CCC) (Select Par Health Clinics inside Walgreens Pharmacy)			
In-Network	$35	$30	$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	$300	$300	$300
Out-of-Network	$300	$300	$300
Urgent Care Centers (UCC)			
In-Network	$50	$50	$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	$250	$400	$200
Out-of-Network	Not Covered	Not Covered	DED + 40%
Independent Clinical Lab (Quest Diagnostics is preferred in network lab.)			
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)	$300	$50	$200
In-Network - Other Diagnostic Services	$50	$0	$50
Out-of-Network	Not Covered	Not Covered	DED + 40%
Inpatient Hospital & Inpatient Rehab. Facility (per admission)			
In-Network	$100 Per Admission DED + DED + 20%	$500 Per Day / $2,500 maximum	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	DED + 20%	$500	$300
Out-of-Network	Not Covered	Not Covered	DED + 40%
Therapy at Outpatient Hospital (per visit)			
In-Network	$65	$50	$50
Out-of-Network	Not Covered	Not Covered	DED + 40%

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OTHER SPECIAL SERVICES AND LOCATION			
Advanced Imaging Services in Physician's Office (per visit)			
In-Network Family Physician	$300	$50	$200
In-Network Specialist	$300	$50	$200
Out-of-Network	Not Covered	Not Covered	DED + 40%
Birthing Center			
In-Network	DED + 20%	$0	DED + 20%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Diabetic Equipment * (Insulin Pump & Supplies) (Coordinated via CareCentrix)			
In-Network	$0	$0	DED + 20%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Durable Medical Equipment, Prosthetics, Orthotics (Coordinated via 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 PBP (Coordinated via Par Vendor, CareCentrix)	35 visits PBP	Unlimited	60 visits PBP
In-Network	$0	$0	DED + 20%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Hospice			
In-Network	DED + 20%	$0	DED + 20%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Outpatient Therapy and Spinal Manipulations (26 PBP) Combined Benefit Period Maximum	35 visits PBP	35 visits PBP	35 visits PBP
Outpatient Rehab Therapy Center (per visit)			
In-Network	$65	$30	$30
Out-of-Network	Not Covered	Not Covered	DED + 40%
Outpatient Hospital Facility Services (per visit)			
In-Network	$65	$50	$50
Out-of-Network	Not Covered	Not Covered	DED + 40%
Skilled Nursing Facility PBP	60 days PBP	60 days PBP	60 days PBP
In-Network	DED + 20%	$0	DED + 20%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Medical Pharmacy (Physician Administered in office setting/Home Health setting)			
In-Network Monthly Out of Pocket Max** for medication only	$200/$200	$0/$0	$0/$0
In-Network Provider (cost of medication)	20%/20%	0%/0%	0%/0%
Out-of-Network Provider	Not Covered	Not Covered	DED + 40%
Other Covered Services:			
Bariatric Surgery: Only Gastric Sleeve effective 1/1/2020. Special Guidelines apply. Please contact Patty Nguyen, Florida Blue Rep. at 813-794-2492 for details.			

* Diabetic Supplies (lancets, strips, meters, 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, CGMs) 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.