2023 Pasco County School Board Plan Comparison

Cost Sharing Maximums shown are Per Benefit Period (PBP) unless noted	**HMO PLAN 48** **HMO Basic** BlueCare	**HMO PLAN 61** **HMO Premium** BlueCare	**PPO 03768** **PPO Standard** BlueOptions
Deductible (DED) (Per Person/Family Agg)			
In-Network	$2,000/$6,000	$1,500/$4,500	$2,500/$7,500
Out-of-Network	Not Covered	Not Covered	$4,000/$12,000
Hospital Per Admission Deductible (PAD)			
In-Network	$0 Copay	$0 Copay	$0 Copay
Coinsurance (Member Responsibility)			
In-Network	20%	10%	30%
Out-of-Network	Not Covered	Not Covered	40%
Out of Pocket Maximum (Per Person/Family Agg) (DED/Coins./Medical & Rx 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 (office)			
In-Network Family Physician	$20 Copay	$20 Copay	$20 Copay
In-Network Specialist	$20 Copay	$20 Copay	$20 Copay
Out-of-Network	Not Covered	Not Covered	DED + 40%
Allergy Testing (office)			
In-Network Family Physician	$40 Copay	$35 Copay	$40 Copay
In-Network Specialist	$75 Copay	$65 Copay	$80 Copay
Out-of-Network	Not Covered	Not Covered	DED + 40%
Virtual Visit Services			
In-Network Value Choice PCP	$0 Copay	$0 Copay	$0 Copay
In-Network Value Choice Specialist	$20 Copay	$20 Copay	$20 Copay
In-Network Family Physician	$0 Copay	$0 Copay	$0 Copay
In-Network Behavioral Health Specialist	$35 Copay	$35 Copay	$35 Copay
In-Network Specialist	$75 Copay	$65 Copay	$45 Copay
Out-of-Network	Not Covered	Not Covered	Not Covered
Office Services (per visit)			
In-Network Value Choice PCP	$0 Copay	$0 Copay	$0 Copay
In-Network Value Choice Specialist	$20 Copay	$20 Copay	$20 Copay
In-Network Family Physician	$40 Copay	$35 Copay	$40 Copay
In-Network Specialist (Includes Chiropractor office visit)	$75 Copay	$65 Copay	$80 Copay
In-Network Behavioral Health Specialist	$40 Copay	$35 Copay	$40 Copay
Out-of-Network	Not Covered	Not Covered	DED + 40%
Provider Services at Hospital and ER			
In-Network Family Physician	DED + 20%	DED + 10%	$80 Copay
In-Network Specialist	DED + 20%	DED + 10%	$80 Copay
Out-of-Network **(For HMO Plans, only for emergencies)**	INN DED + 20%	INN DED + 10%	$80 Copay
Provider Services at Other Locations			
In-Network Family Physician	$40 Copay	$35 Copay	$40 Copay
In-Network Specialist	$75 Copay	$65 Copay	$80 Copay
Out-of-Network	Not Covered	Not Covered	DED + 40%
Radiology, Pathology and Anesthesiology Provider Services at Ambulatory Surgical Center (ASC)			
In-Network Specialist	$75 Copay	$65 Copay	$80 Copay
Out-of-Network	Not Covered	Not Covered	$80 Copay

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PREVENTIVE CARE			
Adult Wellness Office Services (Annual Physical/Well Woman, one per calendar year)			
In-Network Family Physician	$0 Copay	$0 Copay	$0 Copay
In-Network Specialist	$0 Copay	$0 Copay	$0 Copay
Out-of-Network	Not Covered	Not Covered	40% Coinsurance
Colonoscopies (Routine age 45+; Diagnostic, no age criteria)			
In-Network	$0 Copay	$0 Copay	$0 Copay
Out-of-Network	Not Covered	Not Covered	40% Coinsurance
Mammograms (Routine & Diagnostic)			
In-Network	$0 Copay	$0 Copay	$0 Copay
Out-of-Network	Not Covered	Not Covered	$0
Well Child Office Visits			
In-Network Family Physician	$0 Copay	$0 Copay	$0 Copay
In-Network Specialist	$0 Copay	$0 Copay	$0 Copay
Out-of-Network	Not Covered	Not Covered	40% Coinsurance
EMERGENCY/URGENT/CONVENIENT CARE			
Ambulance Services (Air, Ground, water)			
In-Network	DED + 20%	DED + 10%	DED + 30%
Out-of-Network **(For HMO Plans, only for emergencies)**	INN DED + 20%	INN DED + 10%	INN DED + 30%
Convenient Care Centers (CCC) (Advent Health Express Care inside Walgreens Pharmacy)			
In-Network	$40 Copay	$35 Copay	$40 Copay
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	$500 Copay	$500 Copay	$500 Copay
Out-of-Network	$500 Copay	$500 Copay	$500 Copay
Urgent Care Centers (UCC)			
Value Choice Urgent Care Provider **($0 for visits 1-2 per benefit period)**	$0, then $50 Copay	$0, then $50 Copay	$0, then $50 Copay
In-Network	$50 Copay	$50 Copay	$50 Copay
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 Copay	$200 Copay	$200 Copay
Out-of-Network	Not Covered	Not Covered	DED + 40%
Independent Clinical Lab (Quest Diagnostics is preferred in network lab.)			
In-Network	$0 Copay	$0 Copay	$0 Copay
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 Copay	$200 Copay	$300 Copay
In-Network - Other Diagnostic Services (x-rays, ultrasounds)	$50 Copay	$50 Copay	$50 Copay
Out-of-Network	Not Covered	Not Covered	DED + 40%
Inpatient Hospital & Inpatient Rehab. Facility (per admission)			
In-Network	DED + 20%	DED + 10%	DED + 30%
Out-of- Network	Not Covered	Not Covered	DED + 40%

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Outpatient Hospital (per visit) (Surgical or Non-Surgical Svcs., i.e., lab work/ Dx Testing)			
In-Network	DED + 20%	DED + 10%	$300 Copay
Out-of-Network	Not Covered	Not Covered	DED + 40%
Therapy at Outpatient Hospital (per visit)			
In-Network	$75 Copay	$65 Copay	$80 Copay
Out-of-Network	Not Covered	Not Covered	DED + 40%
OTHER SPECIAL SERVICES			
Advanced Imaging Services in Physician's Office (per visit)			
In-Network Family Physician	$300 Copay	$200 Copay	$300 Copay
In-Network Specialist	$300 Copay	$200 Copay	$300 Copay
Out-of-Network	Not Covered	Not Covered	DED + 40%
Birthing Center			
In-Network	DED + 20%	DED + 10%	DED + 30%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Diabetic Equipment[1] (CGM & Insulin Pump) (Coordinated via CareCentrix[2])			
In-Network	$0 Copay	$0 Copay	DED + 30%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Durable Medical Equipment, Prosthetics, Orthotics (Coordinated via CareCentrix[2])			
In-Network	$0/$500 Motorized Wheelchair	$0/$500 Motorized Wheelchair	DED + 30%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Home Health Care PBP (Coordinated via CareCentrix[2])	35 visits PBP	Unlimited	60 visits PBP
In-Network	$0 Copay	$0 Copay	DED + 30%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Hospice			
In-Network	DED + 20%	DED + 10%	DED + 30%
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)	4 modalities/day	4 modalities/day	4 modalities per day
In-Network	$75 Copay	$35 Copay	$40 Copay
Out-of-Network	Not Covered	Not Covered	DED + 40%
Physician Office (per visit)			
In-Network Physical Therapist	$75 Copay	$35 Copay	$40 Copay
Outpatient Hospital Facility Services (per visit)			
In-Network	$75 Copay	$65 Copay	$80 Copay
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%	DED + 10%	DED + 30%
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[3] for medication only	$200/$200	$0/$0	$0/$0
In-Network Provider (cost of medication only, separate cost share for administration)	20%/20%	0%/0%	0%/0%
Out-of-Network Provider	Not Covered	Not Covered	DED + 40%

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Other Covered Services: **Bariatric Surgery: Cover only Gastric Sleeve (CPT code 43775), effective 1/1/2020. Special Guidelines apply. Please contact Patty Nguyen, Florida Blue Rep. at 813-794-2492 or 904-635-9221 for details.**			

Note: Out of Network Services may be subject to balance billing.

1 Diabetic Testing Supplies (lancets, strips, meters, etc.) are covered under the Pharmacy Benefit. Diabetic Equipment (insulin pumps, CGMs) are always covered under the medical benefit.
2 CareCentrix' Phone Number is 1-877-561-9910
3 (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.