2025 Pasco County School Board Plan Comparison

Florida Blue
Your Health Solutions Partner

Cost Sharing Maximums shown are Per Benefit Period (PBP) unless noted	HMO PLAN 71 New HMO Basic BlueCare	HMO PLAN 48 New HMO Premium BlueCare	PPO 03768 PPO Standard BlueOptions
Deductible (DED) (Per Person/Family Agg)			
In-Network	$4,000/$8,000	$2,000/$6,000	$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%	20%	30%
Out-of-Network	Not Covered	Not Covered	40%
Out of Pocket Maximum (Per Person/Family Agg) (Incl. DED,Coins.,Medical & Rx Copays)			
In-Network	$7,900/$15,800	$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	$10 Copay	$20 Copay	$20 Copay
In-Network Specialist	$10 Copay	$20 Copay	$20 Copay
Out-of-Network	Not Covered	Not Covered	DED + 40%
Allergy Testing (office)			
In-Network Family Physician	$40 Copay	$40 Copay	$40 Copay
In-Network Specialist	$75 Copay	$75 Copay	$80 Copay
Out-of-Network	Not Covered	Not Covered	DED + 40%
Virtual Visit Services			
In-Network Value Choice PCP	$10 Copay	$0 Copay	$0 Copay
In-Network Value Choice Specialist	$20 Copay	$20 Copay	$20 Copay
In-Network Family Physician	$10 Copay	$0 Copay	$0 Copay
In-Network Specialist	$75 Copay	$75 Copay	$45 Copay
In-Network Behavior Health Specialist (LMHC, Psychiatrist)	$35 Copay	$35 Copay	$35 Copay
Out-of-Network	Not Covered	Not Covered	Not Covered
Office Services (per visit)			
In-Network Value Choice PCP	$10 Copay	$0 Copay	$0 Copay
In-Network Value Choice Specialist	$20 Copay	$20 Copay	$20 Copay
In-Network Family Physician	$40 Copay	$40 Copay	$40 Copay
In-Network Specialist (Includes Chiropractor office visit)	$75 Copay	$75 Copay	$80 Copay
In-Network Behavioral Health Specialist (LMHC, Psychiatrist)	$40 Copay	$40 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 + 20%	$80 Copay
In-Network Specialist	DED + 20%	DED + 20%	$80 Copay
Out-of-Network **(For HMO Plans, only for emergencies)**	INN DED + 20%	INN DED + 20%	$80 Copay
Provider Services at Other Locations			
In-Network Family Physician	$40 Copay	$40 Copay	$40 Copay
In-Network Specialist	$75 Copay	$75 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	$250 Copay	$75 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+; Non-Routine/Diagnostic, no age criteria)			
In-Network	$0 Copay	$0 Copay	$0 Copay
Out-of-Network	Not Covered	Not Covered	40% Coinsurance
Mammograms (Routine, one per calendar year; Diagnostic no frequency limit)			
In-Network	$0 Copay	$0 Copay	$0 Copay
Out-of-Network	Not Covered	Not Covered	$0
Well Child Office Visits (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
EMERGENCY/URGENT/CONVENIENT CARE/TELADOC TELEHEALTH			
Ambulance Services (Air, Ground, water)			
In-Network	DED + 20%	DED + 20%	DED + 30%
Out-of-Network **(For HMO Plans, only for emergencies)**	INN DED + 20%	INN DED + 20%	INN DED + 30%
Convenient Care Centers (CCC)			
In-Network	$40 Copay	$40 Copay	$40 Copay
Out-of-Network	Not Covered	Not Covered	DED + 40%
Emergency Room Facility Services (per visit) (Copayment waived if admitted) (Refer to Professional Provider Services on page 1.)			
In-Network	$1,000 Copay	$500 Copay	$500 Copay
Out-of-Network	$1,000 Copay	$500 Copay	$500 Copay
Urgent Care Centers (UCC)			
Value Choice Urgent Care Provider **($0 for visits 1-2 per benefit period)** In-Network	$0, then $75 Copay $75 Copay	$0, then $50 Copay $50 Copay	$0, then $50 Copay $50 Copay
Out-of-Network	Not Covered	Not Covered	DED + $50
TELADOC TELEHEALTH (Register on www.teladoc.com, no code needed)			
General Medicine Dermatologist Behavior Health Specialist (LMHC)	$10 Copay $25 Copay $25 Copay	$10 Copay $25 Copay $25 Copay	$10 Copay $25 Copay $25 Copay
DIAGNOSTIC TESTING (e.g., Lab, x-rays) **Independent Clinical Lab (Quest Diagnostic is preferred in-network lab.)** In-Network Out-of-Network	$0 Copay Not Covered	$0 Copay Not Covered	$0 Copay 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)	$500 Copay	$300 Copay	$300 Copay
In-Network - Other Diagnostic Services (x-rays, ultrasounds)	$100 Copay	$50 Copay	$50 Copay
Out-of-Network	Not Covered	Not Covered	DED + 40%

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FACILITY (SURGICAL/NON-SURGICAL, THERAPY) **(Note: Physicians billed separately for services in a Hospital, ASC or ER., Refer to Professional Provider Services on Page 1.)**			
Ambulatory Surgical Center (ASC)			
In-Network	$750 Copay	$400 Copay	$200 Copay
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%	DED + 20%	$300 Copay
Out-of-Network	Not Covered	Not Covered	DED + 40%
Inpatient Hospital & Inpatient Rehab. (per admission)			
In-Network	DED + 20%	DED + 20%	DED + 30%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Therapy at Outpatient Hospital (per visit)			
In-Network	$100 Copay	$75 Copay	$80 Copay
Out-of-Network	Not Covered	Not Covered	DED + 40%
OTHER SPECIAL SERVICES AND LOCATION			
Advanced Imaging Services in Physician's Office (per visit)			
In-Network Family Physician	$500 Copay	$300 Copay	$300 Copay
In-Network Specialist	$500 Copay	$300 Copay	$300 Copay
Out-of-Network	Not Covered	Not Covered	DED + 40%
Birthing Center			
In-Network	DED + 20%	DED + 20%	DED + 30%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Diabetic Equipment[1] (CGM & Insulin Pump) (Coordinated via CareCentrix[2])			
In-Network	DED + 20%	$0 Copay	DED + 30%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Durable Medical Equipment, Prosthetics, Orthotics (Coordinated via CareCentrix[2])			
In-Network	DED + 20%	$0/$500 Motorized Wheelchair	DED + 30%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Home Health Care PBP (Coordinated via CareCentrix[2])	60 visits PBP	35 visits PBP	60 visits PBP
In-Network	DED + 20%	$0 Copay	DED + 30%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Hospice			
In-Network	DED + 20%	DED + 20%	DED + 30%
Out-of-Network	Not Covered	Not Covered	DED + 40%

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Outpatient Therapy and Spinal Manipulations Combined Benefit Period Maximum	30 Visits PBP 4 modalities/day	35 visits PBP 4 modalities/day	35 visits PBP 4 modalities per day
Outpatient Rehab Therapy Center (per visit)			
In-Network	$75 Copay	$75 Copay	$40 Copay
Out-of-Network	Not Covered	Not Covered	DED + 40%
Physician Office (per visit)			
In-Network Physical Therapist	$75 copay	$75 Copay	$40 Copay
Outpatient Hospital Facility Services (per visit)			
In-Network	$100 Copay	$75 Copay	$80 Copay
Out-of-Network	Not Covered	Not Covered	DED + 40%
Skilled Nursing Facility PBP	45 days PBP	60 days PBP	60 days PBP
In-Network	DED + 20%	DED + 20%	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	$200/$200	$0/$0
In-Network Provider (cost of medication only, separate cost share for administration)	20%/20%	20%/20%	0%/0%
Out-of-Network Provider	Not Covered	Not Covered	DED + 40%
2025 NEW CHANGES: • **$20,000 LIFETIME MAXIMUM FOR ALL BARIATRIC SURGERY AND RELATED SERVICES.** • **RECONSTRUCTION SURGERY RELATED TO BARIATRIC SURGERY WILL NO LONGER BE COVERED EFFECTIVE JANUARY 1, 2025.**			

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.