2026 Pasco County School Board Plan Summary

Florida Blue
Your Health Solutions Partner

Cost Sharing Maximums shown are Per Benefit Period (PBP) unless noted	HMO PLAN BlueCare
Deductible (DED) (Per Person/Family Agg)	
In-Network	$3,500/$7,000
Out-of-Network	Not Covered
Hospital Per Admission Deductible (PAD)	
In-Network	$0 Copay
Coinsurance (Member Responsibility)	
In-Network	30%
Out-of-Network	Not Covered
Out of Pocket Maximum (Per Person/Family Agg) (Incl. DED,Coins.,Medical & Rx Copays)	
In-Network	$8,000$16,000
Out-of-Network	Not Covered
Lifetime Maximum	Unlimited
PROFESSIONAL PROVIDER SERVICES	
Allergy Injections (office)	
In-Network Family Physician	$15 Copay
In-Network Specialist	$15 Copay
Out-of-Network	Not Covered
Allergy Testing (office)	
In-Network Family Physician	$60 Copay
In-Network Specialist	$100 Copay
Out-of-Network	Not Covered
Virtual Visit Services	
In-Network Value Choice PCP	$15 Copay
In-Network Value Choice Specialist	$30 Copay
In-Network Family Physician	$30 Copay
In-Network Specialist	$100 Copay
In-Network Behavior Health Specialist (LMHC, Psychiatrist)	$55 Copay
Out-of-Network	Not Covered
Office Services (per visit)	
In-Network Value Choice PCP	$15 Copay
In-Network Value Choice Specialist	$30 Copay
In-Network Family Physician	$60 Copay
In-Network Specialist (Includes Chiropractor office visit)	$100 Copay
In-Network Behavioral Health Specialist (LMHC, Psychiatrist)	$75 Copay
Out-of-Network	Not Covered
Provider Services at Hospital and ER	
In-Network Family Physician	DED + 30%
In-Network Specialist	DED + 30%
Out-of-Network (**only for emergencies**)	INN DED + 30%
Provider Services at Other Locations	
In-Network Family Physician	$60 Copay
In-Network Specialist	$100 Copay
Out-of-Network	Not Covered
Radiology, Pathology and Anesthesiology Provider Services at Ambulatory Surgical Center (ASC)	
In-Network Specialist	$500 Copay
Out-of-Network	Not Covered

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PREVENTIVE CARE	
Adult Wellness Office Services (Annual Physical & Well Woman, one per calendar year)	
In-Network Family Physician	$0 Copay
In-Network Specialist	$0 Copay
Out-of-Network	Not Covered
Colonoscopies (Routine age 45+; Non-Routine/Diagnostic, no age criteria)	
In-Network	$0 Copay
Out-of-Network	Not Covered
Mammograms (Routine, one per calendar year; Diagnostic no frequency limit)	
In-Network	$0 Copay
Out-of-Network	Not Covered
Well Child Office Visits (one per calendar year)	
In-Network Family Physician	$0 Copay
In-Network Specialist	$0 Copay
Out-of-Network	Not Covered
EMERGENCY/URGENT/CONVENIENT CARE/TELADOC TELEHEALTH	
Ambulance Services (Air, Ground, water)	
In-Network	DED + 30%
Out-of-Network (**only for emergencies**)	INN DED + 30%
Convenient Care Centers (CCC)	
In-Network	$60 Copay
Out-of-Network	Not Covered
Emergency Room Facility Services (per visit) (Copayment waived if admitted) (Refer to Professional Provider Services on page 1.)	
In-Network	$1,000 Copay
Out-of-Network	$1,000 Copay
Urgent Care Centers (UCC)	
Value Choice Urgent Care Provider **($0 for visits 1-2 per benefit period)**	$0, then $150 Copay
In-Network	$150 Copay
Out-of-Network	Not Covered
TELADOC TELEHEALTH (To register, call 1-866-789-8155 or access www.MyHealthtoolkitFL.com)	
General Medicine	$15 Copay
Dermatologist	$40 Copay
Behavior Health Specialist (LMHC)	$40 Copay
DIAGNOSTIC TESTING (e.g., Lab, x-rays)	
Independent Clinical Lab (Quest Diagnostic is preferred in-network lab in Florida.)	
In-Network	$0 Copay
Out-of-Network	Not Covered
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
In-Network - Other Diagnostic Services (x-rays, ultrasounds)	$100 Copay
Out-of-Network	Not Covered

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FACILITY (SURGICAL/NON-SURGICAL, THERAPY) **(Note: Physicians bill separately for services in a Hospital, ASC or ER., Refer to Professional Provider Services on Page 1 for your cost shares.)**	
Ambulatory Surgical Center (ASC)	
In-Network	$750 Copay
Out-of- Network	Not Covered
Outpatient Hospital (per visit) (Surgical or Non-Surgical Svcs., i.e., lab work/Dx Testing)	
In-Network	DED + 30%
Out-of-Network	Not Covered
Inpatient Hospital & Inpatient Rehab. (per admission)	
In-Network	DED + 30%
Out-of-Network	Not Covered
Therapy at Outpatient Hospital (per visit)	
In-Network	$150 Copay
Out-of-Network	Not Covered
OTHER SPECIAL SERVICES AND LOCATION	
Advanced Imaging Services in Physician's Office (per visit)	
In-Network Family Physician	$500 Copay
In-Network Specialist	$500 Copay
Out-of-Network	Not Covered
Birthing Center	
In-Network	DED + 30%
Out-of-Network	Not Covered
Diabetic Equipment[1] (Select CGMs & Insulin Pumps) (Coordinated via CareCentrix[2])	
In-Network	DED + 30%
Out-of-Network	Not Covered
Durable Medical Equipment, Prosthetics, Orthotics (Coordinated via CareCentrix[2])	
In-Network	DED + 30%
Out-of-Network	Not Covered
Home Health Care (Coordinated via CareCentrix[2])	60 visits PBP
In-Network	DED + 30%
Out-of-Network	Not Covered
Hospice	
In-Network	DED + 30%
Out-of-Network	Not Covered

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Outpatient Therapy and Spinal Manipulations Combined Benefit Period Maximum	30 Visits PBP
Outpatient Rehab Therapy Center (per visit)	4 modalities/day
In-Network	$150 Copay
Out-of-Network	Not Covered
Physician Office (per visit)	
In-Network Physical Therapist	$150 copay
Outpatient Hospital Facility Services (per visit)	
In-Network	$150 Copay
Out-of-Network	Not Covered
Skilled Nursing Facility PBP	45 days PBP
In-Network	DED + 30%
Out-of-Network	Not Covered
Medical Pharmacy (Physician Administered in office setting/home health setting)	
In-Network Provider (Preferred or Non-Preferred Medication)[3] (cost of medication only, separate cost share for administration)	20%/20%
Out-of-Network Provider	Not Covered
Bariatric Surgery Program: Coverage for Gastric Sleeve procedure (CPT code 43775) only. Must follow pre-surgery and post-surgery guidelines. Contact Patty Nguyen at 813-794-2492 for details. • **$20,000 LIFETIME MAXIMUM FOR ALL BARIATRIC SURGERY AND RELATED SERVICES.** • **RECONSTRUCTION SURGERY POST COVERED BARIATRIC SURGERY IS NOT COVERED.**	

1 Diabetic Testing Supplies (lancets, strips, meters, etc.) are covered under the Pharmacy Benefit. Diabetic Equipment (insulin pumps, certain CGMs) are 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