2026 Pasco County School Board Plan Summary



Deductible (DED) (Per Person/Family Agg) In-Network \$3,500/\$7,000 Not Covered \$3,000/\$7,000 Not Covered Unlimited \$3,000/\$7,000 Not Covered Unlimited \$3,000/\$7,000 Not Covered Unlimited \$4,000/\$7,000 Not Covered Unlimited \$4,000/\$7,000 Not Covered \$1,000/\$7,000 Not	Cost Sharing	HMO PLAN
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	Out-of-Network	Not Covered

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Cost Sharing	HMO PLAN
Maximums shown are Per Benefit Period (PBP) unless noted	BlueCare
PREVENTIVE CARE	
Adult Wellness Office Services (Annual Physical & Well Woman, one per calendar year) In-Network Family Physician In-Network Specialist Out-of-Network	\$0 Copay \$0 Copay Not Covered
Colonoscopies (Routine age 45+; Non-Routine/Diagnostic, no age criteria) In-Network Out-of-Network	\$0 Copay Not Covered
Mammograms (Routine, one per calendar year; Diagnostic no frequency limit) In-Network Out-of-Network	\$0 Copay Not Covered
Well Child Office Visits (one per calendar year) In-Network Family Physician In-Network Specialist Out-of-Network	\$0 Copay \$0 Copay Not Covered
EMERGENCY/URGENT/CONVENIENT CARE/TELADOC TELEHEALTH	
Ambulance Services (Air, Ground, water) In-Network Out-of-Network (only for emergencies)	DED + 30% INN DED + 30%
Convenient Care Centers (CCC) In-Network Out-of-Network	\$60 Copay Not Covered
Emergency Room Facility Services (per visit) (Copayment waived if admitted) (Refer to Professional Provider Services on page 1.) In-Network Out-of-Network	\$1,000 Copay \$1,000 Copay
Urgent Care Centers (UCC) Value Choice Urgent Care Provider (\$0 for visits 1-2 per benefit period) In-Network Out-of-Network	\$0, then \$150 Copay \$150 Copay Not Covered
TELADOC TELEHEALTH (To register, call 1-866-789-8155 or access www.MyHealthtoolkitFL.com) General Medicine Dermatologist Behavior Health Specialist (LMHC)	\$15 Copay \$40 Copay \$40 Copay
DIAGNOSTIC TESTING (e.g., Lab, x-rays) Independent Clinical Lab (Quest Diagnostic is preferred in-network lab in Florida.) In-Network Out-of-Network Independent Diagnostic Testing Facility (IDTF) - X-rays and AIS (Includes Physician Services)	\$0 Copay Not Covered
In-Network - Advanced Imaging Services (AIS) (I.E., MRI's, CT scans, Nuclear Medicine) In-Network - Other Diagnostic Services (x-rays, ultrasounds) Out-of-Network	\$500 Copay \$100 Copay Not Covered

2026 Pasco County School Board Plan Summary



Coot Shaving	HMO PLAN
Cost Sharing Maximums shown are Per Benefit Period (PBP) unless noted	BlueCare
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 Out-of- Network	\$750 Copay Not Covered
Outpatient Hospital (per visit) (Surgical or Non-Surgical Svcs., i.e., lab work/Dx Testing)	
In-Network Out-of-Network	DED + 30% Not Covered
Inpatient Hospital & Inpatient Rehab. (per admission)	
In-Network Out-of-Network	DED + 30% Not Covered
Therapy at Outpatient Hospital (per visit) In-Network Out-of-Network	\$150 Copay Not Covered
OTHER SPECIAL SERVICES AND LOCATION	
Advanced Imaging Services in Physician's Office (per visit) In-Network Family Physician In-Network Specialist Out-of-Network	\$500 Copay \$500 Copay Not Covered
Birthing Center In-Network Out-of-Network	DED + 30% Not Covered
Diabetic Equipment¹ (Select CGMs & Insulin Pumps) (Coordinated via CareCentrix²) In-Network Out-of-Network	DED + 30% Not Covered
Durable Medical Equipment, Prosthetics, Orthotics (Coordinated via CareCentrix²) In-Network Out-of-Network	DED + 30% Not Covered
Home Health Care (Coordinated via CareCentrix²) In-Network Out-of-Network	60 visits PBP DED + 30% Not Covered
Hospice In-Network Out-of-Network	DED + 30% Not Covered

2026 Pasco County School Board Plan Summary



Cost Sharing	HMO PLAN
Maximums shown are Per Benefit Period (PBP) unless noted	BlueCare
Outpatient Therapy and Spinal Manipulations Combined Benefit Period Maximum Outpatient Rehab Therapy Center (per visit) In-Network Out-of-Network Physician Office (per visit)	30 Visits PBP 4 modalities/day \$150 Copay Not Covered
In-Network Physical Therapist Outpatient Hospital Facility Services (per visit) In-Network Out-of-Network	\$150 copay \$150 Copay Not Covered
Skilled Nursing Facility PBP In-Network Out-of-Network	45 days PBP DED + 30% 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. 	

2 CareCentrix' Phone Number is 1-877-561-9910

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.

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.

^{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