

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 Out-of-Network	\$2,000/\$6,000 Not Covered	\$1,500/\$4,500 Not Covered	\$2,500/\$7,500 \$4,000/\$12,000
Hospital Per Admission Deductible (PAD) In-Network	\$0 Copay	\$0 Copay	\$0 Copay
Coinsurance (Member Responsibility) In-Network Out-of-Network	20% Not Covered	10% Not Covered	30% 40%
Out of Pocket Maximum (Per Person/Family Agg) (DED/Coins./Medical & Rx Copays) In-Network Out-of-Network	\$5,500/\$11,000 Not Covered	\$5,500/\$11,000 Not Covered	\$5,500/\$11,000 \$8,250/\$16,500
Lifetime Maximum	Unlimited	Unlimited	Unlimited
PROFESSIONAL PROVIDER SERVICES			
Allergy Injections (office) In-Network Family Physician In-Network Specialist Out-of-Network	\$20 Copay \$20 Copay Not Covered	\$20 Copay \$20 Copay Not Covered	\$20 Copay \$20 Copay DED + 40%
Allergy Testing (office) In-Network Family Physician In-Network Specialist Out-of-Network	\$40 Copay \$75 Copay Not Covered	\$35 Copay \$65 Copay Not Covered	\$40 Copay \$80 Copay DED + 40%
Virtual Visit Services In-Network Value Choice PCP In-Network Value Choice Specialist In-Network Family Physician In-Network Behavioral Health Specialist In-Network Specialist Out-of-Network	\$0 Copay \$20 Copay \$0 Copay \$35 Copay \$75 Copay Not Covered	\$0 Copay \$20 Copay \$0 Copay \$35 Copay \$65 Copay Not Covered	\$0 Copay \$20 Copay \$0 Copay \$35 Copay \$45 Copay Not Covered
Office Services (per visit) In-Network Value Choice PCP In-Network Value Choice Specialist In-Network Family Physician In-Network Specialist (Includes Chiropractor office visit) In-Network Behavioral Health Specialist Out-of-Network	\$0 Copay \$20 Copay \$40 Copay \$75 Copay \$40 Copay Not Covered	\$0 Copay \$20 Copay \$35 Copay \$65 Copay \$35 Copay Not Covered	\$0 Copay \$20 Copay \$40 Copay \$80 Copay \$40 Copay DED + 40%
Provider Services at Hospital and ER In-Network Family Physician In-Network Specialist Out-of-Network (For HMO Plans, only for emergencies)	DED + 20% DED + 20% INN DED + 20%	DED + 10% DED + 10% INN DED + 10%	\$80 Copay \$80 Copay \$80 Copay
Provider Services at Other Locations In-Network Family Physician In-Network Specialist Out-of-Network	\$40 Copay \$75 Copay Not Covered	\$35 Copay \$65 Copay Not Covered	\$40 Copay \$80 Copay DED + 40%
Radiology, Pathology and Anesthesiology Provider Services at Ambulatory Surgical Center (ASC) In-Network Specialist Out-of-Network	\$75 Copay Not Covered	\$65 Copay Not Covered	\$80 Copay \$80 Copay

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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	\$0 Copay \$0 Copay Not Covered	\$0 Copay \$0 Copay 40% Coinsurance
Colonoscopies (Routine age 45+; Diagnostic, no age criteria) In-Network Out-of-Network	\$0 Copay Not Covered	\$0 Copay Not Covered	\$0 Copay 40% Coinsurance
Mammograms (Routine & Diagnostic) In-Network Out-of-Network	\$0 Copay Not Covered	\$0 Copay Not Covered	\$0 Copay \$0
Well Child Office Visits In-Network Family Physician In-Network Specialist Out-of-Network	\$0 Copay \$0 Copay Not Covered	\$0 Copay \$0 Copay Not Covered	\$0 Copay \$0 Copay 40% Coinsurance
EMERGENCY/URGENT/CONVENIENT CARE			
Ambulance Services (Air, Ground, water) In-Network Out-of-Network (For HMO Plans, only for emergencies)	DED + 20% INN DED + 20%	DED + 10% INN DED + 10%	DED + 30% INN DED + 30%
Convenient Care Centers (CCC) (Advent Health Express Care inside Walgreens Pharmacy) In-Network Out-of-Network	\$40 Copay Not Covered	\$35 Copay Not Covered	\$40 Copay DED + 40%
Emergency Room Facility Services (per visit) (Copayment waived if admitted) (also see Professional Provider Services) In-Network Out-of-Network	\$500 Copay \$500 Copay	\$500 Copay \$500 Copay	\$500 Copay \$500 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 \$50 Copay \$50 Copay Not Covered	\$0, then \$50 Copay \$50 Copay Not Covered	\$0, then \$50 Copay \$50 Copay 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 Out-of-Network	\$400 Copay Not Covered	\$200 Copay Not Covered	\$200 Copay DED + 40%
Independent Clinical Lab (Quest Diagnostics 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) In-Network - Other Diagnostic Services (x-rays, ultrasounds) Out-of-Network	\$300 Copay \$50 Copay Not Covered	\$200 Copay \$50 Copay Not Covered	\$300 Copay \$50 Copay DED + 40%
Inpatient Hospital & Inpatient Rehab. Facility (per admission) In-Network Out-of- Network	DED + 20% Not Covered	DED + 10% Not Covered	DED + 30% 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 Equipment¹ (CGM & Insulin Pump) (Coordinated via CareCentrix²)			
In-Network	\$0 Copay	\$0 Copay	DED + 30%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Durable Medical Equipment, Prosthetics, Orthotics (Coordinated via CareCentrix²)			
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 CareCentrix²)			
In-Network	35 visits PBP	Unlimited	60 visits PBP
Out-of-Network	\$0 Copay	\$0 Copay	DED + 30%
	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			
Outpatient Rehab Therapy Center (per visit)			
In-Network	35 visits PBP	35 visits PBP	35 visits PBP
Out-of-Network	4 modalities/day	4 modalities/day	4 modalities per day
	\$75 Copay	\$35 Copay	\$40 Copay
	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			
In-Network	60 days PBP	60 days PBP	60 days PBP
Out-of-Network	DED + 20%	DED + 10%	DED + 30%
	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.