

Hernando County School District Benefit Plans



Please visit [www.FloridaBlue.com](http://www.FloridaBlue.com) for a complete listing of In-network Providers, Hospitals, Emergency Care Centers, and Durable Medical Equipment Suppliers.

Calendar Year Deductible (CYD)				
(Individual/Family)	In-Network	\$750 / \$1,250	\$500 / \$500	\$5,000/\$10,000
	Out-of-Network	\$3,000 / \$5,000	Not Covered	Not Covered
Coinsurance				
	In-Network	30%	20%	30%
	Out-of-Network	50%	Not Covered	Not Covered
Out of Pocket Maximum (In-Network/Out-of-Network)				
(Individual/Family)	In-Network	\$4,000 / \$8,000	\$3,000 / \$6,000	\$6,350/\$12,700
	Out-of-Network	\$7,000 / \$14,000	Not Covered	Not Covered

Services		BlueOptions PPO 05770	BlueCare HMO 60	BlueCare HMO 54
<b>Virtual Visits</b>				
	In-Network Family Physician	\$0 Copayment	\$0 Copayment	\$0 Copayment
	In-Network Specialist	\$20 Copayment	\$20 Copayment	\$20 Copayment
<b>Teledoc</b>				
	In-Network	\$0 Copay	\$0 Copay	\$0 Copay
<b>Office Services</b>				
	In-Network Family Physician	\$25 Copay	\$25 Copay	\$40 Copay
	In-Network Specialist	\$50 Copay	\$50 Copay	\$65 Copay
	Out-of-Network Providers	DED + 50%	Not Covered	Not Covered
<b>Independent Clinical Laboratory</b>				
	In-Network	\$0 Copay	\$0 Copay	\$0 Copay
	Out-of-Network	DED + 50%	Not Covered	Not Covered
<b>Advanced Imaging (AIS) (MRI, MRA, PET, CT &amp; Nuclear Medicine)</b>				
<b>Independent Diagnostic Testing Center</b>				
	In-Network	\$200 Copay	\$200 Copay	\$200 Copay
	Out-of-Network	DED + 50%	Not Covered	Not Covered
<b>Outpatient Hospital Facility</b>				
	In-Network	DED + 30%	\$275 Copay	30% after Ded
	Out-of-Network	DED + 50%	Not Covered	Not Covered
<b>Outpatient Therapy</b>				
	In-Network Family Physician	\$25 Copay	\$10 Copay	\$40 Copay
	In-Network Specialist	\$45 Copay	\$10 Copay	\$65 Copay
	Out-of-Network	DED + 50%	Not Covered	Not Covered
<b>Provider Services at Hospital &amp; ER</b>				
	In-Network	\$100 Copay	\$0 Copay	30% after Ded
	Out-of-Network	\$100 Copay	Not Covered	Not Covered
<b>Hospital Services</b>				
<b>Inpatient</b>				
	In-Network	\$1,000 copay	\$325 per Day / \$1,625 max	30% after Ded
	Out-of-Network	\$3,500 copay	Not Covered	Not Covered
<b>Outpatient</b>				
	In-Network	DED + 30%	\$275 Copayment	30% after Ded
	Out-of-Network	DED + 50%	Not Covered	Not Covered
<b>Emergency Room Services</b>				
	In-Network	\$200 Copay	\$200 Copay	\$300 Copay
	Out-of-Network	\$200 Copay	\$200 Copay	\$300 Copay
<b>Urgent Care Services</b>				
	In-Network	\$50 Copay	\$45 Copay	\$85 Copay
	Out-of-Network	DED + \$50 Copayment	Not Covered	Not Covered
<b>Convenient Care Center</b>				
	In-Network	\$25 Copay	\$25 Copay	\$40 Copay
	Out-of-Network	DED + 50%	Not Covered	Not Covered
<b>Ambulance Services</b>				
	In-Network	30% after Ded	20% after Ded	30% after Ded
	Out-of-Network	INN DED + 30%	INN DED + 20%	INN DED + 30%
<b>Preventive Health</b>				
	Mammograms	\$0 Copay	\$0 Copay	\$0 Copay
	Well Child	\$0 Copay	\$0 Copay	\$0 Copay
	Adult Wellness In-Network	\$0 Copay	\$0 Copay	\$0 Copay
	Adult Wellness Out-of-Network	50%	Not Covered	Not Covered
<b>Mental Health And Substance Dependency Services</b>				
	In-Network	\$0 Copay	\$0 Copay	\$0 Copay
	Out-of-Network	50%	Not Covered	Not Covered
	Inpatient Hospital Out-of-Network	\$500 Copay	Not Covered	Not Covered
<b>Prescription Drug Copays:</b>				
		BlueOptions PPO 05770	BlueCare HMO 60	BlueCare HMO 54
		<i>Mail Order is 2x Copay for 90 day supply</i>		
	Generic	\$10	\$10	\$10
	Brand	\$30	\$30	\$50
	Non-formulary	\$50	\$50	\$80
<b>Diabetes Supplies (CareCentrix 877-561-9910)</b> - Insulin Pumps and Supplies (except for Insulin) - Continuous Glucose Monitor Devices		*You can get Diabetic supplies, such as strips, needles and meters, from your local in-network retail pharmacy or sign up for home delivery.		
<b>Breast Pumps (CareCentrix 877-561-9910)</b>		*One personal breast pump provided through CareCentrix per delivery.		