PHSC | PASCO-HERNANDO STATE COLLEGE

2021 Benefits Comparison

FCSRMC	BlueCare HMO 58	BlueOptions PPO 03769	BlueOptions PPO 05190 & HSA Individual Plan Account Funding: EE Only=$500	BlueOptions PPO 05191 & HSA Family Plan Account Funding: EE+1=$1,000 or EE+2=$1,500
Cost Sharing - Member's Responsibility				
Deductible (DED) (Per Person/Family Aggregate)				
In-Network	NA	$800 / $2,400	$1,750 / NA	$3,500 / $3,500
Out-of-Network	NA	Combined w/ INN	$5,000 / NA	$10,000 / $10,000
Coinsurance (BCBSF pays / Member pays)				
In-Network	80% / 20%	80% / 20%	80% / 20%	80% / 20%
Out-of-Network	Not Covered	60% / 40%	60% / 40%	60% / 40%
Out of Pocket Maximum (Per Person/Family Aggregate) Includes Pharmacy		Includes Pharmacy	Includes Pharmacy	Includes Pharmacy
In-Network	$6,000 / $12,000	$7,000 / $14,000	$4,500 / NA	$6,850 / $9,000
Out-of-Network	N/A	Combined w/ INN	$9,000 / NA	$18,000 / $18,000
Medical / Surgical Care by a Physician				
Office Services				
In-Network Family Physician	$40	$40	DED + 20%	DED + 20%
In-Network Specialist	$60	$60	DED + 20%	DED + 20%
Out-of-Network	Not Covered	Ded + 40%	DED + 40%	DED + 40%
Physician Services at Hospital				
In-Network	$0	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	Not Covered	INN DED + 20%	INN DED + 20%	INN DED + 20%
Medical / Surgical Care at a Facility				
Inpatient Hospital Facility (per admit)				
In-Network	$350 per day up to $1,750 max	Option 1: $1,250 Option 2: $2,250	Option 1: Ded + 20% Option 2: Ded + 25%	Option 1: Ded + 20% Option 2: Ded + 25%
Out-of-Network	Not Covered	Ded + 40%	$500 PAD + DED + 40%	$500 PAD + DED + 40%
Outpatient Hospital Facility (per visit) (Surgical)				
In-Network	$750	Option 1: Ded + 20% Option 2: Ded + 20%	Option 1: Ded + 20% Option 2: Ded + 25%	Option 1: Ded + 20% Option 2: Ded + 25%
Out-of-Network	Not Covered	Ded + 40%	DED + 40%	DED + 40%
Emergency and Urgent Care				
Emergency Room Facility (per visit)				
In-Network	20%	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	20%	INN DED + 20%	INN DED + 20%	INN DED + 20%
Urgent Care Centers				
In-Network	$80	$65	DED + 20%	DED + 20%
Ambulance				
In-Network	20%	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	20%	INN DED + 20%	INN DED + 20%	INN DED + 20%
Other Special Services				
Gastric Bypass	1 PBP	1 PBP	1 PBP	1 PBP
TeleMedicine Services	$10	$10	DED + Coin, Allowance Maximum $45	DED + Coin, Allowance Maximum $45
Prescription Drugs				
In-Network				
Retail - Generic/Brand/Non-Preferred/ Specialty RX Maximum	$15 / $45 / $65 /$250	$15 / $45 / $65 / $250	DED	DED
Mail Order - Generic/Brand/Non-Preferred	$30 / $90 / $130	$30 / $90 / $130	DED	DED
Dependent Coverage Cost (Monthly)	$1,360.00	$760.00	Not a Dependent Plan	$330.00