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Plan Benefits

Academic Medical Group (AMG)

90963 (HSA)

HSA Qualified HDHP

Effective January 1, 2024

BlueCross BlueShield of Alabama

Academic Medical Group (AMG)
90963 – HSA Option
Effective January 1, 2024

BENEFIT	Tier I Domestic Network	Tier 2 Select Providers	Tier 3 BlueOptions	Tier 4 Out-of-Network
Benefit payments are based on the amount of the provider's charge that Blue Cross and/or Blue Shield plans recognize for payment of benefits. The allowed amount may vary depending upon the type provider and where services are received.				
HEALTH SAVINGS ACCOUNT (HSA)				
A Health Savings Account (HSA) is an account established with pre-taxed money in order to save for future medical expenses. In order to establish an HSA you must first be enrolled in an HSA-Qualified High Deductible Health Plan (HDHP). An HDHP is a health plan that satisfies certain government requirements for use in conjunction with a HSA. This plan is designed to meet those government requirements. Enrolling in an HDHP allows you the opportunity to make contributions to an HSA on a pre-tax basis.				
Maximum Contribution: The maximum contribution amount is indexed each year by the U.S. Treasury. The 2024 maximum contribution is **$4,150** for single coverage and **$8,300** for family coverage. If you have any questions about the benefits of an HSA, please consult your tax accountant.				
SUMMARY OF COST SHARING PROVISIONS **(Includes Mental Health Disorders and Substance Abuse)**				
Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.				
Calendar Year Deductible Tier 1, 2 and 3 deductibles apply to each other and Tier 4 deductible is separate. For self-only coverage, no benefits, except preventive care, are paid by the plan until medical expenses paid by the individual equal the deductible amount. For family coverage, no benefits except preventive care, are paid by the plan until that individual family member meets the individual deductible amount or the total medical expenses paid by the family equal the family deductible amount.	$5,000 Individual $12,000 Family	$5,000 Individual $12,000 Family	$5,000 Individual $12,000 Family	$10,000 Individual $25,000 Family
Calendar Year Out-of-Pocket Maximum Tier 1, 2 and 3 out-of-pocket maximum applies to each other and Tier 4 out-of-pocket maximum is separate After you reach your self-only Calendar Year Out-of-Pocket Maximum (even if you are covered under family coverage), applicable expenses for you will be covered at 100% of the allowed amount for remainder of calendar year.	$6,750 Individual $13,500 Family All deductibles, copays and coinsurance apply to the out-of-pocket maximum and out of network mental health disorders and substance abuse emergency services apply to the in-network Tier 1 out of pocket maximum, including prescription drugs.	$6,750 Individual $13,500 Family All deductibles, copays and coinsurance apply to the out-of-pocket maximum and out of network mental health disorders and substance abuse emergency services apply to the in-network Tier 2 out of pocket maximum, including prescription drugs.	$6,750 Individual $13,500 Family All deductibles, copays and coinsurance apply to the out-of-pocket maximum and out of network mental health disorders and substance abuse emergency services apply to the in-network Tier 3 out of pocket maximum, including prescription drugs.	$12,750 Individual $25,500 Family All deductibles, copays and coinsurance apply to the Tier 4 out-of-pocket maximum, including prescription drugs.

BENEFIT	Tier I Domestic Network	Tier 2 Select Providers	Tier 3 BlueOptions	Tier 4 Out-of-Network
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS **(Includes Mental Health Disorders and Substance Abuse)**				
Precertification is required for inpatient admissions (except medical emergency services, maternity and as required by Federal law); notification within 48 hours for medical emergencies. Generally, if precertification is not obtained, a penalty of $750 may be applied to applicable claims. Call 1-855-288-8357 (toll-free) for precertification.				
Inpatient Hospital and Residential Treatment Facilities	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Inpatient Physician Visits and Consultations	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 80% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Inpatient Bariatric Surgery	**Facility:** Covered at 80% of the allowed amount subject to calendar year deductible **Physician:** Covered at 80% of the allowed amount; subject to calendar year deductible	**Facility:** Covered at 80% of the allowed amount subject to calendar year deductible **Physician:** Covered at 80% of the allowed amount; subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Organ Transplants • Benefits are only provided at Blue Distinction Centers and Centers of Excellence • Tampa General Hospital preferred for adult heart, liver, lungs, pancrease, kidney and pediatric kidney	**Facility:** Covered at 100% of the allowed amount subject to calendar year deductible **Physician:** Covered at 100% of the allowed amount; subject to calendar year deductible	**Facility:** Covered at 100% of the allowed amount subject to calendar year deductible **Physician:** Covered at 100% of the allowed amount; subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Not Covered
OUTPATIENT HOSPITAL **(Includes Mental Health Disorders and Substance Abuse)**				
Precertification is required for some outpatient hospital benefits; please see benefit booklet. Precertification is also required for provider-administered drugs; visit FL.ExploreMyPlan.com If precertification is not obtained, no benefits are available.				
Outpatient Surgery **(Including Ambulatory Surgical Centers)**	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Outpatient Bariatric Surgery	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Emergency Room (Medical Emergency and Accidental Care)	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to the in network calendar year deductible
Emergency Room (Physician)	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to the in network calendar year deductible
Urgent Care	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible

BENEFIT	Tier I Domestic Network	Tier 2 Select Providers	Tier 3 BlueOptions	Tier 4 Out-of-Network
Outpatient Diagnostic Lab & Pathology	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Outpatient X-Ray	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Advanced Imaging (MRA, MRI, CT or PET scans and nuclear medicine) • Precertification required for Tier 2, 3 and 4	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Dialysis	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Not Covered
Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
PHYSICIAN BENEFITS **(Includes Mental Health Disorders and Substance Abuse)**				
Precertification is required for some physician benefits; please see benefit booklet. **Precertification is also required for provider-administered drugs; FL.ExploreMyPlan.com. If precertification is not obtained, no benefits are available.**				
Office Visits & Consultations • Including telehealth visits • Primary care physicians includes family practice, general practice, non-specialized internal medicine, pediatrics, clinics, physician assistant, certified nurse practitioner, midwife, obstetrics/gynecology, or treatment of mental health and substance use disorders. All other physicians are considered Specialists	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
TGH Virtual Care Includes general medical and behavioral health services	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Not Covered
Tava (Virtual Mental Health Program) For behavioral health services	Covered at 100% of billed charges, subject to the deductible	Covered at 100% of billed charges, subject to the deductible	Covered at 100% of billed charges, subject to the deductible	Not Covered

BENEFIT	Tier I Domestic Network	Tier 2 Select Providers	Tier 3 BlueOptions	Tier 4 Out-of-Network
Second Surgical Opinion	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Surgery & Anesthesia	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Outpatient Bariatric Surgery	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Prenatal Maternity Care	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Maternity Delivery	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Urgent Care	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Applied Behavioral Analysis (ABA) Therapy • No age limit	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Diagnostic Lab & Pathology	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Diagnostic X-ray	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Dialysis	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Not Covered
TELEHEALTH SERVICES				
Benefits are provided for Telehealth Services subject to applicable cost-share for in-network and out-of-network services, when services rendered are performed within the scope of the health care providers license and deemed medically necessary.				

BENEFIT	Tier I Domestic Network	Tier 2 Select Providers	Tier 3 BlueOptions	Tier 4 Out-of-Network
PREVENTIVE CARE BENEFITS				
Routine Immunizations and Preventive Services • See **FL.ExploreMyPlan.com/FLPreventiveServices** and **FL.ExploreMyPlan.com/druglist** and select **Standard ACA Preventive Drug List** for a listing of the specific drugs, immunizations and preventive services or call our Customer Service Department for a printed copy • Certain immunizations may also be obtained through the Pharmacy Vaccine Network. Visit **FL.ExploreMyPlan.com/druglist** and select Vaccine Network Drug List for more information about covered immunizations	Covered at 100% of the allowed amount; no copay or deductible; in addition to the preventive services listed on the website, all in-network routine labs are provided at 100% of the allowed amount, **no** copay **or** deductible Additional Preventive Services • EKG • Urinalysis • Lab tests with a routine diagnosis	Covered at 100% of the allowed amount; no copay or deductible; in addition to the preventive services listed on the website, all in-network routine labs are provided at 100% of the allowed amount, **no** copay **or** deductible Additional Preventive Services • EKG • Urinalysis • Lab tests with a routine diagnosis	Covered at 100% of the allowed amount; no copay or deductible; in addition to the preventive services listed on the website, all in-network routine labs are provided at 100% of the allowed amount, **no** copay **or** deductible Additional Preventive Services • EKG • Urinalysis • Lab tests with a routine diagnosis	Covered at 50% of the allowed amount, subject to calendar year deductible; in addition to the preventive services listed on the website, all in-network routine labs are provided at 50% of the allowed amount, subject to the deductible Additional Preventive Services • EKG • Urinalysis • Lab tests with a routine diagnosis
Note: In some cases, office visit copays or facility copays may apply. Blue Cross and Blue Shield of Florida will process these claims as required by Section 1557 of the Affordable Care Act.				

BENEFIT	Tier I Domestic Network	Tier 2 Select Providers	Tier 3 BlueOptions	Tier 4 Out-of-Network
PRESCRIPTION DRUG BENEFITS **(Includes Mental Health Disorders and Substance Abuse)**				
Precertification is required for some drugs; if precertification is not obtained, no benefits are available.				
Retail Prescription Prepaid Drug Benefits • The pharmacy network for the plan is **Prime Participating Pharmacy Network** • View the **Standard Drug List** that applies to the plan at **FL.ExploreMyPlan.com/druglist** • Members can fill up to a 90 day supply of maintenance and non-maintenance drugs at the retail pharmacy • Topical Retinoids covered • Acne Medications Covered • Fertility Medications Covered ($20,000 lifetime maximum health + RX) • Erectile Dysfunction Drugs Covered (quantity limits apply) • Weight loss/weight gain medications excluded	**Tier 1 drugs**: Covered at 70% of the allowed amount, subject to calendar year deductible **Tier 2 drugs:** Covered at 70% of the allowed amount, subject to calendar year deductible **Tier 3 drugs:** Covered at 70% of the allowed amount, subject to calendar year deductible **Generic drugs mandatory and may be classified at any Tier.** **If generic is available and brand name is selected, member will be responsible for the difference in price plus the brand copay, unless the physician indicates, dispense as written. If the physician indicates dispense as written only the brand name copay will apply.**			Not covered
Mail Order Drug Benefits • Maintenance and non-maintenance drugs can be dispensed for up to a 90-day supply with one copay per 30 days • Mail Order drugs are available through the **Home Delivery Network** (Enroll online at **FL.ExploreMyPlan.com/HomeDeliveryNetwork**) • View the **Standard Drug** list that applies to the plan at **FL.ExploreMyPlan.com/druglist**	**Tier 1 drugs**: Covered at 70% of the allowed amount, subject to calendar year deductible **Tier 2 drugs:** Covered at 70% of the allowed amount, subject to calendar year deductible **Tier 3 drugs:** Covered at 70% of the allowed amount, subject to calendar year deductible			Not covered
• View the **Additional Standard HSA Drug List** that applies to the plan at **FL.ExploreMyPlan.com/druglist**	**Covered at 100% of the allowed amount, not subject to calendar year deductible**			Not covered
Specialty Drug Benefits • Specialty Drugs are available through the **Pharmacy Select Network** • View the **Standard Drug List** that applies to the plan at **FL.ExploreMyPlan.com/druglist**	**Tier 4 drugs:** Covered at 70% of the allowed amount, subject to calendar year deductible			Not covered

BENEFIT	Tier I Domestic Network	Tier 2 Select Providers	Tier 3 BlueOptions	Tier 4 Out-of-Network
BENEFITS FOR OTHER COVERED SERVICES (Includes Mental Health Disorders and Substance Abuse)				
Precertification is required for some other covered services; please see your benefit booklet. If precertification is not obtained, no benefits are available.				
Allergy Testing & Treatment	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Allergy Serum	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Abortion (elective and non-elective)	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Assisted Reproductive Technology • $20,000 lifetime maximum (includes medical and prescription drugs) • IVF services must be rendered at Shady Grove of Tampa Bay (includes surgeries and outpatient procedures) • No age limit/service requirement	Covered at 100% of the allowed amount, subject to calendar year deductible	Not Covered	Not Covered	Not Covered
Ambulance Service	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to in network calendar year deductible
Cardiac Pulmonary Rehabilitation • Limited to combined maximum of 20 visits per member per calendar year	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Cardiac Rehabilitation • Phase 1 and 2	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Chiropractic Services • Limited to a maximum of 20 visits per member per calendar year	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Durable Medical Equipment (DME), Casts, Prosthetics and Orthotics	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Home Health • Limited to combined maximum of 60 visits per member per calendar year	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Home Infusion	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible

BENEFIT	Tier I Domestic Network	Tier 2 Select Providers	Tier 3 BlueOptions	Tier 4 Out-of-Network
Hospice Services & Bereavement Counseling	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Occupational and Physical Therapy Limited to combined maximum of 20 visits per member per calendar year	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Occupational, Physical and Speech Therapy for Autism Spectrum Disorders • No age or visit limits	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Medical Nutrition Therapy For adults and children, limited to 6 hours per member per calendar year	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Skilled Nursing Facility Maximum Benefit 60 days per member per calendar year	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Speech Therapy Limited to a maximum of 20 visits per member per calendar year	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Sterilizations Reverse sterilizations not covered	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, no copay or deductible	Not Covered
TMJ Services Limited to treatment for Phase I only (including medical examinations, x-rays, diagnostic study casts, and joint repositioning appliances)	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Gene Therapy Must be performed in an approved facility	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Not Covered
Travel and Housing for Gene Therapy Services • Maximum Benefits per episode of gene therapy $10,000	Covered at 100% of the allowed amount subject to calendar year deductible	Covered at 100% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Not covered
Travel and Housing for Transplant Services • Maximum Benefits per transplant $10,000	Covered at 100% of the allowed amount subject to calendar year deductible	Covered at 100% of the allowed amount subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible	Not covered

HEALTH MANAGEMENT AND ADDITIONAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)	
Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury. For more information, please call 1-855-288-8356.
Chronic Condition Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and other specialized conditions.
Baby Yourself®	A maternity program; For more information, please call 1-855-288-8356. You can also enroll online at **FL.ExploreMyPlan.com/BabyYourself**.
Nurse Advice Line	A toll free nurse line that gives you access to a registered nurse 24 hours a day, seven days a week, 365 days a year. For more information, please call 1-877-837-7358.

Useful Information to Maximize Benefits

- *To maximize your benefits, always use in-network providers for services covered by your health benefit plan. To find in-network providers, check a provider directory, provider finder website **(FL.ExploreMyPlan.com/FindADoctor)** or call 1-855-630-6824).*
- *In-network hospitals, physicians and other healthcare providers have a contract with Blue Cross and Blue Shield of Florida or another Blue Cross and/or Blue Shield Plan for furnishing healthcare services at a reduced price (examples: BlueCard® PPO, PMD). In-network pharmacies are pharmacies that participate with Blue Cross and Blue Shield or its Pharmacy Benefit Manager(s).*
- *In Florida, in-network services provided by mental health disorders and substance abuse professionals are available. Sometimes an in-network provider may furnish a service to you that is not covered under the contract between the provider and a Blue Cross and/or Blue Shield Plan. When this happens, benefits may be denied or reduced. Please refer to your benefit booklet for the type of provider network that we determine to be an in-network provider for a particular service or supply.*
- *Out-of-network providers generally do not contract with Blue Cross and Blue Shield of Florida or another Blue Cross and/or Blue Shield Plan. If you use out-of-network providers, you may be responsible for filing your own claims and paying the difference between the provider's charge and the allowed amount. The allowed amount may be based on the negotiated rate payable to in-network providers in the same area or the average charge for care in the area, or in accordance with applicable Federal law.*

This is not a contract or benefit booklet.
Benefits are subject to the terms, limitations and conditions of your contract with us (including your benefit booklet).
Check your benefit booklet for more detailed coverage information.
Please visit our website or call Customer Service.
Member: 1-833-708-2308
Provider: 1-855-630-6825

Notice of Nondiscrimination

Blue Cross and Blue Shield of Florida complies with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact our 1557 Compliance Coordinator. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email at:
Blue Cross and Blue Shield of Florida, Birmingham Service Center, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-844-594-6009, 711 (TTY), 1-205-220-2984 (fax), Grievance1557@exploremyplan.com (email). If you need help filing a grievance, our 1557 Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201,
1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Foreign Language Assistance

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-594-6009 (TTY: 711)
French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-594-6009 (TTY: 711).
Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-594-6009 (TTY: 711).
Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-844-594-6009（TTY: 711）。
Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-594-6009 (TTY: 711).
French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-594-6009 (ATS: 711). MKT215FL
Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-594-6009 (TTY: 711).
Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-594-6009 (телетайп: 711).
Arabic: ةباتنا: اذإ ثدحتت تنك ةيبرعلا ةغللاب قلعتي امیف ةدعاسم تامدخ دجوت، ةفلكتن ودب، 6009-594-844-1) يصنلا فتاهلا: 711 لكل ةحاتم. لصتا.(-
Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-844-594-6009 (TTY: 711)번으로 전화해 주십시오.
Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-594-6009 (TTY: 711).
German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-594-6009 (TTY: 711).
Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-594-6009 (TTY: 711).
Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે 1-844-594-6009 પર કોલ કરો (TTY: 711).
Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-844-594-6009 (TTY: 711) （TTY: 711）まで、お電話にてご連絡
ください。