TGH Imaging (EPO) Plan

Effective January 1, 2025

TGH Imaging EPO Plan Effective January 1, 2025

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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 intry vary dopending upon the type provider and where services are received. SUMMARY OF COST SHARING PROVISIONS	BENEFIT	Tier I	Tier 2	Tier 3	Tier 4
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BENEFIT	Tier I	Tier 2	Tier 3	Tier 4
	TGH Advantage	Select Providers	BlueOptions	Out-of-Network
		T HOSPITAL AND PHYSICIAN		
Noto: If a Tior 1 or Tior 2		lental Health Disorders and Subs same day as a physician service		waived (Tior 4 excluded)
		cal emergency services, maternity ar		
		not obtained, a penalty of 50% may		
		precertification.		
Inpatient Hospital and	Covered at 100% of the	Covered at 100% of the allowed	Not covered	Not covered
Residential Treatment	allowed amount after \$250	amount after \$1,000 hospital		
Facilities	hospital copay for each admission	copay for each admission		
• Inpatient Emergency Room Admission for Tier 2, 3, 4 Pays at Tier 1 benefit				
Inpatient Physician Visits	Covered at 100% of the	Covered at 100% of the allowed	Not covered	Not covered
and Consultations	allowed amount; no copay or	amount; no copay or deductible		
	deductible	amount, no copay or deductible		
Inpatient Emergency Room				
Admission for Tier 2, 3, 4				
Pays at Tier 1 benefit	-			
Inpatient Bariatric Surgery	Facility: Covered at 100%	Not covered	Not covered	Not covered
	of the allowed amount after \$250 hospital copay			
	azoo nospital copay			
	Physician: Covered at			
	100% of the allowed			
	amount; no copay or			
	deductible			
		JTPATIENT HOSPITAL BENE		
		lental Health Disorders and Subs		
Note: If a Tier 1 or Tier 2	facility service is filed on the	same day as a physician service	, physician cost sharing will be	e waived. (Tier 4 excluded)
Precertification is requ	lired (excluding Tier 1) for some on If precertification is not	outpatient hospital benefits and physiobtained, a penalty of 50% may be ap	ician-administered drugs; please s oplied to applicable claims.	see your benefit booklet.
Outpatient Surgery	Covered at 100% of the	Covered at 100% of the allowed		Not covered
(Including Ambulatory Surgical	allowed amount, after \$150	amount, after \$500 hospital	allowed amount, subject to	
Centers)	hospital copay	сорау	calendar year deductible	
			Note: No benefits available for services not performed in a free	
			standing facility or ambulatory	
			surgical center	

BENEFIT	Tier I	Tier 2	Tier 3	Tier 4
	TGH Advantage	Select Providers	BlueOptions	Out-of-Network
Outpatient Bariatric Surgery	Covered at 100% of the allowed amount after \$150 hospital copay	Not covered	Not covered	Not covered
Emergency Room (Medical Emergency and Accidental Care)	Covered at 100% of the allowed amount, after \$500 hospital copay	Covered at 100% of the allowed amount, after \$500 hospital copay	Covered at 100% of the allowed amount, after \$500 hospital copay	Covered at 100% of the allowed amount, after \$500 hospital copay
• Emergency Room copay waived if admitted as inpatient within 24 hours	Non-emergent visits are covered at 100% of the allowed amount, after \$500 hospital copay	Non-emergent visits are covered at 100% of the allowed amount, after \$500 hospital copay	Non-emergent visits are not covered	Non-emergent visits are not covered
Emergency Room (Physician)	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	Covered at 100% of the allowed amount, no copay or deductible
	Non-emergent visits are covered at 100% of the allowed amount, no copay or deductible	Non-emergent visits are covered at 100% of the allowed amount, no copay or deductible	Non-emergent visits not covered	Non-emergent visits not covered
 Urgent Care Services such as labs, x-rays, surgery, and anesthesia when submitted with office visit, does not have a separate copay. If labs, x-rays, surgery, and anesthesia are submitted as a separate claim without a physician office visit, copay will apply 	Covered at 100% of the allowed amount, after \$50 copay	Covered at 100% of the allowed amount, after \$50 copay	Covered at 100% of the allowed amount, after \$50 copay	Covered at 80% of the allowed amount, subject to the calendar year deductible
Outpatient Diagnostic Lab & Pathology	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, after \$35 copay per visit	Covered at 100% of the allowed amount, after \$45 copay per visit Note: No benefits available for services not performed in a free standing facility or ambulatory surgical center	Covered at 80% of the allowed amount, subject to the calendar year deductible
Outpatient X-Ray	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, after \$35 copay per visit	Covered at 100% of the allowed amount, after \$45 copay per visit Note: No benefits available for services not performed in a free standing facility or ambulatory surgical center	Covered at 80% of the allowed amount, subject to the calendar year deductible

BENEFIT	Tier I	Tier 2	Tier 3	Tier 4
	TGH Advantage	Select Providers	BlueOptions	Out-of-Network
Advanced Imaging (MRA,	Covered at 100% of the	Covered at 90% of the allowed	Covered at 60% of the	Not covered
MRI, CT or PET scans and	allowed amount; no copay or	amount, subject to calendar	allowed amount, subject to	
nuclear medicine)	deductible	year deductible	calendar year deductible	
Precertification required for			Note: No benefits available for	
Tier 2 and 3			services not performed in a free	
			standing facility or ambulatory surgical center	
IV Therapy,	Covered at 100% of the	Covered at 100% of the allowed	Covered at 60% of the	Not covered
Chemotherapy &	allowed amount; no copay or	amount, after \$100 copay per	allowed amount, subject to	
Radiation Therapy	deductible	visit	calendar year deductible	
		Maximum copay per calendar year	Note: No benefits available for	
		of \$500 claims paid (facility and	services not performed in a free	
		physician maximums cross-apply)	standing facility or ambulatory surgical center	
Dialysis	Covered at 100% of the	Covered at 100% of the allowed	Covered at 100% of the	Not covered
,	allowed amount, after \$100	amount, after \$100 copay with a	allowed amount, after \$100	
• Facility & Physician out-of-	copay with a maximum out-	maximum out-of-pocket of \$300	copay with a maximum out-	
pocket maximums are combined (each tier has	of-pocket of \$300		of-pocket of \$500	
separate amount)			Note: No benefits available for	
ooparato amounty			services not performed in a free	
			standing facility or ambulatory	
			surgical center	
Intensive Outpatient	Covered at 100% of the	Covered at 100% of the allowed	Covered at 100% of the	Not covered
Services and Partial	allowed amount, no copay or	amount, no copay or deductible	allowed amount, no copay or	
Hospitalization for Mental	deductible		deductible	
Health Disorders and				
Substance Abuse Services			Note: No benefits available for	
			services not performed in a free	
			standing facility or ambulatory surgical center	
		PHYSICIAN BENEFITS		
Noto: If a Tior 1 or Tior 2	(Includes N	lental Health Disorders and Subs same day as a physician service	stance Abuse)	waived (Tior 4 excluded)
Precertification is required (ex	xcluding Tier 1) for some physicia	in benefits and physician-administer	ed drugs; please see your benefit l	booklet. If precertification is not
		penalty of 50% may be applied to ap		
Office Visits & Consultations	Covered at 100% of the	Covered at 100% of the	Covered at 100% of the allowed amount, after \$45	Covered at 80% of the allowed amount, subject to
	allowed amount, after	allowed amount, after \$35	· · ·	
Primary care physicians	\$10 primary care	primary care physician copay or \$45 specialist	primary care physician copay or \$55 specialist	the calendar year deductible
Includes family practice, general practice, non-	physician copay or \$25			
specialized internal medicine,	specialist physician	physician copay	physician copay	
pediatrics, clinics, physician	сорау		Mental health disorders and	Mental health disorders and
assistant, certified nurse	Mental health disorders and	Mental health disorders and	substance abuse services	substance abuse services
practitioner, midwife,	substance abuse services	substance abuse services	covered at 100% of the allowed	covered at 80% of the allowed
obstetrics/gynecology, or	covered at 100% of the allowed	covered at 100% of the allowed	amount, after \$10 physician	amount, subject to calendar year
treatment of mental health	amount, after \$10 physician	amount, after \$10 physician copay	copay	deductible
and substance use disorders.	сорау			
1 2				
All other physicians are considered Specialists				

BENEFIT	Tier I	Tier 2	Tier 3	Tier 4
	TGH Advantage	Select Providers	BlueOptions	Out-of-Network
 Physician Office Services Services such as labs, x-rays, surgery, and anesthesia when submitted with office visit, does not have a separate copay. If labs, x-rays, surgery, and anesthesia are submitted as a separate claim without a 	Covered at 100% of the allowed amount, subject to office visit copay	Covered at 100% of the allowed amount, subject to office visit copay	Covered at 100% of the allowed amount, subject to office visit copay	Covered at 80% of the allowed amount, subject to the calendar year deductible
physician office visit, copay will apply				
Second Surgical Opinion	Covered at 100% of the allowed amount, after \$10 primary care physician copay or \$25 specialist physician copay	Covered at 100% of the allowed amount, after \$10 primary care physician copay or \$25 specialist physician copay	Covered at 100% of the allowed amount, after \$10 primary care physician copay or \$25 specialist physician copay	Covered at 80% of the allowed amount, subject to the calendar year deductible
 TGH Virtual Care Includes general medical and behavioral health services 	Covered at 100% of billed charges, after \$10 copay	Covered at 100% of billed charges, after \$10 copay	Covered at 100% of billed charges, after \$10 copay	Not covered
Tava (Virtual Mental Health Program) • For behavioral health services	Covered at 100% of billed charges, after \$10 copay	Covered at 100% of billed charges, after \$10 copay	Covered at 100% of billed charges, after \$10 copay	Not covered
Surgery & Anesthesia	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, no copay or deductible	Covered at 60% of the allowed amount, subject to the calendar year deductible	Not covered
Outpatient Bariatric Surgery	Covered at 100% of the allowed amount, no copay or deductible	Not covered	Not covered	Not covered
Prenatal Maternity Care	Covered at 100% of the allowed amount, subject to the physician office copay at first visit only	Covered at 100% of the allowed amount, subject to the physician office copay at first visit only	Covered at 100% of the allowed amount, subject to the physician office copay at first visit only	Covered at 100% of the allowed amount, subject to the physician office copay at first visit only
Maternity Delivery	Covered at 100% of the allowed amount, subject to a \$500 hospital copay	Not covered	Not covered	Not covered
 Urgent Care Services such as labs, x-rays, surgery, and anesthesia when submitted with office visit, does not have a separate copay. If labs, x-rays, surgery, and anesthesia are submitted as a separate claim without a physician office visit, copay 	Covered at 100% of the allowed amount, after \$50 physician copay	Covered at 100% of the allowed amount, after \$50 physician copay	Covered at 100% of the allowed amount, after \$50 physician copay	Covered at 80% of the allowed amount, subject to the calendar year deductible

BENEFIT	Tier I TGH Advantage	Tier 2 Select Providers	Tier 3 BlueOptions	Tier 4 Out-of-Network
Applied Behavioral Analysis (ABA) Therapy • No age limit	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	Covered at 80% of the allowed amount, subject to the calendar year deductible
Diagnostic Lab & Pathology	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, after \$35 copay per visit	Covered at 100% of the allowed amount, after \$45 copay per visit	Covered at 80% of the allowed amount, subject to the calendar year deductible
Diagnostic X-ray	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, after \$35 copay per visit	Covered at 100% of the allowed amount, after \$45 copay per visit	Covered at 80% of the allowed amount, subject to the calendar year deductible
IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, after \$100 copay per visit Maximum copay per calendar year of \$500 claims paid (facility and physician maximums cross-apply)	Covered at 60% of the allowed amount, subject to calendar year deductible	Not covered
 Dialysis Facility & Physician out-of- pocket maximums are combined (each tier has 	Covered at 100% of the allowed amount, after \$100 copay with a max out of pocket of \$300	Covered at 100% of the allowed amount, after \$100 copay with a max out of pocket of \$300	Covered at 100% of the allowed amount, after \$100 copay with a max out of pocket of \$500	Not covered

BENEFIT	Tier I	Tier 2	Tier 3	Tier 4
	TGH Advantage	Select Providers	BlueOptions	Out-of-Network
		PREVENTIVE CARE BENEFIT	TS	
 Routine Immunizations and Preventive Services See FL.ExploreMyPlan.com/FL PreventiveServices and FL.ExploreMyPlan.com/dr uglist and select Standard ACA PreventiveDrugList 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/dr uglist 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, <u>no</u> copay <u>or</u> deductible	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, <u>no</u> copay <u>or</u> deductible	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, <u>no</u> copay <u>or</u> deductible	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, <u>no</u> copay <u>or</u> deductible
Routine Skin Cancer	Covered at 100% of the	Covered at 100% of the allowed	Covered at 100% of the	Not covered
ScreeningOne per calendar year	allowed amount; no copay or deductible	amount; no copay or deductible	allowed amount; no copay or deductible	
1557 of the Affordable Care A	ct.	ROUTINE VISION BENEFITS	5	
Eye ExamLimited to one exam and refraction every 24 months	Covered at 100% of the allowed amount, after \$25 copay per visit	Covered at 100% of the allowed amount, after \$45 copay per visit	Covered at 100% of the allowed amount, after \$55 copay per visit	Not covered
 Limited to one exam every 24 months 	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
		ROUTINE HEARING BENEFIT	TS	
Hearing Exam and Tests	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, no copay or deductible	Covered at 60% of the allowed amount, subject to calendar year deductible	Not covered

BENEFIT	Tier I	Tier 2	Tier 3	Tier 4
	TGH Advantage	Select Providers	BlueOptions	Out-of-Network
Hearing Aids	Covered at 100% of the	Covered at 100% of the	Covered at 60% of the	Not covered
5	allowed amount, no copay	allowed amount, no copay or	allowed amount, subject to	
 Maximum for all Tiers cross apply 	or deductible	deductible	calendar year deductible	
	 Limited to 1 hearing aid every three years in the amount of \$2,990 per ear Member pays the difference between \$2,990 paid by the plan, and the additional cost of the device 	 Limited to 1 hearing aid every three years in the amount of \$2,990 per ear Member pays the difference between \$2,990 paid by the plan, and the additional cost of the device 	 Limited to 1 hearing aid every three years in the amount of \$2,990 per ear Member pays the difference between \$2,990 paid by the plan, and the additional cost of the device 	
Cochlear Implants	Covered at 100% of the	Covered at 100% of the	Covered at 60% of the	Not covered
(Internal Component)	allowed amount, no copay or deductible	allowed amount, no copay or deductible	allowed amount, subject to calendar year deductible	
 External component (sound processor) is covered under DME Implant procedure is covered under surgery 				
		PRESCRIPTION DRUG BENEF	ITS	
		lental Health Disorders and Subs		
Prec		ne drugs; if precertification is no		ilable.
Retail Prescription Prepaid		amount after the following copays t		Not covered
Benefits	each prescription:	0.1.7		
 The pharmacy network for the plan is Prime Participating Network View the Standard Drug that applies to the plan at FL.ExploreMyPlan.com/d 	Tier 1 drugs: \$45 copay per prescription Tier 2 drugs: 25% with a minimum of \$60 ar Tier 3 drugs: 35% with a minimum of \$80 ar			
 ruglist The only in-network pharmacies for drugs over \$400 are Tampa General and any pharmacy referred by Tampa General 				
 Topical retinoids covered Acne medications covered 				
Fertility medications covered				
 Erectile Dysfunction Drugs Covered (quantity limits apply) 				
 Weight loss/weight gain medications covered 				

BENEFIT	Tier I	Tier 2	Tier 3	Tier 4
	TGH Advantage	Select Providers	BlueOptions	Out-of-Network
 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/d ruglist The only in-network pharmacies for drugs over \$400 are Tampa General, USF Pharmacy Plus or any 	Covered at 100% of the allowed prescription: Tier 4 drugs: 35% with a minimum of \$100 ar	amount after the following copays for	a 31-day supply for each	Not covered
pharmacy they refer to TGH In-House Drug Benefits • Also available at USF Pharmacy Plus	prescription: Tier 1 drugs: \$20 copay per prescription Tier 2 drugs: \$30 copay per prescription Tier 3 drugs: \$40 copay per prescription Tier 4 drugs: \$120 copay per prescription Covered at 100% of the allowed prescription: Tier 1 drugs: \$40 copay per prescription Tier 2 drugs: \$40 copay per prescription Tier 3 drugs: \$60 copay per prescription Tier 3 drugs: \$80 copay per prescription TGH In-House Pharmacy Diate Bayer products \$0 FreeStyle Libre Reader: \$15 cc FreeStyle Libre sensors: One rr Free Style Libre sensors: 14 da 100 Precision Neostrips: \$20 cc Dexcom 10 day sensors (3/moo 1 Dexcom transmitter (refill eve	opay nonth supply: \$15 copay ays each/one month supply: \$15 cop opay nth): \$20 copay ry three months): \$20 copay cose data (may refill after one year):	or a 90-day supply for each	Not covered

BENEFIT	Tier I	Tier 2	Tier 3	Tier 4
	TGH Advantage	Select Providers	BlueOptions	Out-of-Network
 Mail Order Pharmacy Benefits Up to 90-day supply with one copay for each 90-day supply Mail Order drugs are available through the Home Delivery Network (Enroll online at FL.ExploreMyPlan.com or coll 1 955 703 5226) 		amount after the following copays fo		Not covered
 call 1-855-793-5326) Maintenance and non-maintenance drugs can be purchased through the home delivery View the Standard Drug List that applies to the plan at FL.ExploreMyPlan.com/dr 				
 Specialty drugs are not covered through the Home Delivery Network 				
Note: If a Tier 1 or Tier 2 Pres	(Includes M) facility service is filed on the certification is required (<i>excludin</i>)	ITS FOR OTHER COVERED S lental Health Disorders and Subs same day as a physician service g Tier 1) for some other covered ser obtained, a penalty of 50% may be ap	stance Abuse) , physician cost sharing will b rvices; please see your benefit bo	e waived. (Tier 4 excluded) oklet.
Acupuncture (for pain	Covered at 100% of the	Covered at 100% of the allowed	Covered at 100% of the	Not covered
therapy)	allowed amount, after \$10 copay per visit	amount, after \$35 copay per visit	allowed amount, after \$55 copay per visit	
 Limited to combined maximum of 30 visits per calendar year 				
Allergy Testing & Treatment	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
Ambulance Service	Covered at 100% of billed	Covered at 100% of billed	Covered at 100% of billed	Covered at 100% of billed
Non-true emergency ambulance not covered	charges, no copay or deductible	charges, no copay or deductible	charges, no copay or deductible	charges, no copay or deductible
 Chiropractic Services Limited to combined maximum of 40 visits per calendar year 	Covered at 100% of the allowed amount, after \$10 copay per visit	Covered at 100% of the allowed amount, after \$45 copay per visit	Covered at 100% of the allowed amount, after \$55 copay per visit	Covered at 80% of the allowed amount, subject to the calendar year deductible

BENEFIT	Tier I	Tier 2	Tier 3	Tier 4
	TGH Advantage	Select Providers	BlueOptions	Out-of-Network
Cardiac Pulmonary Rehabilitation	Covered at 100% of the allowed amount, after \$25 copay per visit	Covered at 100% of the allowed amount, after \$45 copay per visit	Covered at 100% of the allowed amount, after \$55 copay per visit For facility services: No benefits available for services not performed in a free standing facility or ambulatory surgical center	Not covered
 Cardiac Rehabilitation Phase 1 and 2 	Covered at 100% of the allowed amount, after \$25 copay per visit	Covered at 100% of the allowed amount, after \$45 copay per visit	Covered at 100% of the allowed amount, after \$55 copay per visit For facility services: No benefits available for services not performed in a free standing facility or ambulatory surgical center	Not covered
Durable Medical Equipment (DME), Casts, Prosthetics and Orthotics Including Implantable Hearing Devices	Covered at 90% of the allowed amount, no copay or deductible	Covered at 90% of the allowed amount, no copay or deductible	Covered at 90% of the allowed amount, no copay or deductible	Not covered
 Home Health Limited to combined maximum of 100 visits per calendar year 	Covered at 90% of the allowed amount, no copay or deductible	Covered at 90% of the allowed amount, no copay or deductible	Covered at 90% of the allowed amount, no copay or deductible	Not covered
Home Infusion	Covered at 90% of the allowed amount, no copay or deductible	Covered at 90% of the allowed amount, no copay or deductible	Covered at 90% of the allowed amount, no copay or deductible	Not covered
Hospice Services & Bereavement Counseling	Covered at 90% of the allowed amount, no copay or deductible	Covered at 90% of the allowed amount, no copay or deductible	Covered at 90% of the allowed amount, no copay or deductible For facility services: No benefits available for services not performed in a free standing facility or ambulatory surgical center	Not covered

BENEFIT	Tier I	Tier 2	Tier 3	Tier 4
	TGH Advantage	Select Providers	BlueOptions	Out-of-Network
 Occupational and Physical Therapy Limited to combined maximum of 80 visits per calendar year for Tier 1 and Tier 2 	Covered at 100% of the allowed amount, after \$10 copay per visit	Covered at 100% of the allowed amount, after \$45 copay per visit	Covered at 100% of the allowed amount, after \$55 copay per visit	Not covered
 Limited to combined maximum of 40 visits per calendar year for Tier 3 Medical Necessity will be reviewed after 80 visits for Tiers 1 and 2 No additional benefits allowed for Tier 3 after 40 visits 			For facility services: No benefits available for services not performed in a free standing facility or ambulatory surgical center	
Occupational, Physical and Speech Therapy for Autism Spectrum Disorders	Covered at 100% of the allowed amount, after \$10 copay per visit	Covered at 100% of the allowed amount, after \$45 copay per visit	Covered at 100% of the allowed amount, after \$55 copay per visit	Not covered
 Skilled Nursing Facility Maximum Benefit 120 days per calendar year 	Covered at 90% of the allowed amount, no copay or deductible	Covered at 90% of the allowed amount, no copay or deductible	Covered at 90% of the allowed amount, no copay or deductible For facility services: No benefits available for services not performed in a free standing facility or ambulatory surgical center	Not covered
 Speech Therapy Limited to combined maximum of 40 visits per calendar year Medical Necessity will be reviewed after 40 visits for Tier 1 and 2 No additional benefits allowed for Tier 3 after 40 visits 	Covered at 100% of the allowed amount, after \$10 copay per visit	Covered at 100% of the allowed amount, after \$45 copay per visit	Covered at 100% of the allowed amount, after \$55 copay per visit For facility services: No benefits available for services not performed in a free standing facility or ambulatory surgical center	Not covered
Sterilizations	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 For facility services: No benefits available for services not performed in a free standing facility or ambulatory surgical center	Not covered

BENEFIT	Tier I	Tier 2	Tier 3	Tier 4
BEREITI	TGH Advantage	Select Providers	BlueOptions	Out-of-Network
 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, no copay or deductible	Covered at 100% of the allowed amount, no copay or deductible	Covered at 60% of the allowed amount, subject to calendar year deductible For facility services: No benefits available for services not performed in a free standing facility or ambulatory surgical center	Not covered
 Transplant Services For Travel and Housing Maximum Benefits per transplant \$10,000 Services available up to one year at Designated Facility Must be pre-authorized by TGH 	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	Covered at 100% of the allowed amount, no copay or deductible
 Wigs (Cranial Prostheses, Toupees, or Hairpieces) Related to Cancer Treatment or Alopecia Areata only Maximum benefit per calendar year \$500 of claims paid 	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
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.			
Contraceptive Management	Covers prescription contraceptives, which includes: birth control pills, injectables, diaphragms, IUDs and other non-experimental FDA approved contraceptives; subject to applicable deductibles, copays and coinsurance.			

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 of Florida or its Pharmacy Benefit Manager(s).
- Note: Home Sleep Studies are not subject to medical criteria for coverage; however, Outpatient Sleep Studies are subject to standard medical criteria for coverage in all tiers.
- 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: 1-844-594-6012 Provider: 1-855-630-6825