

**Tampa General Hospital  
Out-of-Area Plan  
HSA Qualified HDHP**

January 1, 2025

**Tampa General Hospital  
Out-of-Area HSA Plan  
Effective January 1, 2025**

BENEFIT	In-Network	Out-of-Network
<p><i>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.</i></p>		
<b>HEALTH SAVINGS ACCOUNT (HSA)</b>		
<p>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.</p>		
<p><b>Maximum Contribution:</b> The maximum contribution amount is indexed each year by the U.S. Treasury. The 2025 maximum contribution is <b>\$4,300</b> for single coverage and <b>\$8,550</b> for family coverage. If you have any questions about the benefits of an HSA, please consult your tax accountant.</p>		
<b>SUMMARY OF COST SHARING PROVISIONS (Includes Mental Health Disorders and Substance Abuse)</b>		
<b>Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.</b>		
<p><b>Calendar Year Deductible</b></p> <p>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.</p>	<p>\$5,000 Individual \$10,000 Family</p>	<p>\$10,000 Individual \$20,000 Family</p>
<p><b>Calendar Year Out-of-Pocket Maximum</b></p> <p>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.</p> <p>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 out of pocket maximum, including prescription drugs</p>	<p>\$7,000 Individual \$15,000 Family</p>	<p>Individual – No Limit Family – No Limit</p>
<b>INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)</b>		
<p><b>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 50% may be applied to applicable claims. Call 1-855-288-8357 (toll-free) for precertification.</b></p>		
<b>Inpatient Hospital and Residential Treatment Facilities</b>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>Inpatient Physician Visits and Consultations</b>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>Inpatient Bariatric Surgery</b>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<p><b>Organ Transplants</b></p> <ul style="list-style-type: none"> <li>Benefits are only provided at Blue Distinction Centers and Center of Excellence</li> </ul>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)</b>		
<p><b>Precertification is required for some outpatient hospital benefits and physician-administered drugs; please see your benefit booklet. If precertification is not obtained, a penalty of 50% may be applied to applicable claims.</b></p>		
<b>Outpatient Surgery</b> (Including Ambulatory Surgical Centers)	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>Outpatient Bariatric Surgery</b>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<p><b>Emergency Room (Medical Emergency and Accidental Care)</b></p> <p>Emergency Room copay waived if admitted as inpatient within 24 hours</p>	<p>Covered at 80% of the allowed amount, subject to the calendar year deductible</p> <p>Non-emergent visits not covered</p>	<p>Covered at 80% of the allowed amount, subject to the in-network calendar year deductible</p> <p>Non-emergent visits not covered</p>

BENEFIT	In-Network	Out-of-Network
<b>Emergency Room (Physician)</b>	Covered at 80% of the allowed amount, subject to the calendar year deductible  Non-emergent visits not covered	Covered at 80% of the allowed amount, subject to the in-network calendar year deductible  Non-emergent visits not covered
<b>Urgent Care</b>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>Outpatient Diagnostic Lab &amp; Pathology</b>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>Outpatient X-Ray</b>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>Advanced Imaging (MRA, MRI, CT or PET scans and nuclear medicine)</b>  Precertification required	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>IV Therapy, Chemotherapy &amp; Radiation Therapy</b>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>Dialysis</b>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services</b>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered

**PHYSICIAN BENEFITS**  
(Includes Mental Health Disorders and Substance Abuse)

Precertification is required for some physician benefits and physician-administered drugs; please see your benefit booklet. If precertification is not obtained, a penalty of 50% may be applied to applicable claims

<b>Office Visits &amp; Consultations</b> • Includes 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 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>TGH Virtual Care</b> Includes general medical and behavioral health services	Covered at 80% of billed charges, subject to the calendar year deductible	Not covered
<b>Tava (Virtual Mental Health Program)</b> For behavioral health services	Covered at 100% of billed charges, subject to the calendar year deductible	Not covered
<b>Second Surgical Opinion</b>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>Surgery &amp; Anesthesia</b>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>Outpatient Bariatric Surgery</b>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>Prenatal Maternity Care</b>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>Maternity Delivery</b>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>Urgent Care</b>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>Applied Behavioral Analysis (ABA) Therapy</b> No age limit	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>Diagnostic Lab &amp; Pathology</b>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>Diagnostic X-ray</b>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>IV Therapy, Chemotherapy &amp; Radiation Therapy</b>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>Dialysis</b>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered

**TELEHEALTH SERVICES**

Benefits are provided for Telehealth Services subject to applicable cost-share for services, when services rendered are performed within the scope of the health care providers license and deemed medically necessary.

BENEFIT	In-Network	Out-of-Network
<b>PREVENTIVE CARE BENEFITS</b>		
<b>Routine Immunizations and Preventive Services</b> <ul style="list-style-type: none"> <li>See <a href="http://FL.ExploreMyPlan.com/FLPreventiveServices">FL.ExploreMyPlan.com/FLPreventiveServices</a> and <a href="http://FL.ExploreMyPlan.com/druglist">FL.ExploreMyPlan.com/druglist</a> and select <b>Standard ACA PreventiveDrugList</b> for a listing of the specific drugs, immunizations and preventive services or call our Customer Service Department for a printed copy</li> <li>Certain immunizations may also be obtained through the Pharmacy Vaccine Network. Visit <a href="http://FL.ExploreMyPlan.com/druglist">FL.ExploreMyPlan.com/druglist</a> and select Vaccine Network Drug List for more information about covered immunizations</li> </ul>	Covered at 100% of the allowed amount; no copay or deductible	Not covered
<b>Routine Skin Cancer Screening</b> <ul style="list-style-type: none"> <li>One per calendar year</li> </ul>	Covered at 100% of the allowed amount; no copay or deductible	Not covered
<b>Note:</b> 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.		
<b>ROUTINE VISION BENEFITS</b>		
<b>Eye Exam</b> <ul style="list-style-type: none"> <li>Limited to one exam and refraction every 24 months</li> </ul>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>Refraction</b> <ul style="list-style-type: none"> <li>Limited to one exam every 24 months</li> </ul>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>ROUTINE HEARING BENEFITS</b>		
<b>Hearing Exam and Tests</b>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>Hearing Aids</b> <ul style="list-style-type: none"> <li>Limited to 1 hearing aid every three years in the amount of \$2,990 per ear</li> <li>Member pays the difference between \$2,990 paid by the plan, and the additional cost of the device</li> </ul>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>Cochlear Implants (Internal Component)</b> <ul style="list-style-type: none"> <li>External component (sound processor) is covered under DME</li> <li>Implant procedure is covered under surgery</li> </ul>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>PRESCRIPTION DRUG BENEFITS</b> (Includes Mental Health Disorders and Substance Abuse)		
<b>Precertification is required for some drugs; if precertification is not obtained, no benefits are available.</b>		
<b>Retail Prescription Prepaid Benefits</b> <ul style="list-style-type: none"> <li>The pharmacy network for the plan is <b>Prime Participating Network</b></li> <li>View the <b>Standard Drug</b> that applies to the plan at <a href="http://FL.ExploreMyPlan.com/druglist">FL.ExploreMyPlan.com/druglist</a></li> <li>Topical retinoids covered</li> <li>Acne medications covered</li> <li>Fertility medications not covered</li> <li>Erectile Dysfunction Drugs Covered (quantity limits apply)</li> <li>Weight loss/weight gain medications covered</li> </ul>	Covered for a <b>31-day</b> supply for each prescription: <b>Tier 1 drugs:</b> \$45 copay per prescription subject to calendar year deductible <b>Tier 2 drugs:</b> 25% coinsurance per prescription subject to calendar year deductible (minimum of \$60 and a maximum of \$150) <b>Tier 3 drugs:</b> 35% coinsurance per prescription subject to calendar year deductible (minimum of \$80 and a maximum of \$300)	Not covered
<b>Specialty Drug Benefits</b> <ul style="list-style-type: none"> <li>Specialty Drugs are available through the <b>Pharmacy Select Network</b></li> <li>View the <b>Standard Drug List</b> that applies to the plan at <a href="http://FL.ExploreMyPlan.com/druglist">FL.ExploreMyPlan.com/druglist</a></li> </ul>	Covered for a <b>31-day</b> supply for each prescription: <b>Tier 4 drugs:</b> 35% coinsurance per prescription subject to calendar year deductible (minimum of \$80 and a maximum of \$300)	Not covered
<ul style="list-style-type: none"> <li>View the <b>Additional Standard HSA Drug List</b> that applies to the plan at <a href="http://FL.ExploreMyPlan.com/druglist">FL.ExploreMyPlan.com/druglist</a></li> </ul>	Covered at 100% of the allowed amount, not subject to calendar year deductible	Not covered

BENEFIT	In-Network	Out-of-Network
<p><b>Mail Order Pharmacy Benefits</b></p> <ul style="list-style-type: none"> <li>Up to 90-day supply with one copay for each 90-day supply</li> <li>Mail Order drugs are available through the <b>Home Delivery Network</b> (Enroll online at <a href="http://FL.ExploreMyPlan.com">FL.ExploreMyPlan.com</a> or call 1-855-793-5326)</li> <li>Maintenance and non-maintenance drugs can be purchased through the home delivery</li> <li>View the <b>Standard Drug List</b> that applies to the plan at <a href="http://FL.ExploreMyPlan.com/druglist">FL.ExploreMyPlan.com/druglist</a></li> </ul> <p>Specialty drugs are not covered through the Home Delivery Network</p>	<p>Covered at 100% of the allowed amount <b>after deductible</b> and the following copays for each prescription:</p> <p><b>Tier 1 drugs:</b> \$30 copay per prescription</p> <p><b>Tier 2 drugs:</b> \$40 copay per prescription</p> <p><b>Tier 3 drugs:</b> \$50 copay per prescription</p> <p><b>Tier 4 drugs:</b> Not covered</p>	<p>Not covered</p>

**BENEFITS FOR OTHER COVERED SERVICES  
(Includes Mental Health Disorders and Substance Abuse)**

**Recertification is required for some other covered services; please see your benefit booklet.  
If precertification is not obtained, a penalty of 50% may be applied to applicable claims.**

<p><b>Acupuncture (for pain therapy)</b></p> <p>Limited to combined maximum of 30 visits per calendar year</p>	<p>Covered at 80% of the allowed amount, subject to the calendar year deductible</p>	<p>Not covered</p>
<p><b>Allergy Testing &amp; Treatment</b></p>	<p>Covered at 80% of the allowed amount, subject to the calendar year deductible</p>	<p>Not covered</p>
<p><b>Ambulance Service</b></p> <p>Non-true emergency ambulance not covered</p>	<p>Covered at 80% of the allowed amount, subject to the calendar year deductible</p>	<p>Covered at 80% of the allowed amount, subject to the in-network calendar year deductible</p>
<p><b>Assisted Reproductive Technologies</b></p>	<p>Not Covered</p>	<p>Not Covered</p>
<p><b>Chiropractic Services</b></p> <p>Limited to combined maximum of 40 visits per calendar year</p>	<p>Covered at 80% of the allowed amount, subject to the calendar year deductible</p>	<p>Not covered</p>
<p><b>Cardiac Pulmonary Rehabilitation</b></p>	<p>Covered at 80% of the allowed amount, subject to the calendar year deductible</p>	<p>Not covered</p>
<p><b>Cardiac Rehabilitation</b></p> <p>Phase 1 &amp; 2</p>	<p>Covered at 80% of the allowed amount, subject to the calendar year deductible</p>	<p>Not covered</p>
<p><b>Durable Medical Equipment (DME), Casts, Prosthetics and Orthotics</b></p> <p>Including Implantable Hearing Devices</p>	<p>Covered at 80% of the allowed amount, subject to the calendar year deductible</p>	<p>Not covered</p>
<p><b>Home Health</b></p> <p>Limited to combined maximum of 100 visits per calendar year</p>	<p>Covered at 80% of the allowed amount, subject to the calendar year deductible</p>	<p>Not covered</p>
<p><b>Home Infusion Benefit</b></p> <p>No visit limit</p>	<p>Covered at 80% of the allowed amount, subject to the calendar year deductible</p>	<p>Not covered</p>
<p><b>Hospice Services &amp; Bereavement Counseling</b></p>	<p>Covered at 80% of the allowed amount, subject to the calendar year deductible</p>	<p>Not covered</p>
<p><b>Occupational and Physical Therapy</b></p> <p>Limited to a combined maximum of 80 visits per calendar year</p>	<p>Covered at 80% of the allowed amount, subject to the calendar year deductible</p>	<p>Not covered</p>
<p><b>Occupational, Physical and Speech Therapy for Autism Spectrum Disorders</b></p> <p>No age or visit limitations</p>	<p>Covered at 80% of the allowed amount, subject to the calendar year deductible</p>	<p>Not covered</p>
<p><b>Skilled Nursing Facility</b></p> <p>Maximum Benefit 120 days per calendar year</p>	<p>Covered at 80% of the allowed amount, subject to the calendar year deductible</p>	<p>Not covered</p>
<p><b>Speech Therapy</b></p> <p>Limited to combined maximum of 40 visits per calendar year</p>	<p>Covered at 80% of the allowed amount, subject to the calendar year deductible</p>	<p>Not covered</p>

BENEFIT	In-Network	Out-of-Network
<b>Sterilizations</b>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>TMJ Services</b>  Limited to treatment for Phase I only (including medical examinations, x-rays, diagnostic study casts, and joint repositioning appliances)	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered
<b>Transplant Services For Travel and Housing</b>  <ul style="list-style-type: none"> <li>Maximum of \$10,000 per transplant</li> <li>Services available up to one year at Designated Facility</li> <li>Must be pre-authorized</li> </ul>	Covered at 100% of the allowed amount, subject to the calendar year deductible	Not covered
<b>Wigs (Cranial Prostheses, Toupees, or Hairpieces)</b>  <ul style="list-style-type: none"> <li>Related to Cancer Treatment or Alopecia Areata only</li> <li>Maximum benefit per calendar year \$500 of claims paid</li> </ul>	Covered at 80% of the allowed amount, subject to the calendar year deductible	Not covered

**HEALTH MANAGEMENT AND ADDITIONAL BENEFITS**  
(Includes Mental Health Disorders and Substance Abuse)

<b>Individual Case Management</b>	Coordinates care in event of catastrophic or lengthy illness or injury. For more information, please call 1-855-288-8356.	
<b>Chronic Condition Management</b>	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and other specialized conditions.	
<b>Contraceptive Management</b>	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](http://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 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.

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