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Plan Benefits

Academic Medical Group (AMG)

Group 90960 (EPO)

Effective January 1, 2024

BlueCross BlueShield of Alabama

Academic Medical Group (AMG)
90960 – EPO Plan
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.				
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. If family coverage is elected, the full family deductible amount must be meet before the PLAN will begin paying at the participation level	$0 Individual $0 Family	$0 Individual $0 Family	$1,000 Individual $2,000 Family	$1,000 Individual $2,000 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 If family coverage is elected, the full family out-of-pocket maximum amount must be met (with no one member meeting more than the individual out-of-pocket maximum) before the PLAN will begin paying at the participation level for remainder of the calendar year 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	$1,500 Individual $3,000 Family	$2,500 Individual $5,000 Family	$5,000 Individual $10,000 Family	$5,000 Individual $10,000 Family

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)** **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 waived. (Tier 4 excluded)**				
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 $300 may be applied to applicable claims. Call 1-855-288-8357 (toll-free) for precertification.				
Inpatient Hospital and Residential Treatment Facilities Inpatient Emergency Room Admission for Tier 2, 3, 4 Pays at Tier 1 benefit	Covered at 100% of the allowed amount after $200 hospital copay for each admission	Covered at 100% of the allowed amount after $1,000 hospital copay for each admission	Not covered	Not covered
Inpatient Physician Visits and Consultations Inpatient Emergency Room Admission for Tier 2, 3, 4 Pays at Tier 1 benefit	Covered at 100% of the allowed amount; no copay or deductible	Covered at 100% of the allowed amount; no copay or deductible	Not covered	Not covered
Inpatient Bariatric Surgery	**Facility:** Covered at 100% of the allowed amount after $200 hospital copay for each admission **Physician:** Covered at 100% of the allowed amount; no copay or deductible	Not covered	Not covered	Not covered
Organ Transplants • Benefits are only provided at Blue Distinction Centers and Center of Excellence • Tampa General Hospital preferred for adult heart, liver, lung, pancreas, kidney and pediatric kidney services	**Facility:** Covered at 100% of the allowed amount after $200 hospital copay for each admission **Physician:** Covered at 100% of the allowed amount; no copay or deductible	**Facility:** Covered at 100% of the allowed amount after $1,000 hospital copay for each admission **Physician:** Covered at 100% of the allowed amount; no copay or deductible	Not covered	Not covered
OUTPATIENT HOSPITAL BENEFITS **(Includes Mental Health Disorders and Substance Abuse)** **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 waived. (Tier 4 excluded)**				
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 $300 may be applied to applicable claims.				
Outpatient Surgery (Including Ambulatory Surgical Centers)	Covered at 100% of the allowed amount, after $100 hospital copay	Covered at 100% of the allowed amount, after $500 hospital copay	Covered at 60% of the allowed amount, subject to calendar year deductible **Note:** No benefits available for services not performed in a free standing facility or ambulatory surgical center	Not covered
Outpatient Bariatric Surgery	Covered at 100% of the allowed amount after $100 hospital copay	Not covered	Not covered	Not covered

BENEFIT	Tier I Domestic Network	Tier 2 Select Providers	Tier 3 BlueOptions	Tier 4 Out-of-Network
Emergency Room (Medical Emergency and Accidental Care) Emergency Room copay waived if admitted as inpatient within 24 hours	Covered at 100% of the allowed amount, after $200 hospital copay Non-emergent visits are covered at 100% of the allowed amount, after $200 hospital copay	Covered at 100% of the allowed amount, after $200 hospital copay Non-emergent visits are covered at 100% of the allowed amount, after $200 hospital copay	Covered at 100% of the allowed amount, after $200 hospital copay Non-emergent visits are not covered	Covered at 100% of the allowed amount, after $200 hospital copay Non-emergent visits are not covered
Emergency Room (Physician)	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	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	Covered at 100% of the allowed amount, no copay or deductible Non-emergent visits not covered	Covered at 100% of the allowed amount, no copay or deductible 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 $30 copay	Covered at 100% of the allowed amount, after $50 copay	Covered at 100% of the allowed amount, after $50 copay	Not covered
Outpatient Diagnostic Lab & Pathology	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 **Note:** No benefits available for services not performed in a free standing facility or ambulatory surgical center	Not covered
Outpatient X-Ray	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, after $25 copay per visit	Covered at 100% of the allowed amount, after $50 copay per visit **Note:** No benefits available for services not performed in a free standing facility or ambulatory surgical center	Not covered
Advanced Imaging (MRA, MRI, CT or PET scans and nuclear medicine) Precertification required for Tier 2 and 3	Covered at 100% of the allowed amount, after $50 copay per visit	Covered at 100% of the allowed amount, after $300 copay per visit	Covered at 60% of the allowed amount, subject to calendar year deductible **Note:** No benefits available for services not performed in a free standing facility or ambulatory surgical center	Not covered

BENEFIT	Tier I Domestic Network	Tier 2 Select Providers	Tier 3 BlueOptions	Tier 4 Out-of-Network
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 **Note:** No benefits available for services not performed in a free standing facility or ambulatory surgical center	Not covered
Dialysis Facility & Physician out-of-pocket maximums are combined (each tier has separate amount)	Covered at 100% of the allowed amount, after $100 copay with a maximum out-of-pocket of $300	Covered at 100% of the allowed amount, after $100 copay with a maximum out-of-pocket of $300	Covered at 100% of the allowed amount, after $100 copay with a maximum out-of-pocket of $500 **Note:** No benefits available for services not performed in a free standing facility or ambulatory surgical center	Not covered
Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services	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 **Note:** No benefits available for services not performed in a free standing facility or ambulatory surgical center	Not covered
PHYSICIAN BENEFITS **(Includes Mental Health Disorders and Substance Abuse)** **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 waived. (Tier 4 excluded)** **Precertification is required for some physician benefits and physician-administered drugs; please see your benefit booklet. If precertification is not obtained, a penalty of $300 may be applied to applicable claims**				
Office Visits & Consultations • Includes Telehealth visits • Primary care physicians İncludes 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, after $10 primary care physician copay or $25 specialist physician copay **Mental health disorders and substance abuse services** covered at 100% of the allowed amount, after $10 physician copay	Covered at 100% of the allowed amount, after $10 primary care physician copay or $25 specialist physician copay **Mental health disorders and substance abuse services** covered at 100% of the allowed amount, after $10 physician copay	Covered at 100% of the allowed amount, after $30 primary care physician copay or $45 specialist physician copay **Mental health disorders and substance abuse services** covered at 100% of the allowed amount, after $10 physician copay	Not covered
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 physician office visit, copay will apply	Covered at 100% of the allowed amount, subject to applicable office visit copay	Covered at 100% of the allowed amount, subject to applicable office visit copay	Covered at 100% of the allowed amount, subject to applicable office visit copay	Not covered
TGH Virtual Care Includes general medical and behavioral health services	Covered at 100% of the allowed amount, after a $10 copay	Covered at 100% of the allowed amount, after a $10 copay	Covered at 100% of the allowed amount, after a $10 copay	Not covered

BENEFIT	Tier I Domestic Network	Tier 2 Select Providers	Tier 3 BlueOptions	Tier 4 Out-of-Network
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
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 $30 primary care physician copay or $45 specialist physician 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 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	Not covered
Maternity Delivery	Covered at 100% of the allowed amount, subject to a $200 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 will apply.	Covered at 100% of the allowed amount, after $30 physician copay	Covered at 100% of the allowed amount, after $50 physician copay	Covered at 100% of the allowed amount, after $50 physician copay	Not covered
Applied Behavioral Analysis (ABA) Therapy No age limit	Covered at 100% of the allowed amount, after $10 physician copay	Covered at 100% of the allowed amount, after $10 physician copay	Covered at 100% of the allowed amount, after $30 physician copay	Not covered
Diagnostic Lab & Pathology	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
Diagnostic X-ray	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, after $25 copay per visit	Covered at 100% of the allowed amount, after $50 copay per visit	Not covered
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 separate amount)	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 Domestic Network	Tier 2 Select Providers	Tier 3 BlueOptions	Tier 4 Out-of-Network
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.				
PREVENTIVE CARE BENEFITS				
Routine Immunizations and Preventive Services • See **FL.ExploreMyPlan.com/FLPreventiveServices** and **FL.ExploreMyPlan.com/druglist** 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/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	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	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	Not covered
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.				
ROUTINE VISION BENEFITS				
Eye Exam • Limited 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 $25 copay per visit	Covered at 100% of the allowed amount, after $45 copay per visit	Not covered
Refraction • 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 BENEFITS				
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
Hearing Aids • Maximum for all Tiers cross apply	Covered at 100% of the allowed amount, no copay or deductible • Limited to 1 hearing aid every three years in the amount of $2,000 per ear • Member pays the difference between $2000 paid by the plan, and the additional cost of the device	Covered at 100% of the allowed amount, no copay or deductible • Limited to 1 hearing aid every three years in the amount of $2,000 per ear • Member pays the difference between $2,000 paid by the plan, and the additional cost of the device	Covered at 60% of the allowed amount, subject to calendar year deductible • Limited to 1 hearing aid every three years in the amount of $2,000 per ear • Member pays the difference between $2,000 paid by the plan, and the additional cost of the device	Not covered

BENEFIT	Tier I Domestic Network	Tier 2 Select Providers	Tier 3 BlueOptions	Tier 4 Out-of-Network
Cochlear Implants (Internal Component) • External component (sound processor) is covered under DME • Implant procedure is covered under surgery	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
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 Benefits • The pharmacy network for the plan is **Prime Participating Network** • View the **Standard Drug** that applies to the plan at **FL.ExploreMyPlan.com/druglist** • The only in-network pharmacies for drugs over $400 are Tampa General and any pharmacy referred by Tampa General	Covered at 100% of the allowed amount after the following copays for a **31-day** supply for each prescription: **Tier 1 drugs**: $40 copay per prescription **Tier 2 drugs:** 20% with a minimum of $60 and a maximum of $150 **Tier 3 drugs:** 30% with a minimum of $80 and a maximum of $300 **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
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** • The only in-network pharmacies for drugs over $400 are Tampa General, USF Pharmacy Plus or any pharmacy they refer to	Covered at 100% of the allowed amount after the following copays for a **31-day** supply for each prescription: **Tier 4 drugs:** 30% with a minimum of $100 and a maximum of $400			Not covered

BENEFIT	Tier I Domestic Network	Tier 2 Select Providers	Tier 3 BlueOptions	Tier 4 Out-of-Network
TGH In-House Drug Benefits • Also available at USF Pharmacy Plus	Covered at 100% of the allowed amount after following copays for a **31-day** supply for each prescription: **Tier 1 drugs:** $10 copay per prescription **Tier 2 drugs:** $15 copay per prescription **Tier 3 drugs:** $20 copay per prescription **Tier 4 drugs:** $80 copay per prescription Covered at 100% of the allowed amount after the following copays for a **90-day** supply for each prescription: **Tier 1 drugs:** $20 copay per prescription **Tier 2 drugs:** $30 copay per prescription **Tier 3 drugs:** $40 copay per prescription **TGH In-House Pharmacy Diabetic Coverage:** Bayer products $0 FreeStyle Libre Reader: $15 copay FreeStyle Libre sensors: One month supply: $15 copay Free Style Libre sensors: 14 days each/one month supply: $15 copay 100 Precision Neostrips: $20 copay Dexcom 10 day sensors (3/month): $20 copay 1 Dexcom transmitter (refill every three months): $20 copay Dexcom receiver to display glucose data (may refill after one year): $20 copay Decom Test strips for calibrations: $20 copay			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)** **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 waived. (Tier 4 excluded)**				
Precertification is required for some other covered services; please see your benefit booklet. **If precertification is not obtained, a penalty of $300 may be applied to applicable claims.**				
Acupuncture (for pain therapy) • Limited to combined maximum of 30 visits per calendar year	Covered at 100% of the allowed amount, after $25 copay per visit	Covered at 100% of the allowed amount, after $25 copay per visit	Covered at 100% of the allowed amount, after $45 copay per visit	Not covered
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 • Non-true emergency ambulance not covered	Covered at 100% of billed charges, no copay or deductible	Covered at 100% of billed charges, no copay or deductible	Covered at 100% of billed charges, no copay or deductible	Covered at 100% of billed charges, no copay or deductible
Assisted Reproductive Technologies	Not Covered	Not Covered	Not Covered	Not Covered
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 $20 copay per visit	Covered at 100% of the allowed amount, after $30 copay per visit	Not covered
Cardiac Pulmonary Rehabilitation	Covered at 100% of the allowed amount, after $10 copay per visit	Covered at 100% of the allowed amount, after $20 copay per visit	Covered at 100% of the allowed amount, after $30 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 & 2	Covered at 100% of the allowed amount, after $10 copay per visit	Covered at 100% of the allowed amount, after $20 copay per visit	Covered at 100% of the allowed amount, after $30 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

BENEFIT	Tier I Domestic Network	Tier 2 Select Providers	Tier 3 BlueOptions	Tier 4 Out-of-Network
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 Benefit No visit limit	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
Occupational and Physical Therapy • Limited to combined maximum of 80 visits per calendar year for Tier 1 and Tier 2 • 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	Covered at 100% of the allowed amount, after $10 copay per visit	Covered at 100% of the allowed amount, after $20 copay per visit	Covered at 100% of the allowed amount, after $30 copay per visit **For facility services:** No benefits available for services not performed in a free standing facility or ambulatory surgical center	Not covered
Occupational, Physical and Speech Therapy for Autism Spectrum Disorders No age or visit limitations	Covered at 100% of the allowed amount, after $10 copay per visit	Covered at 100% of the allowed amount, after $20 copay per visit	Covered at 100% of the allowed amount, after $30 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 $20 copay per visit	Covered at 100% of the allowed amount, after $30 copay per visit **For facility services:** No benefits available for services not performed in a free standing facility or ambulatory surgical center	Not covered

BENEFIT	Tier I Domestic Network	Tier 2 Select Providers	Tier 3 BlueOptions	Tier 4 Out-of-Network
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
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.			
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).*
- *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: 1-833-708-2308
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: انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، ب 1-844-594-6009 (الهاتف النصي: 711متاحة لك. اتصل .(-
Korean: 주 의 : 한국어를 사 하 는 □ □ 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 .
1-844-594-6009 (TTY: 711)번 로 □ 전화해 주 십시오 .
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 નિઃશુલ્ક ઉપલબ્ધ છે 1-844-594-6009 પર કૉલ કરો (TTY: 711).
Thai: ‡√◊ : ∑ß•¥øß¡ ‘À“%∏∑Ë•¥Ã¬ ƒ∑,’ç ƒ¢‘ ƒ å√’ÕŸ ∏∑®‘À“%¡ƒ,∏ƒ 1-844-594-6009 (TTY: 711) （TTY: 711）まで、お電話にてご連絡
ください。