MCMS, Inc. Insurance Trust Fund - Lee Associate Members
NEW Employee Plans B, C, I, L Comparison
Effective March 1, 2020

Florida Blue

	Employee Plan B	Employee Plan C	Employee Plan I	Employee Plan L
	Blue Options	Blue Options	Blue Options	Blue Care (HMO)
Cost Sharing - Member's Responsibility				
Deductible (DED) (Per Person/Family Aggregate)	Amounts are combined INN and OON	Amounts are combined INN and OON	Deductible amounts cross accumulate	Embedded
In-Network	$500/$1,500	$500/$1500	$1,500/$3,000	$5,000/$10,000
Out-of-Network			$3,000/$6,000	NA / NA
Coinsurance (BCBSF pays / Member pays)				
In-Network	80%/20%	80%/20%	70% / 30%	70% / 30%
Out-of-Network	50%/50%	60%/40%	50% / 50%	NA / NA
Out of Pocket Maximum (Per Person/Family Aggregate) *Includes Deductibles, Copays, Coinsurance & RX*				Embedded
In-Network	$6,450/$12,900	$6,450/$12,900	$6,450/$12,900	$6,350/$12,700
Out-of-Network	$12,900/$25,800	$12,900/$25,800	$12,900/$25,800	NA / NA
Medical Pharmacy OOP Maximum (Per Person Per Calendar Month)				
In-Network (Preferred)	$200	$200	$200	$200
Out-of-Network	N/A	N/A	N/A	NA
Medical / Surgical Care by a Physician				
Office Services				
In-Network Family Physician	$20	DED + 20%	$30	$40
In-Network Specialist	DED + 20%	DED + 20%	$55	$65
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Virtual Visits				
In-Network Family Physician	$10	$10	$10	$10
In-Network Specialist	$10	$10	$10	$10
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Allergy Injections (Office)				
In-Network Family Physician	$10	$10	$10	$10
In-Network Specialist	$10	$10	$10	$10
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Health Care Professional Administered Medications in the Office (Medical Pharmacy)				
In-Network (Preferred)	20%	20%	20%	20%
In-Network (Non-Preferred)	20%	20%	20%	20%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%	Not Covered
Maternity Office Services				
In-Network Family Physician	$20	DED + 20%	$30	$40
In-Network Specialist	DED + 20%	DED + 20%	$55	$65
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Convenient Care Center				
In-Network	$20	DED + 20%	$30	$40
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered

Note: INN PCP: Family practice, General practice, Internal Medicine & Pediatrician/ Note: OON providers can balance bill for amount above BC allowance. INN providers Not permitted to balance bill.

Updated on 1/7/2020

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NEW Employee Plans B, C, I, L Comparison
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Florida Blue

	Employee Plan B	Employee Plan C	Employee Plan I	Employee Plan L
	Blue Options	Blue Options	Blue Options	Blue Care (HMO)
Physician Services at Hospital				
In-Network	DED + 20%	DED + 20%	DED + 30%	DED + 30%
Out-of-Network	INN DED + 20%	INN DED + 20%	INN DED + 30%	Not Covered
Radiology, Pathology and Anesthesiology Provider Services at Hospital				
In-Network	DED + 20%	DED + 20%	DED + 30%	DED + 30%
Out-of-Network	INN DED + 20%	INN DED + 20%	INN DED + 30%	Not Covered
Radiology, Pathology and Anesthesiology Provider Services at ASC				
In-Network	DED + 20%	DED + 20%	DED + 30%	$100
Out-of-Network	INN DED + 20%	INN DED + 20%	INN DED + 30%	Not Covered
Physician Services at Locations other than Office, Hospital and ER				
In-Network Family Physician	DED + 20%	DED + 20%	DED + 30%	DED + 30%
In-Network Specialist	DED + 20%	DED + 20%	DED + 30%	DED + 30%
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Accident Benefit				
In-Network	20%	20%	30%	30%
Out-of-Network	50%	40%	50%	Not Covered
Preventive Services-Adult Wellness Services				
Office Services				
In-Network Family Physician	$0	$0	$0	$0
In-Network Specialist	$0	$0	$0	$0
Out-of-Network	50%	40%	50%	Not Covered
Independent Clinical Laboratory *(Quest Diagnostics is the In-Network Lab in Florida)*				
In-Network	$0	$0	$0	$0
Out-of-Network	50%	40%	50%	Not Covered
Mammograms *(Routine & Diagnostic)*				
In-Network	$0	$0	$0	$0
Out-of-Network	$0	$0	$0	Not Covered
Colonoscopies *Routine/Screening colonoscopy is recommended for average risk adults every ten years, beginning at age 50. Routine includes polyp removal.*				
In-Network	$0	$0	$0	$0
Out-of-Network	$0	$0	$0	Not Covered
Preventive Services-Well Child Services				
Office Services				
In-Network Family Physician	$0	$0	$0	$0
In-Network Specialist	$0	$0	$0	$0
Out-of-Network	50%	40%	50%	Not Covered

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Florida Blue

	Employee Plan B	Employee Plan C	Employee Plan I	Employee Plan L
	Blue Options	Blue Options	Blue Options	Blue Care (HMO)
Independent Clinical Laboratory *(Quest Diagnostics is the In-Network Lab in Florida)*				
In-Network	$0	$0	$0	$0
Out-of-Network	50%	40%	50%	Not Covered
Medical / Surgical Care at a Facility				
Ambulatory Surgical Center (ASC)				
In-Network	$100	$100	DED + 30%	DED + 30%
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Inpatient Hospital Facility (per admit)				
In-Network	DED + 20%	DED + 20%	DED + 30%	DED + 30%
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Outpatient Hospital Facility (per visit)				
In-Network	DED + 20%	DED + 20%	DED + 30%	DED + 30%
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Emergency and Urgent Care				
Emergency Room Facility (per visit)				
In-Network	$100	DED + 20%	DED + 30%	$300
Out-of-Network	$100	INN DED + 20%	INN DED + 30%	$300
Physician Services at ER (With or without Surgery performed or with or without admit)				
In-Network	DED + 20%	DED + 20%	DED + 30%	DED + 30%
Out-of-Network	INN DED + 20%	INN DED + 20%	INN DED + 30%	INN DED + 30%
Urgent Care Centers				
In-Network	$40	$40	$60	$85
Out-of-Network	INN DED + $40	INN DED + $40	INN DED + $60	Not Covered
Ambulance				
In-Network	DED + 20%	DED + 20%	DED + 30%	DED + 30%
Out-of-Network	INN DED + 20%	INN DED + 20%	INN DED + 30%	INN DED + 30%
Diagnostic Testing (e.g., Lab, x-ray)				
Physician Office				
In-Network Family Physician	$20	DED + 20%	$30	$40
In-Network Specialist	DED + 20%	DED + 20%	$55	$65
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Independent Clinical Laboratory *(Quest Diagnostics is the In-Network Lab in Florida)*				
In-Network	$0	$0	$0	$0
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Independent Diagnostic Testing Center				
In-Network	$50	$50	$50	$65
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Outpatient Hospital Facility				
In-Network	DED + 20%	DED + 20%	DED + 30%	DED + 30%
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered

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NEW Employee Plans B, C, I, L Comparison
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Florida Blue

	Employee Plan B	Employee Plan C	Employee Plan I	Employee Plan L
	Blue Options	Blue Options	Blue Options	Blue Care (HMO)
Advanced Imaging (AIS) (MRI, MRA, PET, CT & Nuclear Medicine) *Subject to Prior Authorization*				
Physician Office				
In-Network Family Physician	$100	$100	$100	$300
In-Network Specialist	$100	$100	$100	$300
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Independent Diagnostic Testing Center				
In-Network	$100	$100	$100	$200
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Outpatient Hospital Facility				
In-Network	DED + 20%	DED + 20%	DED + 30%	DED + 30%
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Outpatient Therapy **Services Include:*				
Physician Office				
In-Network Family Physician	$20	DED + 20%	$30	$40
In-Network Specialist	DED + 20%	DED + 20%	$55	$65
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Outpatient Rehabilitation Facility				
In-Network	DED + 20%	DED + 20%	$55	$65
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Outpatient Hospital Facility				
In-Network	DED + 20%	DED + 20%	DED + 30%	$85
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Mental Health/Substance Dependency Services *Subject to Prior Authorization*				
Physician Office				
In-Network Family Physician	$0	$0	$0	$0
In-Network Specialist	$0	$0	$0	$0
Out-of-Network	50%	40%	50%	Not Covered
Inpatient Hospital Facility				
In-Network	$0	$0	$0	$0
Out-of-Network	50%	40%	50%	Not Covered
Outpatient Hospital Facility				
In-Network	$0	$0	$0	$0
Out-of-Network	50%	40%	50%	Not Covered
Emergency Room Facility(per visit)				
In-Network	$0	$0	$0	$0
Out-of-Network	$0	$0	$0	$0
Physician Services at Hospital and ER				
In-Network	$0	$0	$0	$0
Out-of-Network ER	$0	$0	$0	$0
Out-of-Network Hospital	$0	$0	$0	Not Covered

**Medically necessary Chiropractic, Physical Therapy, Massage Therapy, Speech Therapy & Occupational Therapy. Medical policy guidelines apply.*

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Florida Blue

	Employee Plan B	Employee Plan C	Employee Plan I	Employee Plan L
	Blue Options	Blue Options	Blue Options	Blue Care (HMO)
Other Special Services and Locations				
Durable Medical Equipment/Orthodics & Prosthetics *Subject to Prior Authorization*				
In-Network Motorized Wheelchairs	DED + 20%	DED + 20%	DED + 30%	$500
In-Network All Other	DED + 20%	DED + 20%	DED + 30%	$0
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Skilled Nursing Facility				
In-Network	DED + 20%	DED + 20%	DED + 30%	DED + 30%
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Home Health Care				
In-Network	DED + 20%	DED + 20%	DED + 30%	$0
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Hospice				
In-Network	DED + 20%	DED + 20%	DED + 30%	DED + 30%
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Dialysis Center				
In-Network	DED + 20%	DED + 20%	DED + 30%	DED + 30%
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Birthing Center				
In-Network	DED + 20%	DED + 20%	DED + 30%	DED + 30%
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Diabetic Equipment & Supplies				
In-Network	DED + 20%	DED + 20%	DED + 30%	$0
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Wisdom Teeth (Surgical removal of impacted Wisdom Teeth)				
In-Network	Covered based on LOS	Covered based on LOS	Covered based on LOS	DED + 30%
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Accidental Dental Injury treatment *				
In-Network	Covered based on LOS	Covered based on LOS	Covered based on LOS	DED + 30%
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
Benefit Maximums				
Home Health Care				
Combined (INN & OON)	30 Visits PBP	30 Visits PBP	30 Visits PBP	60 Visits PBP (INN ONLY)
Inpatient Rehabilitation				
Combined (INN & OON)	30 Days PBP	30 Days PBP	30 Days PBP	30 Days PBP (INN ONLY)
Outpatient Therapy & Spinal Manipulations				
Combined (INN & OON)	75 Visits PBP	75 Visits PBP	75 Visits PBP	30 Visits PBP (INN ONLY)
Skilled Nursing Facility				
Combined (INN & OON)	60 Days PBP	60 Days PBP	60 Days PBP	45 Days PBP (INN ONLY)
Spinal Manipulations				
Combined (INN & OON)	26 PBP	26 PBP	26 PBP	30 PBP (INN ONLY)

**Initiated within 62 days of the date of the accidental injury for the treatment of damage to sound, natural teeth. No time limit applies to complete treatment if initiated within 62 days.*
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Florida Blue

	Employee Plan B	Employee Plan C	Employee Plan I	Employee Plan L
	Blue Options	Blue Options	Blue Options	Blue Care (HMO)
Prescription Drugs				
	OPEN FORMULARY*	**OPEN FORMULARY***	**CLOSED FORMULARY**	**CLOSED FORMULARY***
Deductible	N/A	$100 (Brand Only)	$800 (Brand Only)	Integrated with Health
In-Network				
Retail				
Generic/Brand/Non-Preferred	20%/40%/40%	20%/40% after DED/50% after DED	$10/$60 after Rx DED/Not Covered	$10 after DED/ $60 after DED/ Not Covered
Mail Order **				
Generic/Brand/Non-Preferred	20%/40%/40%	20%/40% after DED/50% after DED	$20/$120 after Rx DED/Not Covered	$20 after DED/ $120 after DED/ Not Covered
Out-of-Network				
Retail				
Generic/Brand/Non-Preferred	50%/50%/50%	50%/50%/50%	50%/50%/Not Covered	Not Covered
Mail Order				
Generic/Brand/Non-Preferred	Not Covered	Not Covered	Not Covered	Not Covered

All Pharmacy Medication Guides are available at <https://www.floridablue.com/tools-resources/pharmacy/medication-guide>.

- See current medication guide for a listing of specialty medications. Updates are made in January and July
- OON Pharmacy services are subject to the pharmacy deductible (where applicable) and paid at 50% of allowance.
- 90 day supply available at select retail extended supply pharmacies. Visit the providers directory at www.FloridaBlue.com to find retail.
- Pharmacy utilization programs (eg) Responsible Rx, Mandatory Generic Rx, Exclusions apply to all plans (see Medication Guide).

Closed Formulary Note:
- Rx-Specialty Medication – Not Covered – Except for oral oncology and HIV Medications

Plans B, C, & L Rx* Note:
- Condition Care Rx Program Value List applies: $0 Copay for listed Brand Medications

- **Medical Pharmacy (Office Setting):** Coverage for self-administered specialty medications are excluded except for medications used for immediate stabilization (e.g. securing an airway, controlling a hemorrhage, or treating shock).
Please refer to retail pharmacy for coverage of self-administered specialty medications.

**90 day supply available through Prime Theraputics
***All RX meet Center for Medicare and Medicaid Part D-Creditable Coverage Guidelines.

This is a summary of benefits and not a contract. All benefits are subject to the provisions, exclusions and limitations set forth in the master contract.
To verify a provider's specialty or participation status, the insured may contact Florida Blue, or review the most recent Pro vider Directory.
It is the insured's sole responsibility to select and verify a provider's network participation status at the time services a re rendered.

Updated on 1/7/2020