

Product / Plan Number	BlueOptions 03559	BlueOptions 05302	BlueOptions 05190	BlueOptions 05191	BlueOptions 05787
<b>Plan Family</b>	Predictable Cost	Lower Premium	HSA Compatible	HSA Compatible	Predictable Cost
<b>Divison Number</b>	005 / C05 / R05	012 / C12 / R12	310 / CAE / RAE 410 / CBE / RBE	311 / CAF / RAF 411 / CBF / RBF	326 / CAS / RAS
<b>MCMST Plan Name</b>	C	I	H - INDV	H - FAM	P
<b>MCMS Plan Type</b>	Employee Plan	Employee Plan	Employee Plan	Employee Plan	Wild Card Plan
<b>Cost Sharing - Member's Responsibility</b>					
<b>Deductible (DED)</b> (Per Person/Family Aggregate)	Embedded	Embedded	Non-Embedded	Non-Embedded	Embedded
In-Network	\$750 / \$1,500 Combined w/Out-of-Network	\$1,500 / \$3,000 Cross Accumulates	\$1,750 / NA	\$3,500 / \$3,500	\$7,350 / \$14,700
Out-of-Network	Combined w/In-Network	\$3,000 / \$6,000 Cross Accumulates	\$3,500 / NA	\$7,000 / \$7,000	\$14,700 / \$29,400
<b>Coinsurance (BCBSF pays / Member pays)</b>					
In-Network	80% / 20%	70% / 30%	80% / 20%	80% / 20%	100% / 0%
Out-of-Network	60% / 40%	50% / 50%	60% / 40%	60% / 40%	50% / 50%
<b>Out of Pocket Maximum</b> (Per Person/Family Aggregate)	Embedded	Embedded	Non-Embedded	Embedded	Embedded
In-Network	\$6,450 / \$12,900	\$6,450 / \$12,900	\$6,450 / NA	\$6,450 / \$12,900	\$7,350 / \$14,700
Out-of-Network	\$12,900 / \$25,800	\$12,900 / \$25,800	\$12,900 / NA	\$25,800 / \$25,800	\$15,700 / \$30,400
<b>Medical Pharmacy OOP Maximum</b> (Per Person per calendar month)					
In-Network (Preferred)	\$200	\$200	NA	NA	\$200
In-Network (Non-Preferred)	Combined with Preferred OOP	Combined with Preferred OOP	NA	NA	Combined with Preferred OOP
Out-of-Network	NA	NA	NA	NA	NA
<b>Medical / Surgical Care by a Physician</b>					
<b>Virtual Visits</b>					
Value Choice PCP	\$0 Copayment	\$0 Copayment	DED	DED	\$0 Copayment
Value Choice Specialist	\$20 Copayment	\$20 Copayment	DED	DED	\$20 Copayment
In-Network Family Physician	\$0 Copayment	\$0 Copayment	DED + 20%	DED + 20%	\$0 Copayment
In-Network Specialist	DED + 20%	\$55 Copayment	DED + 20%	DED + 20%	\$65 Copayment
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
<b>Office Services</b>	Nutritional counseling for a diagnosis of diabetes is covered at \$0 copayment when billed by a VCP Specialist in the office.	Nutritional counseling for a diagnosis of diabetes is covered at \$0 copayment when billed by a VCP Specialist in the office.			Nutritional counseling for a diagnosis of diabetes is covered at \$0 copayment when billed by a VCP Specialist in the office.
Value Choice PCP	\$0 Copayment	\$0 Copayment	DED	DED	\$0 Copayment
Value Choice Specialist	\$20 Copayment	\$20 Copayment	DED	DED	\$20 Copayment
In-Network Family Physician	DED + 20%	\$30 Copayment	DED + 20%	DED + 20%	\$35 Copayment
In-Network Specialist	DED + 20%	\$55 Copayment	DED + 20%	DED + 20%	\$65 Copayment
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Allergy Injections (Office)</b>					
Value Choice PCP	\$0 Copayment	\$0 Copayment	DED	DED	\$0 Copayment
Value Choice Specialist	\$10 Copayment	\$10 Copayment	DED	DED	\$10 Copayment
In-Network Family Physician	\$10 Copayment	\$10 Copayment	DED + 20%	DED + 20%	\$10 Copayment
In-Network Specialist	\$10 Copayment	\$10 Copayment	DED + 20%	DED + 20%	\$10 Copayment
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Allergy Testing (Office)</b>					
Value Choice PCP	Included under physician office services	Included under physician office services	Included under physician office services	Included under physician office services	Included under physician office services
Value Choice Specialist	Included under physician office services	Included under physician office services	Included under physician office services	Included under physician office services	Included under physician office services
In-Network Family Physician	Included under physician office services	Included under physician office services	Included under physician office services	Included under physician office services	Included under physician office services
In-Network Specialist	Included under physician office services	Included under physician office services	Included under physician office services	Included under physician office services	Included under physician office services
Out-of-Network	Included under physician office services	Included under physician office services	Included under physician office services	Included under physician office services	Included under physician office services

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<b>Divison Number</b>	005 / C05 / R05	012 / C12 / R12	310 / CAE / RAE 410 / CBE / RBE	311 / CAF / RAF 411 / CBF / RBF	326 / CAS / RAS
<b>MCMST Plan Name</b>	C	I	H -INDV	H - FAM	P
<b>MCMS Plan Type</b>	Employee Plan	Employee Plan	Employee Plan	Employee Plan	Wild Card Plan
<b>Health Care Professional Administered Medications in the Office (Medical Pharmacy)</b>					
In-Network (Preferred)	20%	20%	DED + 20%	DED + 20%	20%
In-Network (Non-Preferred)	20%	20%	DED + 20%	DED + 20%	20%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%	DED + 50%	DED + 50%
<b>Maternity Office Services</b>	Cost share applies for first maternity visit. Remaining cost share for routine pregnancy applicable at delivery. Additional services outside of routine pregnancy (e.g., amniocentesis) may require additional cost share.	Cost share applies for first maternity visit. Remaining cost share for routine pregnancy applicable at delivery. Additional services outside of routine pregnancy (e.g., amniocentesis) may require additional cost share.	Cost share applies for first maternity visit. Remaining cost share for routine pregnancy applicable at delivery. Additional services outside of routine pregnancy (e.g., amniocentesis) may require additional cost share.	Cost share applies for first maternity visit. Remaining cost share for routine pregnancy applicable at delivery. Additional services outside of routine pregnancy (e.g., amniocentesis) may require additional cost share.	Cost share applies for first maternity visit. Remaining cost share for routine pregnancy applicable at delivery. Additional services outside of routine pregnancy (e.g., amniocentesis) may require additional cost share.
In-Network Family Physician	DED + 20%	\$30 Copayment	DED + 20%	DED + 20%	\$35 Copayment
In-Network Specialist	DED + 20%	\$55 Copayment	DED + 20%	DED + 20%	\$65 Copayment
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Convenient Care Center</b>					
In-Network	DED + 20%	\$30 Copayment	DED + 20%	DED + 20%	\$35 Copayment
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Physician Services at Hospital</b>					
In-Network	DED + 20%	DED + 30%	DED + 20%	DED + 20%	\$0 Copayment
Out-of-Network	INN DED + 20%	INN DED + 30%	INN DED + 20%	INN DED + 20%	\$0 Copayment
<b>Radiology, Pathology and Anesthesiology Provider Services at Hospital</b>					
In-Network	DED + 20%	DED + 30%	DED + 20%	DED + 20%	\$0 Copayment
Out-of-Network	INN DED + 20%	INN DED + 30%	INN DED + 20%	INN DED + 20%	\$0 Copayment
<b>Radiology, Pathology and Anesthesiology Provider Services at ASC</b>					
In-Network	DED + 20%	DED + 30%	DED + 20%	DED + 20%	\$0 Copayment
Out-of-Network	INN DED + 20%	INN DED + 30%	INN DED + 20%	INN DED + 20%	\$0 Copayment
<b>Physician Services at Locations other than Office, Hospital and ER</b>					
In-Network Family Physician	DED + 20%	DED + 30%	DED + 20%	DED + 20%	\$35 Copayment
In-Network Specialist	DED + 20%	DED + 30%	DED + 20%	DED + 20%	\$65 Copayment
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%

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<b>MCMS Plan Type</b>	Employee Plan	Employee Plan	Employee Plan	Employee Plan	Wild Card Plan
<b>Preventive Services - Adult Wellness &amp; Well Child Services</b>					
<b>Office Services</b>					
In-Network Family Physician	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment
In-Network Specialist	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment
Out-of-Network	40%	50%	40%	40%	50%
<b>Convenient Care Center</b>					
In-Network	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment
Out-of-Network	40%	50%	40%	40%	50%
<b>Urgent Care Centers</b>					
In-Network	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment
Out-of-Network	40%	50%	40%	40%	50%
<b>Independent Clinical Laboratory</b>					
In-Network	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment
Out-of-Network	40%	50%	40%	40%	50%
<b>Independent Diagnostic Testing Center</b>					
In-Network	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment
Out-of-Network	40%	50%	40%	40%	50%
<b>Physician Services at Hospital Facility</b>					
In-Network	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment
Out-of-Network	40%	50%	40%	40%	50%
<b>Inpatient Hospital Facility (per admit)</b>					
In-Network	Option 1: \$0 Copayment Option 2: \$0 Copayment	Option 1: \$0 Copayment Option 2: \$0 Copayment	Option 1: \$0 Copayment Option 2: \$0 Copayment	Option 1: \$0 Copayment Option 2: \$0 Copayment	Option 1: \$0 Copayment Option 2: \$0 Copayment
Out-of-Network	40%	50%	40%	40%	50%
<b>Outpatient Hospital Facility (per visit)</b>					
In-Network	Option 1: \$0 Copayment Option 2: \$0 Copayment	Option 1: \$0 Copayment Option 2: \$0 Copayment	Option 1: \$0 Copayment Option 2: \$0 Copayment	Option 1: \$0 Copayment Option 2: \$0 Copayment	Option 1: \$0 Copayment Option 2: \$0 Copayment
Out-of-Network	40%	50%	40%	40%	50%
<b>Mammograms - Adult Wellness</b>	Includes Routine and Diagnostic Mammograms	Includes Routine and Diagnostic Mammograms			Includes Routine and Diagnostic Mammograms
In-Network	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment
Out-of-Network	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment
<b>Colonoscopies - Adult Wellness</b>					
In-Network	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment
Out-of-Network	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment

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<b>MCMST Plan Name</b>	C	I	H -INDV	H - FAM	P
<b>MCMS Plan Type</b>	Employee Plan	Employee Plan	Employee Plan	Employee Plan	Wild Card Plan
<b>Medical / Surgical Care at a Facility</b>					
<b>Ambulatory Surgical Center (ASC)</b>					
In-Network	\$100 Copayment	DED + 30%	DED + 20%	DED + 20%	DED + 0%
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Inpatient Hospital Facility (per admit)</b>	OON only; if admitted as an Inpatient from ER, apply Inpatient Hospital INN Option 1 cost share.	OON only; if admitted as an Inpatient from ER, apply Inpatient Hospital INN Option 1 cost share.	OON only; if admitted as an Inpatient from ER, apply Inpatient Hospital INN Option 1 cost share.	OON only; if admitted as an Inpatient from ER, apply Inpatient Hospital INN Option 1 cost share.	OON only; if admitted as an Inpatient from ER, apply Inpatient Hospital INN Option 1 cost share.
In-Network	Option 1: DED + 20%	Option 1: DED + 30%	Option 1: DED + 20%	Option 1: DED + 20%	Option 1: DED + 0%
	Option 2: DED + 20%	Option 2: DED + 30%	Option 2: DED + 25%	Option 2: DED + 25%	Option 2: DED + 0%
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Outpatient Hospital Facility (per visit) (Surgical)</b>					
In-Network	Option 1: DED + 20%	Option 1: DED + 30%	Option 1: DED + 20%	Option 1: DED + 20%	Option 1: DED + 0%
	Option 2: DED + 20%	Option 2: DED + 30%	Option 2: DED + 25%	Option 2: DED + 25%	Option 2: DED + 0%
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Outpatient Hospital Facility (per visit) (Non-Surgical)</b>					
In-Network	Included with Surgical Services	Included with Surgical Services	Included with Surgical Services	Included with Surgical Services	Included with Surgical Services
Out-of-Network	Included with Surgical Services	Included with Surgical Services	Included with Surgical Services	Included with Surgical Services	Included with Surgical Services
<b>Emergency and Urgent Care</b>					
<b>Emergency Room Facility (per visit) (Surgery performed or with admit)</b>	If admitted as an inpatient from ER, the hospital will submit an inpatient hospital claim instead of an ER facility claim; only inpatient facility cost share will apply.	If admitted as an inpatient from ER, the hospital will submit an inpatient hospital claim instead of an ER facility claim; only inpatient facility cost share will apply.			If admitted as an inpatient from ER, the hospital will submit an inpatient hospital claim instead of an ER facility claim; only inpatient facility cost share will apply.
In-Network	\$250 Copayment	DED + 30%	DED + 20%	DED + 20%	\$300 Copayment
Out-of-Network	\$250 Copayment	INN DED + 30%	INN DED + 20%	INN DED + 20%	\$300 Copayment
<b>Emergency Room Facility (per visit) (No surgery performed or not admitted)</b>	If admitted as an inpatient from ER, the hospital will submit an inpatient hospital claim instead of an ER facility claim; only inpatient facility cost share will apply.	If admitted as an inpatient from ER, the hospital will submit an inpatient hospital claim instead of an ER facility claim; only inpatient facility cost share will apply.			If admitted as an inpatient from ER, the hospital will submit an inpatient hospital claim instead of an ER facility claim; only inpatient facility cost share will apply.
In-Network	\$250 Copayment	DED + 30%	DED + 20%	DED + 20%	\$300 Copayment
Out-of-Network	\$250 Copayment	INN DED + 30%	INN DED + 20%	INN DED + 20%	\$300 Copayment
<b>Physician Services at ER (Surgery performed or with admit)</b>					
In-Network	DED + 20%	DED + 30%	DED + 20%	DED + 20%	\$0 Copayment
Out-of-Network	INN DED + 20%	INN DED + 30%	INN DED + 20%	INN DED + 20%	\$0 Copayment
<b>Physician Services at ER (No surgery performed or not admitted)</b>					
In-Network	DED + 20%	DED + 30%	DED + 20%	DED + 20%	\$0 Copayment
Out-of-Network	INN DED + 20%	INN DED + 30%	INN DED + 20%	INN DED + 20%	\$0 Copayment
<b>Urgent Care Centers</b>					
Value Choice Urgent Care Provider	\$0 Copayment - Visits 1-2 PBP \$40 Copay for remaining Visits PBP	\$0 Copayment - Visits 1-2 PBP \$60 Copay for remaining Visits PBP	DED	DED	\$0 Copayment - Visits 1-2 PBP \$100 Copay for remaining Visits PBP
In-Network	\$40 Copayment	\$60 Copayment	DED + 20%	DED + 20%	\$100 Copayment
Out-of-Network	INN DED + \$40 Copayment	INN DED + \$60 Copayment	INN DED + 20%	INN DED + 20%	DED + \$100 Copayment
<b>Ambulance</b>					
In-Network	DED + 20%	DED + 30%	DED + 20%	DED + 20%	DED + 0%
Out-of-Network	INN DED + 20%	INN DED + 30%	INN DED + 20%	INN DED + 20%	INN DED + 0%

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<b>MCMS Plan Type</b>	Employee Plan	Employee Plan	Employee Plan	Employee Plan	Wild Card Plan
<b>Diagnostic Testing (e.g., Lab, x-ray)</b>					
<b>Physician Office</b>	Low-dose lung cancer screening covered In-Network at \$0 Copay with a limit one per year when USPSTF recommendations are met, for adults ages 50-80.	Low-dose lung cancer screening covered In-Network at \$0 Copay with a limit one per year when USPSTF recommendations are met, for adults ages 50-80.	Low-dose lung cancer screening covered In-Network at \$0 Copay with a limit one per year when USPSTF recommendations are met, for adults ages 50-80.	Low-dose lung cancer screening covered In-Network at \$0 Copay with a limit one per year when USPSTF recommendations are met, for adults ages 50-80.	Low-dose lung cancer screening covered In-Network at \$0 Copay with a limit one per year when USPSTF recommendations are met, for adults ages 50-80.
Value Choice PCP	\$0 Copayment	\$0 Copayment	DED	DED	\$0 Copayment
Value Choice Specialist	\$20 Copayment	\$20 Copayment	DED	DED	\$20 Copayment
In-Network Family Physician	DED + 20%	\$30 Copayment	DED + 20%	DED + 20%	\$35 Copayment
In-Network Specialist	DED + 20%	\$55 Copayment	DED + 20%	DED + 20%	\$65 Copayment
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Independent Clinical Laboratory</b>			<ul style="list-style-type: none"> <li>• INN only; Waive deductible for International Normalized Ratio (INR) testing.</li> <li>• INN only; Waive deductible for Low-density Lipoprotein (LDL) testing.</li> </ul>	<ul style="list-style-type: none"> <li>• INN only; Waive deductible for International Normalized Ratio (INR) testing.</li> <li>• INN only; Waive deductible for Low-density Lipoprotein (LDL) testing.</li> </ul>	
In-Network	\$0 Copayment	\$0 Copayment	DED + 20%	DED + 20%	\$0 Copayment
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Independent Diagnostic Testing Center</b>					
In-Network	\$50 Copayment	\$50 Copayment	DED + 20%	DED + 20%	\$65 Copayment
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Outpatient Hospital Facility</b>					
In-Network	Option 1: DED + 20%	Option 1: DED + 30%	Option 1: DED + 20%	Option 1: DED + 20%	Option 1: DED + 0%
	Option 2: DED + 20%	Option 2: DED + 30%	Option 2: DED + 25%	Option 2: DED + 25%	Option 2: DED + 0%
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Advanced Imaging (AIS) (MRI, MRA, PET, CT &amp; Nuclear Medicine)</b>					
<b>Physician Office</b>					
Value Choice PCP	\$0 Copayment	\$0 Copayment	DED	DED	\$0 Copayment
Value Choice Specialist	\$20 Copayment	\$20 Copayment	DED	DED	\$20 Copayment
In-Network Family Physician	\$100 Copayment	\$100 Copayment	DED + 20%	DED + 20%	DED + 0%
In-Network Specialist	\$100 Copayment	\$100 Copayment	DED + 20%	DED + 20%	DED + 0%
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Independent Diagnostic Testing Center</b>					
Value Choice Provider	\$20 Copayment	\$20 Copayment	DED	DED	\$20 Copayment
In-Network	\$100 Copayment	\$100 Copayment	DED + 20%	DED + 20%	DED + 0%
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Outpatient Hospital Facility</b>					
In-Network	Option 1: DED + 20%	Option 1: DED + 30%	Option 1: DED + 20%	Option 1: DED + 20%	Option 1: DED + 0%
	Option 2: DED + 20%	Option 2: DED + 30%	Option 2: DED + 25%	Option 2: DED + 25%	Option 2: DED + 0%
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Outpatient Therapy</b>					
<b>Physician Office</b>					
Value Choice PCP	\$0 Copayment	\$0 Copayment	DED	DED	\$0 Copayment
Value Choice Specialist	\$20 Copayment	\$20 Copayment	DED	DED	\$20 Copayment
In-Network Family Physician	DED + 20%	\$30 Copayment	DED + 20%	DED + 20%	\$35 Copayment
In-Network Specialist	DED + 20%	\$55 Copayment	DED + 20%	DED + 20%	\$65 Copayment
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Outpatient Rehabilitation Facility</b>					
In-Network	DED + 20%	\$55 Copayment	DED + 20%	DED + 20%	\$45 Copayment
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Outpatient Hospital Facility</b>					
In-Network	Option 1: DED + 20%	Option 1: DED + 30%	Option 1: DED + 20%	Option 1: DED + 20%	Option 1: \$65 Copayment
	Option 2: DED + 20%	Option 2: DED + 30%	Option 2: DED + 25%	Option 2: DED + 25%	Option 2: \$70 Copayment
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%

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<b>Mental Health &amp; Substance Dependency Services</b>					
<b>Virtual Visits</b>	Includes coverage for both Virtual Mental Health and Virtual Substance Dependency Services.	Includes coverage for both Virtual Mental Health and Virtual Substance Dependency Services.	Includes coverage for both Virtual Mental Health and Virtual Substance Dependency Services.	Includes coverage for both Virtual Mental Health and Virtual Substance Dependency Services.	Includes coverage for both Virtual Mental Health and Virtual Substance Dependency Services.
In-Network Family Physician	\$0 Copayment	\$0 Copayment	DED + 20%	DED + 20%	\$0 Copayment
In-Network Specialist	\$0 Copayment	\$0 Copayment	DED + 20%	DED + 20%	\$0 Copayment
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
<b>Physician Office</b>					
In-Network Family Physician	\$0 Copayment	\$0 Copayment	DED + 20%	DED + 20%	\$0 Copayment
In-Network Specialist	\$0 Copayment	\$0 Copayment	DED + 20%	DED + 20%	\$0 Copayment
Out-of-Network	40%	50%	DED + 40%	DED + 40%	50%
<b>Inpatient Hospital Facility</b>	OON only; if admitted as an Inpatient from ER, apply Inpatient Hospital INN Option 1 cost share.	OON only; if admitted as an Inpatient from ER, apply Inpatient Hospital INN Option 1 cost share.	OON only; if admitted as an Inpatient from ER, apply Inpatient Hospital INN Option 1 cost share.	OON only; if admitted as an Inpatient from ER, apply Inpatient Hospital INN Option 1 cost share.	OON only; if admitted as an Inpatient from ER, apply Inpatient Hospital INN Option 1 cost share.
In-Network	Option 1: \$0 Copayment	Option 1: \$0 Copayment	Option 1: DED + 20%	Option 1: DED + 20%	Option 1: \$0 Copayment
	Option 2: \$0 Copayment	Option 2: \$0 Copayment	Option 2: DED + 20%	Option 2: DED + 20%	Option 2: \$0 Copayment
Out-of-Network	40%	50%	DED + 40%	DED + 40%	50%
<b>Outpatient Hospital Facility</b>					
In-Network	Option 1: \$0 Copayment	Option 1: \$0 Copayment	Option 1: DED + 20%	Option 1: DED + 20%	Option 1: \$0 Copayment
	Option 2: \$0 Copayment	Option 2: \$0 Copayment	Option 2: DED + 20%	Option 2: DED + 20%	Option 2: \$0 Copayment
Out-of-Network	40%	50%	DED + 40%	DED + 40%	50%
<b>Emergency Room Facility(per visit)</b>					
In-Network	\$0 Copayment	\$0 Copayment	DED + 20%	DED + 20%	\$0 Copayment
Out-of-Network	\$0 Copayment	\$0 Copayment	INN DED + 20%	INN DED + 20%	\$0 Copayment
<b>Physician Services at Hospital</b>					
In-Network	\$0 Copayment	\$0 Copayment	DED + 20%	DED + 20%	\$0 Copayment
Out-of-Network	\$0 Copayment	\$0 Copayment	INN DED + 20%	INN DED + 20%	\$0 Copayment
<b>Physician Services at ER</b>					
In-Network	\$0 Copayment	\$0 Copayment	DED + 20%	DED + 20%	\$0 Copayment
Out-of-Network	\$0 Copayment	\$0 Copayment	INN DED + 20%	INN DED + 20%	\$0 Copayment
<b>Physician Services at Locations other than Office, Hospital and ER</b>					
In-Network Family Physician	\$0 Copayment	\$0 Copayment	DED + 20%	DED + 20%	\$0 Copayment
In-Network Specialist	\$0 Copayment	\$0 Copayment	DED + 20%	DED + 20%	\$0 Copayment
Out-of-Network	40%	50%	DED + 40%	DED + 40%	50%

Product / Plan Number	BlueOptions 03559	BlueOptions 05302	BlueOptions 05190	BlueOptions 05191	BlueOptions 05787
<b>Plan Family</b>	Predictable Cost	Lower Premium	HSA Compatible	HSA Compatible	Predictable Cost
<b>Divison Number</b>	005 / C05 / R05	012 / C12 / R12	310 / CAE / RAE 410 / CBE / RBE	311 / CAF / RAF 411 / CBF / RBF	326 / CAS / RAS
<b>MCMST Plan Name</b>	C	I	H -INDV	H - FAM	P
<b>MCMS Plan Type</b>	Employee Plan	Employee Plan	Employee Plan	Employee Plan	Wild Card Plan
<b>Other Special Services and Locations</b>					
<b>Durable Medical Equipment</b>	<ul style="list-style-type: none"> <li>• One personal breast pump provided through CareCentrix per delivery.</li> <li>• Initial pair of eyeglasses per cataract surgery subject to \$0 copay for INN and OON, 2 per lifetime</li> <li>• INN only; Waive deductible for Peak flow meter.</li> </ul>	<ul style="list-style-type: none"> <li>• One personal breast pump provided through CareCentrix per delivery.</li> <li>• Initial pair of eyeglasses per cataract surgery subject to \$0 copay for INN and OON, 2 per lifetime</li> <li>• INN only; Waive deductible for Peak flow meter.</li> </ul>	<ul style="list-style-type: none"> <li>• One personal breast pump provided through CareCentrix per delivery.</li> <li>• INN only; Waive deductible for Peak flow meter.</li> </ul>	<ul style="list-style-type: none"> <li>• One personal breast pump provided through CareCentrix per delivery.</li> <li>• INN only; Waive deductible for Peak flow meter.</li> </ul>	<ul style="list-style-type: none"> <li>• One personal breast pump provided through CareCentrix per delivery.</li> <li>• Initial pair of eyeglasses per cataract surgery subject to \$0 copay for INN and OON, 2 per lifetime</li> <li>• INN only; Waive deductible for Peak flow meter.</li> </ul>
In-Network Motorized Wheelchairs	DED + 20%	DED + 30%	DED + 20%	DED + 20%	DED + 0%
In-Network All Other	DED + 20%	DED + 30%	DED + 20%	DED + 20%	DED + 0%
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Orthotics &amp; Prosthetics</b>					
In-Network Family Physician	DED + 20%	DED + 30%	DED + 20%	DED + 20%	DED + 0%
In-Network Specialist	DED + 20%	DED + 30%	DED + 20%	DED + 20%	DED + 0%
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Skilled Nursing Facility</b>					
In-Network	DED + 20%	DED + 30%	DED + 20%	DED + 20%	DED + 0%
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Home Health Care</b>					
In-Network	DED + 20%	DED + 30%	DED + 20%	DED + 20%	DED + 0%
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Health Care Professional Administered Medications in Home Setting (Medical Pharmacy)</b>					
In-Network (Preferred)	DED + 20%	DED + 30%	DED + 20%	DED + 20%	DED + 0%
In-Network (Non-Preferred)	DED + 20%	DED + 30%	DED + 20%	DED + 20%	DED + 0%
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Hospice</b>					
In-Network	DED + 20%	DED + 30%	DED + 20%	DED + 20%	DED + 0%
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Dialysis Center</b>					
In-Network	DED + 20%	DED + 30%	DED + 20%	DED + 20%	DED + 0%
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Birthing Center</b>					
In-Network	DED + 20%	DED + 30%	DED + 20%	DED + 20%	DED + 0%
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Diabetic Equipment &amp; Supplies</b>					
In-Network	DED + 20%	DED + 30%	DED + 20%	DED + 20%	DED + 0%
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Enteral Formula</b>					
In-Network	DED + 20%	DED + 30%	DED + 20%	DED + 20%	DED + 0%
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%
<b>Second Medical Opinion</b>					
In-Network	Included under other physician services	Included under other physician services	Included under other physician services	Included under other physician services	Included under other physician services
Out-of-Network	Included under other physician services	Included under other physician services	Included under other physician services	Included under other physician services	Included under other physician services
<b>Additional Services</b>					
In-Network	DED + 20%	DED + 30%	DED + 20%	DED + 20%	DED + 0%
Out-of-Network	DED + 40%	DED + 50%	DED + 40%	DED + 40%	DED + 50%

Product / Plan Number	BlueOptions 03559	BlueOptions 05302	BlueOptions 05190	BlueOptions 05191	BlueOptions 05787
<b>Plan Family</b>	Predictable Cost	Lower Premium	HSA Compatible	HSA Compatible	Predictable Cost
<b>Divison Number</b>	005 / C05 / R05	012 / C12 / R12	310 / CAE / RAE 410 / CBE / RBE	311 / CAF / RAF 411 / CBF / RBF	326 / CAS / RAS
<b>MCMST Plan Name</b>	C	I	H -INDV	H - FAM	P
<b>MCMS Plan Type</b>	Employee Plan	Employee Plan	Employee Plan	Employee Plan	Wild Card Plan
<b>Benefit Maximums</b>					
<b>Home Health Care</b>					
In-Network	N/A	N/A	N/A	N/A	N/A
Out-of-Network	N/A	N/A	N/A	N/A	N/A
Combined (INN & OON)	60 Visits PBP	35 Visits PBP	60 Visits PBP	60 Visits PBP	60 Visits PBP
<b>Inpatient Rehabilitation Therapy</b>					
In-Network	N/A	N/A	N/A	N/A	N/A
Out-of-Network	N/A	N/A	N/A	N/A	N/A
Combined (INN & OON)	30 Days PBP	30 Days PBP	30 Days PBP	30 Days PBP	30 Days PBP
<b>Outpatient Therapy &amp; Spinal Manipulations</b>	Outpatient therapy for autism and down syndrome will continue to be covered after the benefit maximum is met.	Outpatient therapy for autism and down syndrome will continue to be covered after the benefit maximum is met.	Outpatient therapy for autism and down syndrome will continue to be covered after the benefit maximum is met.	Outpatient therapy for autism and down syndrome will continue to be covered after the benefit maximum is met.	Outpatient therapy for autism and down syndrome will continue to be covered after the benefit maximum is met.
In-Network	N/A	N/A	N/A	N/A	N/A
Out-of-Network	N/A	N/A	N/A	N/A	N/A
Combined (INN & OON)	75 Visits PBP	75 Visits PBP	75 Visits PBP	75 Visits PBP	75 Visits PBP
<b>Outpatient Therapy Modalities</b>					
In-Network	N/A	N/A	N/A	N/A	N/A
Out-of-Network	N/A	N/A	N/A	N/A	N/A
Combined (INN & OON)	4 per day	4 per day	4 per day	4 per day	4 per day
<b>Skilled Nursing Facility</b>					
In-Network	N/A	N/A	N/A	N/A	N/A
Out-of-Network	N/A	N/A	N/A	N/A	N/A
Combined (INN & OON)	60 Days PBP	60 Days PBP	60 Days PBP	60 Days PBP	60 Days PBP
<b>Spinal Manipulations</b>					
In-Network	N/A	N/A	N/A	N/A	N/A
Out-of-Network	N/A	N/A	N/A	N/A	N/A
Combined (INN & OON)	26 PBP	26 PBP	26 PBP	26 PBP	26 PBP



Product / Plan Number	BlueOptions 03559	BlueOptions 05302	BlueOptions 05190	BlueOptions 05191	BlueOptions 05787
Plan Family	Predictable Cost	Lower Premium	HSA Compatible	HSA Compatible	Predictable Cost
Divison Number	005 / C05 / R05	012 / C12 / R12	310 / CAE / RAE 410 / CBE / RBE	311 / CAF / RAF 411 / CBF / RBF	326 / CAS / RAS
MCMST Plan Name	C	I	H -INDV	H - FAM	P
MCMS Plan Type	Employee Plan	Employee Plan	Employee Plan	Employee Plan	Employee Plan
Prescription Drugs	Open Formulary	Closed Formulary	Open Formulary	Open Formulary	Closed Formulary
Deductible	N/A	\$300 Brand	In-Network Deductible	In-Network Deductible	\$800 Brand
In-Network					
Retail					
Generic/Brand/Non-Preferred	20% / 40% / 50%	\$10 / \$60 After Rx Brand DED / NC	20% / 30% / 50%	20% / 30% / 50%	\$10 / \$60 After Rx Brand DED / NC
Rx Specialty (4th Tier)	N/A	Not Covered - Except for Oral Chemotherapy and HIV Medications	N/A	N/A	Not Covered - Except for Oral Chemotherapy and HIV Medications
Mail Order					
Generic/Brand/Non-Preferred	20% / 40% / 50%	\$20 / \$120 After Rx DED / NC	20% / 30% / 50%	20% / 30% / 50%	\$20 / \$120 After Rx DED / NC
Out-of-Network					
Generic/Brand/Non-Preferred	50% / 50% / 50%	50% / 50% / NC	50% / 50% / 50%	50% / 50% / 50%	50% / 50% / NC
Conditioned Care Rx	Conditioned Care Rx Program Value List - \$0 Copay	Conditioned Care Rx Program Value List - Waive Deductible and Copay	Conditioned Care Rx Program H.S.A. Preventive List - Waive Deductible	Conditioned Care Rx Program H.S.A. Preventive List - Waive Deductible	Conditioned Care Rx Program Value List - Waive Deductible and Copay
Additional Benefits					
Accident Care	Not subject to DED, subject to coinsurance	Not subject to DED, subject to coinsurance	N/A	N/A	Not subject to DED, subject to coinsurance
Accidental Dental Injury Treatment	No time limit applies for completion - when care is initiated within 62 days from the date of the accident.	No time limit applies for completion - when care is initiated within 62 days from the date of the accident.	No time limit applies for completion - when care is initiated within 62 days from the date of the accident.	No time limit applies for completion - when care is initiated within 62 days from the date of the accident.	No time limit applies for completion - when care is initiated within 62 days from the date of the accident.
Dependent Eligibility	Dependent Eligibility Endorsement - Dependent Age 26 (End of CY) - Yes	Dependent Eligibility Endorsement - Dependent Age 26 (End of CY) - Yes	Dependent Eligibility Endorsement - Dependent Age 26 (End of CY) - Yes	Dependent Eligibility Endorsement - Dependent Age 26 (End of CY) - Yes	Dependent Eligibility Endorsement - Dependent Age 26 (End of CY) - Yes
Removal of Impacted Teeth Coverage	Covered - Pay based on location of service - INN and OON - MCG Apply	Covered - Pay based on location of service - INN and OON - MCG Apply	Removal of impacted teeth, including impacted wisdom teeth, also covers related X- rays and Anesthesia subject to DED and coinsurance	Removal of impacted teeth, including impacted wisdom teeth, also covers related X- rays and Anesthesia subject to DED and coinsurance	Covered - Pay based on location of service - INN and OON - MCG Apply
Standalone Telemedicine with Teladoc Behavioral Health Services	Standalone Telemedicine with Teladoc (Behavioral Health Services) In-Network / Out-of-Network \$0 / Not Covered Not included with Virtual Visit benefit	Standalone Telemedicine with Teladoc (Behavioral Health Services) In-Network / Out-of-Network \$0 / Not Covered Not included with Virtual Visit benefit	Standalone Telemedicine with Teladoc (Behavioral Health Services) In-Network / Out-of-Network DED + Coins / Not Covered Not included with Virtual Visit benefit	Standalone Telemedicine with Teladoc (Behavioral Health Services) In-Network / Out-of-Network DED + Coins / Not Covered Not included with Virtual Visit benefit	Standalone Telemedicine with Teladoc (Behavioral Health Services) In-Network / Out-of-Network \$0 / Not Covered Not included with Virtual Visit benefit
Standalone Telemedicine with Teladoc General Med	Standalone Telemedicine with Teladoc (General Med) In-Network / Out-of-Network \$0 / Not Covered Not included with Virtual Visit benefit	Standalone Telemedicine with Teladoc (General Med) In-Network / Out-of-Network \$0 / Not Covered Not included with Virtual Visit benefit	Standalone Telemedicine with Teladoc (General Med) In-Network / Out-of-Network DED + Coins / Not Covered Not included with Virtual Visit benefit	Standalone Telemedicine with Teladoc (General Med) In-Network / Out-of-Network DED + Coins / Not Covered Not included with Virtual Visit benefit	Standalone Telemedicine with Teladoc (General Med) In-Network / Out-of-Network \$0 / Not Covered Not included with Virtual Visit benefit