Florida Blue
In the pursuit of health

MCMS, Inc. Insurance Trust 2023 Benefit Plan Portfolio
Benefit Effective Date: 3/1/2023

Product / Plan Number	**BlueCare 54**	**BlueCare 72**
Plan Family	Lower Premium	Lower Premium
Divison Number	321 / CAN / RAN	325 / CAR/ RAR
MCMST Plan Name	**L**	**M**
MCMS Plan Type	**Employee Plan**	**Employee Plan**
Cost Sharing - Member's Responsibility		
Deductible (DED) **(Per Person/Family Aggregate)**	Embedded	Embedded
In-Network	$3,500 / $7,000	$7,500 / $15,000
Out-of-Network	NA / NA	NA / NA
Coinsurance (BCBSF pays / Member pays)		
In-Network	70% / 30%	80% / 20%
Out-of-Network	NA / NA	NA / NA
Out of Pocket Maximum **(Per Person/Family Aggregate)**	Embedded	Embedded
In-Network	$7,500 / $15,000	$8,000 / $16,400
Out-of-Network	NA / NA	NA / NA
Medical Pharmacy OOP Maximum **(Per Person per calendar month)**		
In-Network (Preferred)	$200	$200
In-Network (Non-Preferred)	Combined with Preferred OOP	$700
Out-of-Network	NA	NA
Medical / Surgical Care by a Physician		
Virtual Visits		
Value Choice PCP	$0 Copayment	$0 Copayment
Value Choice Specialist	$20 Copayment	$20 Copayment
In-Network Family Physician	$0 Copayment	$0 Copayment
In-Network Specialist	$65 Copayment	$60 Copayment
Out-of-Network	Not Covered	Not Covered
Office Services	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
Value Choice Specialist	$20 Copayment	$20 Copayment
In-Network Family Physician	$40 Copayment	$0 Copayment - Visits 1-3 PBP $30 Copay for remaining Visits PBP
In-Network Specialist	$65 Copayment	$60 Copayment
Out-of-Network	Not Covered	Not Covered
Allergy Injections (Office)		
Value Choice PCP	$0 Copayment	$0 Copayment
Value Choice Specialist	$10 Copayment	$60 Copayment
In-Network Family Physician	$10 Copayment	$30 Copayment
In-Network Specialist	$10 Copayment	$60 Copayment
Out-of-Network	Not Covered	Not Covered
Allergy Testing (Office)		
Value Choice PCP	$0 Copayment	$0 Copayment
Value Choice Specialist	$65 Copayment	$60 Copayment
In-Network Family Physician	$40 Copayment	$30 Copayment
In-Network Specialist	$65 Copayment	$60 Copayment
Out-of-Network	Not Covered	Not Covered

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MCMST Plan Name	L	M
MCMS Plan Type	Employee Plan	Employee Plan
Health Care Professional Administered Medications in the Office (Medical Pharmacy)		
In-Network (Preferred)	20%	20%
In-Network (Non-Preferred)	20%	20%
Out-of-Network	Not Covered	Not Covered
Maternity Office Services	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	$40 Copayment	$30 Copayment
In-Network Specialist	$65 Copayment	$60 Copayment
Out-of-Network	Not Covered	Not Covered
Convenient Care Center		
In-Network	$40 Copayment	$30 Copayment
Out-of-Network	Not Covered	Not Covered
Physician Services at Hospital		
In-Network	DED + 30%	DED + 20%
Out-of-Network	Not Covered	Not Covered
Radiology, Pathology and Anesthesiology Provider Services at Hospital	OON RAP providers covered at INN cost share with authorization.	OON RAP providers covered at INN cost share with authorization.
In-Network	DED + 30%	DED + 20%
Out-of-Network	Not Covered	Not Covered
Radiology, Pathology and Anesthesiology Provider Services at ASC	OON RAP providers covered at INN cost share with authorization.	OON RAP providers covered at INN cost share with authorization.
In-Network	$100 Copayment	$65 Copayment
Out-of-Network	Not Covered	Not Covered
Physician Services at Locations other than Office, Hospital and ER		
In-Network Family Physician	DED + 30%	$30 Copayment
In-Network Specialist	DED + 30%	$60 Copayment
Out-of-Network	Not Covered	Not Covered

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Divison Number	321 / CAN / RAN	325 / CAR/ RAR
MCMST Plan Name	L	M
MCMS Plan Type	Employee Plan	Employee Plan
Preventive Services - Adult Wellness & Well Child Services		
Office Services		
In-Network Family Physician	$0 Copayment	$0 Copayment
In-Network Specialist	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	Not Covered
Convenient Care Center		
In-Network	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	Not Covered
Urgent Care Centers		
In-Network	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	Not Covered
Independent Clinical Laboratory		
In-Network	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	Not Covered
Independent Diagnostic Testing Center		
In-Network	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	Not Covered
Physician Services at Hospital Facility		
In-Network	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	Not Covered
Inpatient Hospital Facility (per admit)		
In-Network	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	Not Covered
Outpatient Hospital Facility (per visit)		
In-Network	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	Not Covered
Mammograms - Adult Wellness	Includes Routine and Diagnostic Mammograms	Includes Routine and Diagnostic Mammograms
In-Network	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	Not Covered
Colonoscopies - Adult Wellness		
In-Network	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	Not Covered

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Medical / Surgical Care at a Facility		
Ambulatory Surgical Center (ASC)		
In-Network	DED + 30%	$250 Copayment
Out-of-Network	Not Covered	Not Covered
Inpatient Hospital Facility (per admit)		
In-Network	DED + 30%	$100 PAD + DED + 20%
Out-of-Network	Not Covered	Not Covered
Outpatient Hospital Facility (per visit) (Surgical)		
In-Network	DED + 30%	DED + 20%
Out-of-Network	Not Covered	Not Covered
Outpatient Hospital Facility (per visit) (Non-Surgical)		
In-Network	DED + 30%	DED + 20%
Out-of-Network	Not Covered	Not Covered
Emergency and Urgent Care		
Emergency Room Facility (per visit) (Surgery performed or with admit)	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	$300 Copayment	DED + 20%
Out-of-Network	$300 Copayment	INN DED + 20%
Emergency Room Facility (per visit) (No surgery performed or not admitted)	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	$300 Copayment	DED + 20%
Out-of-Network	$300 Copayment	INN DED + 20%
Physician Services at ER (Surgery performed or with admit)	Out-of-Network only covered for emergencies.	Out-of-Network only covered for emergencies.
In-Network	DED + 30%	DED + 20%
Out-of-Network	INN DED + 30%	INN DED + 20%
Physician Services at ER (No surgery performed or not admitted)	Out-of-Network only covered for emergencies.	Out-of-Network only covered for emergencies.
In-Network	DED + 30%	DED + 20%
Out-of-Network	INN DED + 30%	INN DED + 20%
Urgent Care Centers	Out-of-Network only covered out-of-state.	Out-of-Network only covered out-of-state.
Value Choice Urgent Care Provider	$0 Copayment - Visits 1-2 PBP $85 Copay for remaining Visits PBP	$0 Copayment - Visits 1-2 PBP $100 Copay for remaining Visits PBP
In-Network	$85 Copayment	$100 Copayment
Out-of-Network	Not Covered	Not Covered
Ambulance	Out-of-Network only covered for emergencies.	Out-of-Network only covered for emergencies.
In-Network	DED + 30%	DED + 20%
Out-of-Network	INN DED + 30%	INN DED + 20%

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Diagnostic Testing (e.g., Lab, x-ray)		
Physician Office	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
Value Choice Specialist	$20 Copayment	$20 Copayment
In-Network Family Physician	$40 Copayment	$30 Copayment
In-Network Specialist	$65 Copayment	$60 Copayment
Out-of-Network	Not Covered	Not Covered
Independent Clinical Laboratory		
In-Network	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	Not Covered
Independent Diagnostic Testing Center		
In-Network	$65 Copayment	$65 Copayment
Out-of-Network	Not Covered	Not Covered
Outpatient Hospital Facility		
In-Network	DED + 30%	DED + 20%
Out-of-Network	Not Covered	Not Covered
Advanced Imaging (AIS)		
(MRI, MRA, PET, CT & Nuclear Medicine)		
Physician Office		
Value Choice PCP	$0 Copayment	$0 Copayment
Value Choice Specialist	$20 Copayment	$20 Copayment
In-Network Family Physician	$300 Copayment	$250 Copayment
In-Network Specialist	$300 Copayment	$250 Copayment
Out-of-Network	Not Covered	Not Covered
Independent Diagnostic Testing Center		
Value Choice Provider	$20 Copayment	$20 Copayment
In-Network	$300 Copayment	$300 Copayment
Out-of-Network	Not Covered	Not Covered
Outpatient Hospital Facility		
In-Network	DED + 30%	DED + 20%
Out-of-Network	Not Covered	Not Covered
Outpatient Therapy		
Physician Office		
Value Choice PCP	$0 Copayment	$0 Copayment
Value Choice Specialist	$20 Copayment	$20 Copayment
In-Network Family Physician	$40 Copayment	$30 Copayment
In-Network Specialist	$65 Copayment	$60 Copayment
Out-of-Network	Not Covered	Not Covered
Outpatient Rehabilitation Facility		
In-Network	$65 Copayment	$60 Copayment
Out-of-Network	Not Covered	Not Covered
Outpatient Hospital Facility		
In-Network	$85 Copayment	DED + 20%
Out-of-Network	Not Covered	Not Covered

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Mental Health & Substance Dependency Services		
Virtual Visits	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
In-Network Specialist	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	Not Covered
Physician Office		
In-Network Family Physician	$0 Copayment	$0 Copayment
In-Network Specialist	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	Not Covered
Inpatient Hospital Facility		
In-Network	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	Not Covered
Outpatient Hospital Facility		
In-Network	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	Not Covered
Emergency Room Facility(per visit)		
In-Network	$0 Copayment	$0 Copayment
Out-of-Network	$0 Copayment	$0 Copayment
Physician Services at Hospital		
In-Network	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	Not Covered
Physician Services at ER	Out-of-Network only covered for emergencies.	Out-of-Network only covered for emergencies.
In-Network	$0 Copayment	$0 Copayment
Out-of-Network	$0 Copayment	$0 Copayment
Physician Services at Locations other than Office, Hospital and ER		
In-Network Family Physician	$0 Copayment	$0 Copayment
In-Network Specialist	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	Not Covered

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Other Special Services and Locations		
Durable Medical Equipment	• One personal breast pump provided through CareCentrix per delivery. • Initial pair of eyeglasses per cataract surgery subject to $0 copay for INN and OON, 2 per lifetime	• One personal breast pump provided through CareCentrix per delivery. • Initial pair of eyeglasses per cataract surgery subject to $0 copay for INN and OON, 2 per lifetime
In-Network Motorized Wheelchairs	$500 Copayment	$500 Copayment
In-Network All Other	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	Not Covered
Orthotics & Prosthetics		
In-Network Family Physician	$0 Copayment	$0 Copayment
In-Network Specialist	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	Not Covered
Skilled Nursing Facility		
In-Network	DED + 30%	DED + 20%
Out-of-Network	Not Covered	Not Covered
Home Health Care		
In-Network	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	Not Covered
Health Care Professional Administered Medications in Home Setting (Medical Pharmacy)		
In-Network (Preferred)	$0 Copayment	$0 Copayment
In-Network (Non-Preferred)	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	Not Covered
Hospice		
In-Network	DED + 30%	DED + 20%
Out-of-Network	Not Covered	Not Covered
Dialysis Center		
In-Network	DED + 30%	DED + 20%
Out-of-Network	Not Covered	Not Covered
Birthing Center		
In-Network	DED + 30%	DED + 20%
Out-of-Network	Not Covered	Not Covered
Diabetic Equipment & Supplies		
In-Network	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	Not Covered
Enteral Formula		
In-Network	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	Not Covered
Second Medical Opinion		
In-Network	$65 Copayment	$60 Copayment
Out-of-Network	40%	40%
Additional Services		
In-Network	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	Not Covered

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MCMST Plan Name	L	M
MCMS Plan Type	Employee Plan	Employee Plan
Benefit Maximums		
Home Health Care		
In-Network	60 Visits PBP	35 Visits PBP
Out-of-Network	N/A	N/A
Combined (INN & OON)	N/A	N/A
Inpatient Rehabilitation Therapy		
In-Network	30 Days PBP	30 Days PBP
Out-of-Network	N/A	N/A
Combined (INN & OON)	N/A	N/A
Outpatient Therapy & Spinal Manipulations	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	30 Visits PBP	35 Visits PBP
Out-of-Network	N/A	N/A
Combined (INN & OON)	N/A	N/A
Outpatient Therapy Modalities		
In-Network	4 per day	4 per day
Out-of-Network	N/A	N/A
Combined (INN & OON)	N/A	N/A
Skilled Nursing Facility		
In-Network	45 Days PBP	60 Days PBP
Out-of-Network	N/A	N/A
Combined (INN & OON)	N/A	N/A
Spinal Manipulations		
In-Network	30 PBP	26 PBP
Out-of-Network	N/A	N/A
Combined (INN & OON)	N/A	N/A

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Product / Plan Number	**BlueCare 54**	**BlueCare 72**
Plan Family	Lower Premium	Lower Premium
Divison Number	321 / CAN / RAN	325 / CAR/ RAR
MCMST Plan Name	**L**	**M**
MCMS Plan Type	**Employee Plan**	**Employee Plan**
Prescription Drugs	Closed Formulary	Closed Formulary
Deductible	$800 Brand	N/A
In-Network		
Retail		
Generic/Brand/Non-Preferred	$10 / $60 After Rx Brand DED / NC	$10 / 30% / NC
Rx Specialty (4th Tier)	Not Covered - Except for Oral Chemotherapy and HIV Medications	Not Covered - Except for Oral Chemotherapy and HIV Medications
Mail Order		
Generic/Brand/Non-Preferred	$20 / $120 After Rx DED / NC	$25 / 30% / NC
Out-of-Network		
Generic/Brand/Non-Preferred	Not Covered	Not Covered
Conditioned Care Rx	Conditioned Care Rx Program Value List - Waive Deductible and Copay	Condition Care Rx Program Value List - Waive Copay
Additional Benefits		
Accident Care	Not subject to DED, subject to coinsurance	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.
Dependent Eligibility	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 - INN Only - Pay based on location of service - - MCG Apply	Covered - INN Only - Pay based on location of service - - 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 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