

MEDICAL PLAN COVERAGE COMPARISONS: PPO I, II, III AND HMO

For **IN-Network** Providers & Services Only¹

	PPO OPT I	PPO OPT II	PPO OPT III	HMO Avanta BlueCross/CA Care
Annual Deductible*				
(Individual/Family) <i>*EE pays one in a year if certain services received (i.e., surgery or hospitalization)</i>	\$300/\$600	\$400/\$800	\$650/\$1300	NONE
Max EE \$ Out of Pocket**				
(Individual/Family) <i>**deductible and Co-Insurance only; EXCLUDES Co-Pays</i>	\$1,250/\$2500	\$2000/\$4000	\$4000/\$8000	\$1000/\$3000
EE Office Visit Co-pay				
(Primary / Specialist)	\$20/\$30	\$25/\$35	\$25/\$35	\$5
Coinsurance Levels***				
Insurance Pays / EE Pays <i>*** Applies to physician home visits, skilled nursing & home health care, xrays/labwork, physical therapy, radiation/chemo, and inpatient/outpatient hospital related services</i>	100% or 90% / 10% max	80% / 20%	80% / 20%	100% or 100% after \$5 co-pay* <i>*If Co-pay applies</i>
Prescription****				
****Same for all PPO's	Retail: \$7 Generic/\$20 preferred/ \$35 Brand Name (30 day supply) Mail Order: \$0 Generic/\$40 Preferred/\$70 Brand Name (90 day supply)			\$5 Generic/\$10 preferred or brand name No Mail Order Program
MONTHLY PREMIUMS				
Employee (EE) Only	\$825.51	\$762.52	\$559.53	\$686.81
EE +1 dependent	\$1,254.78	\$1,159.06	\$850.46	\$1,022.29
EE + 2 or more dependents	\$1,750.05	\$1,616.57	\$1,186.22	\$1,406.50

¹ To see the fully comprehensive Medical Plan Comparison chart for **NON-Network** coverage visit: <http://www.mcsig.com/healthPlans.html>