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Municipalities, Colleges, Schools Insurance Group

2023 Medical Comparison Chart

Participant's share of (You Pay): **Network: Blue Shield** (provider search blueshieldca.com/mcsig)	**PPO $25**	**PPO $30**	**PPO $40**	**PPO $50**	DEDUCTIBLE MUST BE MET FIRST **PPO $60** **High Deductible Health Plan**	NO OUT OF NETWORK COVERAGE **PPO Select** **(formerly known as EPO)**	**CompleteCare** Medical Expense Reimbursement Plan
Deductibles (Individual / Family)[1]	**$650 / 2x**	**$1,000 / 2x**	**$1,500 / 2x**	**$2,500 / 2x**	**$5,000** **Integrated with Med/Rx Deductible, Per Person**	**$1,000 / 2x**	**Contact your Benefit Representative for more information**
Coinsurance - Network	**20%**	**30%**	**30%**	**30%**	**30%**	**20%**	
Coinsurance - Out Network	40%	50%	50%	50%	No out of network coverage	No out of network coverage. No coverage for Monterey County hospitals and their owned facilities	(877) 872-4232 or email completecare@catilizehealth.com
Out-of-Pocket Co-Ins Maximums-Single In Network[2]	**$4,000**	**$5,500**	**$6,350**	**$6,350**	**$6,350**	**$6,350**	**$9,100 Single per year Annual Reimbursement**
Out-of-Pocket Co-Ins Maximums - Family In Network[2]	2 x Individual	2 x Individual	2 x Individual	2 x Individual	Per person	2 x Individual	**$18,200 Family per year Annual Reimbursement**
Out-Network Co-Insurance Maximums[2]	$7,000 / 2 x Ind.	$11,000 / 2 x Ind	$12,700 / 2 x Ind	$12,700 / 2 x Ind	No out of network coverage	No out of network coverage	For more information on this plan contact your District Benefit Representative
Inpatient Hospital Coinsurance (In-Network)*	$250 copay + 20%	$250 copay + 30%	$250 copay + 30%	$250 copay + 30%	$250 copay + 30%	20%	
Inpatient Hospital Coinsurance (Out-Network)*	40%	50%	50%	50%	No out of network coverage Emergency Services Only	No out of network coverage Emergency Services Only	
Separate Hospital ER Co-Pay (applies if non-emergency)	$500 ER Room	$500 ER Room	$500 ER Room	$500 ER Room	$500 ER Room	$500 ER Room	
Ground/Air Ambulance*	20%/20%	30%/50%	30%/50%	30%/50%	30%/30%	20%/20%	
Physician Benefits	In-Net/Out-Net	In-Net/Out-Net	In-Net/Out-Net	In-Net/Out-Net	In-Network	In-Network Only	
Surgery/Anesthesia*	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30%	20%	
Hospital Visits*	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30%	0%	
Office Visits	**$25 / 40%**	**$30 / 50%**	**$40 / 50%**	**$50 / 50%**	**$60**	**$25**	
Specialist Visits	$35 / 40%	$40 / 50%	$50 / 50%	$50 / 50%	$70	$35	
Physical Exams	0% /40%	0% /50%	0% /50%	0% /50%	0%	0%	
Mental Health/Substance Abuse	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30%	20%	
Outpatient Diagnostic X-ray and Lab Work	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30%	20%	
Acupuncture (Any Licensed Acupuncturist)	$2,000 per year	$2,000 per year	$2,000 per year	$2,000 per year	$2,000 per year	$2,000 per year	
Prescription Drugs					Deductible must be met first		
Out-of-Pocket Co-Ins Max - Single In Network	$1,800	$1,800	$1,800	$1,800	$1,800	$1,800	
Out-of-Pocket Co-Ins Max - Family In Network	$3,600	$3,600	$3,600	$3,600	$3,600	$3,600	
Mail-Generic/Preferred/Brand (NonFormulary), 90 Day Supply	**$0 / $50 / $90**	**$0 / $50 / $90**	**$0 / $50 / $90**	**$0 / $50 / $90**	**$75**	**$0 / $50 / $90**	
Retail-Generic/Preferred/Brand (NonFormulary), 30 Day Supply	$10 / $25 / $45	$10 / $25 / $45	$10 / $25 / $45	$10 / $25 / $45	$25	$10 / $25 / $45	
Retail/Maint.-Gen./Pref./Brand (NonFormulary), 60 Day Supply	$15 / $40 / $60	$15 / $40 / $60	$15 / $40 / $60	$15 / $40 / $60	$50	$15 / $40 / $60	
Specialty, 30 Day Supply	$25 / $75 / $125	$25 / $75 / $125	$25 / $75 / $125	$25 / $75 / $125	$225	$25 / $75 / $125	
Chiropractic Care - CHPC.com (in-network only)	**$10 copay**						
Surgery Benefit Management Program	**100% w/Transcarent Surgery Care (888) 387-3909**						

Chart is for Comparison only; Plan Evidence of Coverage Document Prevails
Co-payments, Co-insurance and Deductibles apply toward out-of-pocket maximum
*Subject to deductible
[1] 2x = family deductible is met by two individuals
[2] Includes deductible