

2020

Municipalities, Colleges, Schools Insurance Group

Medical PPO & EPO Plan Comparison

							DEDUCTIBLE MUST BE MET BEFORE ANY COVERAGE	NO OUT OF NETWORK COVERAGE	<u>CompleteCare</u> Medical Expense Reimbursement Plan
Participant's share of ( You Pay ):	PPO \$20	PPO \$25	PPO \$30	PPO \$35	PPO \$40	PPO \$50	PPO \$60 High Deductible Health Plan	EPO Southern Ca	
							\$5,000 Integrated with Med/Rx Deductible, Per Person		Contact your Benefit Representative for more information
Deductibles (Individual / Family) <sup>1</sup>	\$400 / 2x	\$650 / 2x	\$1,000 / 2x	\$1,200 / 2x	\$1,500 / 2x	\$2,500 / 2x		\$1,000 / 2x	
Coinsurance - Network	10%	20%	30%	30%	30%	30%	30%	20%	No out of network coverage. No coverage for Monterey County hospitals and their owned facilities
Coinsurance - Out Network	40%	40%	50%	50%	50%	50%	No out of network coverage		
Out-of-Pocket Co-Ins Maximums-Single In Network <sup>2</sup>	\$2,000	\$4,000	\$5,500	\$6,000	\$6,350	\$6,350	\$6,350	\$6,350	\$7,900 Max. Annual Reimbursement
Out-of-Pocket Co-Ins Maximums - Family In Network <sup>2</sup>	2 x Individual	2 x Individual	2 x Individual	2 x Individual	2 x Individual	2 x Individual	Per person	2 x Individual	\$15,800 Max. Annual Reimbursement
Out-Network Co-Insurance Maximums <sup>2</sup>	\$4,000 / 2 x Ind	\$7,000 / 2 x Ind.	\$11,000 / 2 x Ind	\$12,000 / 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)*	10%	20%	30%	30%	30%	30%	30%	20%	
Inpatient Hospital Coinsurance (Out-Network)*	40%	40%	50%	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)	\$250 ER Room	\$250 ER Room	\$250 ER Room	\$250 ER Room	\$250 ER Room	\$250 ER Room	\$300 ER Room	\$250 ER Room	
Ground/Air Ambulance*	20%/20%	20%/20%	30%/50%	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-Net/Out-Net	In-Net/Out-Net	In-Network	In-Network Only	
Surgery/Anesthesia*	10% / 40%	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30% / 50%	30%	20%	
Surgery Benefit Management Program	100% benefit when using BridgeHealth (888) 387-3909								
Hospital Visits*	10% / 40%	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30% / 50%	30%	20%	
Office Visits	\$20 / 40%	\$25 / 40%	\$30 / 50%	\$35 / 50%	\$40 / 50%	\$50 / 50%	\$60	\$25	
Specialist Visits	\$30 / 40%	\$35 / 40%	\$40 / 50%	\$50 / 50%	\$50 / 50%	\$50 / 50%	\$70	\$35	
Physical Exams	0% /40%	0% /40%	0% /50%	0% /50%	0% /50%	0% /50%	0%	0%	
Chiropractic Care-Coverage for in Network >Must use Chiropractic HealthPlan Network	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay	
Mental Health/Substance Abuse	10% / 40%	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30% / 50%	30%	20%	
Other Benefits	In-Net/Out-Net	In-Net/Out-Net	In-Net/Out-Net	In-Net/Out-Net	In-Net/Out-Net	In-Net/Out-Net	In-Network	In-Network	
Well Child Care	0% / 40%	0% / 40%	0% / 50%	0% / 50%	0% / 50%	0% / 50%	0%	0%	
Maternity Care*	10% / 40%	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30% / 50%	30%	20%	
Skilled Nursing Facility* (to 365 days/Lifetime)	0%	20%	30% / 50%	30% / 50%	30% / 50%	30% / 50%	30%	20%	
Outpatient Diagnostic X-ray and Lab Work	10% / 40%	20% / 40%	30% / 50%	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	\$2,000 per year	\$2,000 per year	
Durable Medical Equipment*	20% / 40%	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30% / 50%	30%	20%	
Outpatient Rehab/Physical/Occupational Therapy*	10% / 40%	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30% / 50%	30%	No out of network coverage	
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	\$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	\$3,600	\$3,600	
Mail-Generic/Preferred/Brand (NonFormulary), 90 Day Supply	\$0 / \$40 / \$70	\$0 / \$40 / \$70	\$0 / \$50 / \$70	\$0 / \$50 / \$80	\$0 / \$50 / \$80	\$0 / \$50 / \$80	\$75	\$0 / \$50 / \$80	
Retail-Generic/Preferred/Brand (NonFormulary), 30 Day Supply	\$7 / \$20 / \$35	\$7 / \$20 / \$35	\$10 / \$25 / \$40	\$10 / \$25 / \$40	\$10 / \$25 / \$40	\$10 / \$25 / \$40	\$25	\$10 / \$25 / \$40	
Retail/Maint.-Gen./Pref./Brand (NonFormulary), 30 Day Supply	\$9.50 / \$29 / \$44	\$9.50 / \$29 / \$44	\$13 / \$35 / \$50	\$13 / \$35 / \$50	\$13 / \$35 / \$50	\$13 / \$35 / \$50	\$50	\$13 / \$35 / \$50	
Specialty, 30 Day Supply	\$21 / \$60 / \$100	\$21 / \$60 / \$100	\$21 / \$60 / \$100	\$21 / \$60 / \$100	\$21 / \$60 / \$100	\$21 / \$60 / \$100	\$200	\$21 / \$60 / \$100	

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  
<sup>1</sup> 2x = family deductible is met by two individuals  
<sup>2</sup>Includes deductible