



## Municipalities, Colleges, Schools Insurance Group 2025 Medical Comparison Chart

Participant's share of ( You Pay ): <b>Network: Blue Shield</b> (provider search blueshieldca.com/mcsig)	<b>PPO \$25</b>		<b>PPO Select</b>	<b>Trio HMO</b>	<b>CompleteCare</b> Medical Expense Reimbursement Plan
<b>Deductibles (Individual / Family)<sup>1</sup></b>	<b>\$1,000 / 2x</b>		<b>\$1,300 / 2x</b>	<b>\$1,500 / 2x Applies Only to Inpatient and Outpatient Hospital and Ambulatory Surgical Center</b>	<b>Contact your Benefit Representative for more information</b>
<b>Coinsurance - Network</b>	<b>25%</b>		<b>25%</b>	<b>15% -25% for Certain Services<sup>3</sup></b>	
Coinsurance - Out Network	40%		No out of network coverage. No coverage for Monterey County hospitals and their owned facilities (except SVMH)	No out of network coverage.	(877) 872-4232 or email completecare@catilizehealth.com
<b>Out-of-Pocket Co-Ins Maximums-Single In Network<sup>2</sup></b>	<b>\$6,000</b>		<b>\$7,500</b>	<b>\$3,000</b>	<b>\$9,200 Single per year Annual Reimbursement</b>
Out-of-Pocket Co-Ins Maximums - Family In Network <sup>2</sup>	2 x Individual		2 x Individual	2 x Individual	<b>\$18,400 Family per year Annual Reimbursement</b>
Out-Network Co-Insurance Maximums <sup>2</sup>	\$7,000 / 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 + 25%		25%	25%	
Inpatient Hospital Coinsurance (Out-Network)*	40%		No out of network coverage	No out of network coverage	
Hospital ER Co-Pay (**waived if admitted)	\$250 ER Room		Emergency Services Only	Emergency Services Only	
Ground/Air Ambulance*	25%/20%		\$500 ER Room**	\$150 ER Room	
Physician Benefits	In-Net/Out-Net		25%/20%	\$100 Copay	
Surgery/Anesthesia*	25% / 40%		<u>In-Network Only</u>	<u>In-Network Only</u>	
Hospital Visits*	25% / 40%		25%	15% - 30% <sup>3</sup>	
<b>Office Visits</b>	<b>\$25 / 40%</b>		<b>\$25</b>	<b>\$20</b>	
Specialist Visits	\$40 / 40%		\$40	\$20	
Physical Exams	0% / 40%		0%	0%	
Mental Health/Substance Abuse	25% / 40%		25%	\$20 visit / \$0 for some services	
<b>Outpatient Diagnostic X-ray and Lab Work</b>	25% / 40%		25%	\$0	
Acupuncture (Any Licensed Acupuncturist)	\$2,000 per year		\$2,000 per year	No Coverage	
<b>Prescription Drugs</b>					
Out-of-Pocket Co-Ins Max - <u>Single</u> In Network	\$1,800		\$1,800	Included with OOP Max above	
Out-of-Pocket Co-Ins Max - <u>Family</u> In Network	\$3,600		\$3,600	Included with OOP Max above	
<b>Mail-Generic/Preferred/Brand (NonFormulary), 90 Day Supply</b>	<b>\$0 / \$50 / \$90</b>		<b>\$0 / \$50 / \$90</b>	<b>\$20 / \$60 / \$100</b>	
Retail-Generic/Preferred/Brand (NonFormulary), 30 Day Supply	\$10 / \$25 / \$45		\$10 / \$25 / \$45	\$10 / \$30 / \$50	
Retail/Maint.-Gen./Pref./Brand (NonFormulary), 60 Day Supply	\$15 / \$40 / \$60		\$15 / \$40 / \$60	(90 Day Supply) \$30 / \$90 / \$150	
Specialty, 30 Day Supply	\$25 / \$75 / \$125		\$25 / \$75 / \$125	20% to \$250 / \$20% to \$500 90 Day Mail / 20% to \$750 90 Day Retail	
<b>Chiropractic Care</b> - CHPC.com (in-network only)			<b>\$10 copay</b>	No Coverage	
<b>Surgery Benefit Management Program</b>			<b>100% w/Transparent Surgery Care (888) 387-3909</b>	Transparent benefits not included	

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

\*\*PPO Select ER Co-Pay waived when it is a true emergency (e.g. taken by ambulance, severe wounds, broken bones, severe chest pain) or if admitted to the hospital

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

<sup>2</sup>Includes deductible

<sup>3</sup>15% for Ambulatory Surgery Center / 25% for Inpatient Hospital Services and Skilled Nursing Facility / 30% for Hospital Outpatient Surgery / 20% for Diabetes Equipment and Supplies / 50% for Durable Medical Equipment and Allergy Serum billed separately from Office Visit