



Municipalities, Colleges, Schools Insurance Group 2023 Medical Comparison Chart

Participant's share of (You Pay):	PPO \$25	PPO \$30	PPO \$40	PPO \$50	DEDUCTIBLE MUST BE MET FIRST PPO \$60	NO OUT OF NETWORK COVERAGE PPO Select	Trio HMO
Network: Blue Shield (provider search blueshieldca.com/mcsig)					High Deductible Health Plan	(formerly known as EPO)	
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	\$1,500 / 2x Applies Only to Inpatient and Outpatient Hospital and Ambulatory Surgical Center
Coinsurance - Network	20%	30%	30%	30%	30%	20%	15% -25% for Certain Services ³
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	No out of network coverage.
Out-of-Pocket Co-Ins Maximums-Single In Network²	\$4,000	\$5,500	\$6,350	\$6,350	\$6,350	\$6,350	\$3,000
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	2 x Individual
Out-Network Co-Insurance Maximums*	\$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	No out of network coverage
Inpatient Hospital Coinsurance (In-Network)*	\$250 copay + 20%	\$250 copay + 30%	\$250 copay + 30%	\$250 copay + 30%	\$250 copay + 30%	20%	25%
Inpatient Hospital Coinsurance (Out-Network)*	\$125 copay + 40%	\$125 copay + 50%	\$125 copay + 50%	\$125 copay + 50%	No out of network coverage Emergency Services Only	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	\$150 ER Room
Ground/Air Ambulance*	20%/20%	30%/50%	30%/50%	30%/50%	30%/30%	20%/20%	\$100 Copay
Physician Benefits	In-Net/Out-Net	In-Net/Out-Net	In-Net/Out-Net	In-Net/Out-Net	In-Network	In-Network Only	In-Network Only
Surgery/Anesthesia*	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30%	20%	15% - 30% ³
Hospital Visits*	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30%	0%	0%
Office Visits	\$25 / 40%	\$30 / 50%	\$40 / 50%	\$50 / 50%	\$60	\$25	\$20
Specialist Visits	\$35 / 40%	\$40 / 50%	\$50 / 50%	\$50 / 50%	\$70	\$35	\$20
Physical Exams	0% / 40%	0% / 50%	0% / 50%	0% / 50%	0%	0%	0%
Mental Health/Substance Abuse	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30%	20%	\$20 visit / \$0 for some services
Outpatient Diagnostic X-ray and Lab Work	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30%	20%	\$0
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	Included with OOP Max above
Out-of-Pocket Co-Ins Max - Family In Network	\$3,600	\$3,600	\$3,600	\$3,600	\$3,600	\$3,600	Included with OOP Max above
Mail-Generic/Preferred/Brand (NonFormulary), 90 Day Supply	\$0 / \$50 / \$90	\$0 / \$50 / \$90	\$0 / \$50 / \$90	\$0 / \$50 / \$90	\$75	\$0 / \$50 / \$90	\$20 / \$60 / \$100
Retail-Generic/Preferred/Brand (NonFormulary), 30 Day Supply	\$10 / \$25 / \$45	\$10 / \$25 / \$45	\$10 / \$25 / \$45	\$10 / \$25 / \$45	\$25	\$10 / \$25 / \$45	\$10 / \$30 / \$50
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	(90 Day Supply) \$30 / \$90 / \$150
Specialty, 30 Day Supply	\$25 / \$75 / \$125	\$25 / \$75 / \$125	\$25 / \$75 / \$125	\$25 / \$75 / \$125	\$225	\$25 / \$75 / \$125	20% to \$250 / 20% to \$500 90 Day Mail / 20% to \$750 90 Day Retail
Surgery Benefit Management Program	100% w/Transparent Surgery Care (888) 387-3909						
Chiropractic Care - CHPC.com (in-network only)	\$10 copay						

CompleteCare
Medical Expense
Reimbursement Plan

Contact your Benefit Representative for more information

(877) 872-4232 or email
completecare@catilizehealth.com

\$9,100 Single per year Annual Reimbursement

\$18,200 Family per year Annual Reimbursement
For more information on this plan contact your District Benefit Representative

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
³ 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