

Participant's share of (You Pay): <i>Network: Blue Shield</i>	PPO \$25	PPO \$30	PPO \$40	PPO \$50	DEDUCTIBLE MUST BE MET BEFORE ANY COVERAGE PPO \$60 High Deductible Health Plan	NO OUT OF NETWORK COVERAGE PPO Select (formerly known as EPO)	PPO250 City of Seaside	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	\$250 / 3x	Contact your Benefit Representative for more information
Coinsurance - Network	20%	30%	30%	30%	30%	20%	10%	
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	30%	
Out-of-Pocket Co-Ins Maximums-Single In Network ²	\$4,000	\$5,500	\$6,350	\$6,350	\$6,350	\$6,350	\$2,500	\$8,550 Max. 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	2 x Individual	\$17,100 Max. 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	\$6,500 / 2 x Ind	For more information on this plan contact your District Benefit Representative
Inpatient Hospital Coinsurance (In-Network)*	20%	30%	30%	30%	30%	20%	10%	
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	30%	
Separate Hospital ER Co-Pay (applies if non-emergency) Ground/Air Ambulance*	\$500 ER Room 20%/20%	\$500 ER Room 30%/50%	\$500 ER Room 30%/50%	\$500 ER Room 30%/50%	\$500 ER Room 30%/30%	\$500 ER Room 20%/20%	\$500 ER Room 10%/10% (30% non-emerg.)	
Physician Benefits	In-Net/Out-Net	In-Net/Out-Net	In-Net/Out-Net	In-Net/Out-Net	In-Network	In-Network Only	In-Net/Out-Net	You can also call 877-872-4232 or email completecare@catlizehealth.com
Surgery/Anesthesia*	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30%	20%	10% / 30%, up to \$350 (admit)	
Surgery Benefit Management Program	100% benefit when using BridgeHealth (888) 387-3909							
Hospital Visits*	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30%	20%	10% / 30%	
Office Visits	\$25 / 40%	\$30 / 50%	\$40 / 50%	\$50 / 50%	\$60	\$25	\$20 / 30%	
Specialist Visits	\$35 / 40%	\$40 / 50%	\$50 / 50%	\$50 / 50%	\$70	\$35	\$20 / 30%	
Physical Exams	0% / 40%	0% / 50%	0% / 50%	0% / 50%	0%	0%	0% / 30%	
Chiropractic Care - CHPC.com (in-network only)	\$10 copay							
Mental Health/Substance Abuse	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30%	20%	10% / 30%	
Other Benefits	In-Net/Out-Net	In-Net/Out-Net	In-Net/Out-Net	In-Net/Out-Net	In-Network	In-Network	In-Network	
Well Child Care	0% / 40%	0% / 50%	0% / 50%	0% / 50%	0%	0%	0% / 30%	
Maternity Care*	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30%	20%	10% / 30%	
Skilled Nursing Facility* (to 365 days/Lifetime)	20%	30% / 50%	30% / 50%	30% / 50%	30%	20%	10% / 30%	
Outpatient Diagnostic X-ray and Lab Work	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30%	20%	10% / 30%	
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	
Durable Medical Equipment*	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30%	20%	10% / 30%	
Outpatient Rehab/Physical/Occupational Therapy*	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30%	No out of network coverage	10% / 30%	
Prescription Drugs	Deductible must be met first							
Out-of-Pocket Co-Ins Max - <u>Single</u> In Network	\$1,800	\$1,800	\$1,800	\$1,800	\$1,800	\$1,800	\$1,800	
Out-of-Pocket Co-Ins Max - <u>Family</u> In Network	\$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 / \$50 / \$80	\$0 / \$50 / \$80	\$0 / \$50 / \$80	\$75	\$0 / \$50 / \$80	\$0 / \$50 / \$80	
Retail-Generic/Preferred/Brand (NonFormulary), 30 Day Supply	\$7 / \$20 / \$35	\$10 / \$25 / \$40	\$10 / \$25 / \$40	\$10 / \$25 / \$40	\$25	\$10 / \$25 / \$40	\$10 / \$25 / \$40	
Retail/Maint.-Gen./Pref./Brand (NonFormulary), 30 Day Supply	\$9.50 / \$29 / \$44	\$13 / \$35 / \$50	\$13 / \$35 / \$50	\$13 / \$35 / \$50	\$50	\$13 / \$35 / \$50	\$13 / \$35 / \$50	
Specialty, 30 Day Supply	\$21 / \$60 / \$100	\$21 / \$60 / \$100	\$21 / \$60 / \$100	\$21 / \$60 / \$100	\$200	\$21 / \$60 / \$100	\$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

¹ 2x = family deductible is met by two individuals

²Includes deductible