

2019
Municipalities, Colleges, Schools Insurance Group
Medical PPO & EPO Plan Comparison

Participant's share of (You Pay): Network:	PPO \$20	PPO \$25	PPO \$30	PPO \$35	PPO \$40	PPO \$50	DEDUCTIBLE MUST BE MET BEFORE ANY COVERAGE PPO \$60	EPO SOUTHERN CALIFORNIA
	Prudent Buyer	Prudent Buyer	Prudent Buyer	Prudent Buyer	Prudent Buyer	Prudent Buyer	Prudent Buyer	Prudent Buyer
Deductibles (Individual / Family) ¹	\$400 / 2x	\$650 / 2x	\$1,000 / 2x	\$1,200 / 2x	\$1,500 / 2x	\$2,500 / 2x	\$5,000 Integrated with Med/Rx Deductible, Per Person	\$1,000 / 2x
Coinsurance - Network	10%	20%	30%	30%	30%	30%	30%	20%
Coinsurance - Out Network	40%	40%	50%	50%	50%	50%	No out of network coverage	No out of network coverage. No coverage for Monterey County hospitals and their owned facilities
Out-of-Pocket Co-Ins Maximums-Single In Network ²	\$2,000	\$4,000	\$5,500	\$6,000	\$6,350	\$6,350	\$6,350	\$6,350
Out-of-Pocket Co-Ins Maximums - Family In Network ² Out-Network Co-Insurance Maximums ²	2 x Individual \$4,000 / 2 x Ind	2 x Individual \$7,000 / 2 x Ind.	2 x Individual \$11,000 / 2 x Ind	2 x Individual \$12,000 / 2 x Ind	2 x Individual \$12,700 / 2 x Ind	2 x Individual \$12,700 / 2 x Ind	Per person No out of network coverage	2 x Individual No out of network coverage
Inpatient Hospital Coinsurance (In-Network)*	10%	20%	30%	30%	30%	30%	30%	20%
Inpatient Hospital Coinsurance (Out-Network)* Separate Hospital ER Co-Pay (applies if non-emergency)	40%	40%	50%	50%	50%	50%	No out of network coverage Emergency Services Only	No out of network coverage Emergency Services Only
Ground/Air Ambulance*	\$250 ER Room 20%/20%	\$250 ER Room 20%/20%	\$250 ER Room 30%/50%	\$250 ER Room 30%/50%	\$250 ER Room 30%/50%	\$250 ER Room 30%/50%	\$300 ER Room 30%/30%	\$250 ER Room 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 - MHN >Must use MHN Network	Outpatient: \$15/visit network; 40% out-of-network Inpatient: 100% in-network; 40% out-of-network	Outpatient: \$15/visit network; 40% out-of-network Inpatient: 100% in-network; 40% out-of-network	Outpatient: \$15/visit network; 40% out-of-network Inpatient: 100% in-network; 40% out-of-network	Outpatient: \$15/visit network; 40% out-of-network Inpatient: 100% in-network; 40% out-of-network	Outpatient: \$15/visit network; 40% out-of-network Inpatient: 100% in-network; 40% out-of-network	Outpatient: \$15/visit network; 40% out-of-network Inpatient: 100% in-network; 40% out-of-network	Outpatient: \$15/visit network; 40% out-of-network Inpatient: 100% in-network; 40% out-of-network	Outpatient: \$15/visit network; 40% out-of-network Inpatient: 100% in-network; 40% out-of-network
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	30%	\$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	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$5,000	\$1,000
Out-of-Pocket Co-Ins Max - Family In Network	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	Integrated with Med/Rx	\$2,000
Retail-Generic/Preferred/Brand (NonFormulary)	\$7 / \$20 / \$35 30 day supply	\$7 / \$20 / \$35 30 day supply	\$10 / \$25 / \$40 30 day supply	\$10 / \$25 / \$40 30 day supply	\$10 / \$25 / \$40 30 day supply	\$10 / \$25 / \$40 30 day supply	\$25	\$10 / \$25 / \$40 30 day supply
Retail/Maint.-Gen./Pref./Brand (NonFormulary)	\$9.50 / \$29 / \$44 30 day supply	\$9.50 / \$29 / \$44 30 day supply	\$13 / \$35 / \$50 30 day supply	\$13 / \$35 / \$50 30 day supply	\$13 / \$35 / \$50 30 day supply	\$13 / \$35 / \$50 30 day supply	\$50	\$13 / \$35 / \$50 30 day supply
Mail-Generic/Preferred/Brand (NonFormulary)	\$0 / \$40 / \$70 - 90 day supply	\$0 / \$40 / \$70 - 90 day supply	\$0 / \$50 / \$80 90 day supply	\$0 / \$50 / \$80 90 day supply	\$0 / \$50 / \$80 90 day supply	\$0 / \$50 / \$80 90 day supply	\$75	\$0 / \$50 / \$80 90 day supply
Specialty	\$21 / \$60 / \$100 30 day supply	\$21 / \$60 / \$100 30 day supply	\$21 / \$60 / \$100 30 day supply	\$21 / \$60 / \$100 30 day supply	\$21 / \$60 / \$100 30 day supply	\$21 / \$60 / \$100 30 day supply	\$200	\$21 / \$60 / \$100 30 day supply

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

	PPO 20	PPO 25	PPO 30	PPO 35	PPO 40	PPO 50	PPO 60	EPO Southern California
Employee Only	\$ 1,201.00	\$ 851.00	\$ 808.00	\$ 788.00	\$ 766.00	\$ 718.00	\$ 646.00	\$ 578.00
Employee + 1	\$ 2,400.00	\$ 1,698.00	\$ 1,612.00	\$ 1,571.00	\$ 1,528.00	\$ 1,434.00	\$ 1,286.00	\$ 1,152.00
Family	\$ 3,118.00	\$ 2,206.00	\$ 2,095.00	\$ 2,040.00	\$ 1,985.00	\$ 1,863.00	\$ 1,672.00	\$ 1,496.00