2020

Municipalities, Colleges, Schools Insurance Group

Medical PPO & EPO Plan Comparison

Participant's share of (You Pay):	PPO $20	PPO $25	PPO $30	PPO $35	PPO $40	PPO $50	DEDUCTIBLE MUST BE MET BEFORE ANY COVERAGE PPO $60 High Deductible Health Plan	NO OUT OF NETWORK COVERAGE EPO Southern Ca	CompleteCare Medical Expense Reimbursement Plan
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	Contact your Benefit Representative for more information
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	$7,900 Max. Annual Reimbursement
Out-of-Pocket Co-Ins Maximums - Family In Network[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	2 x Individual	$15,800 Max. Annual Reimbursement
Out-Network Co-Insurance Maximums[2]							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							Deductibe 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 Suppply	$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 maximu
*Subject to deductible
[1] 2x = family deductible is met by two individuals
[2]Includes deductible

MCSIG Customer Service: (831) 755-8055 or (800) 287-1442