MCSIG
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Municipalities, Colleges, Schools Insurance Group

2023 Medical Comparison Chart

Participant's share of (You Pay): **Network: Blue Shield** (provider search blueshieldca.com/mcsig)	**PPO $25**	**PPO $30**	**PPO $40**	**PPO $50**	DEDUCTIBLE MUST BE MET FIRST **PPO $60** **High Deductible Health Plan**	NO OUT OF NETWORK COVERAGE **PPO Select** **(formerly known as EPO)**	**Trio HMO**	**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**	**$1,500 / 2x Applies Only to Inpatient and Outpatient Hospital and Ambulatory Surgical Center**	**Contact your Benefit Representative for more information**
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.	(877) 872-4232 or email completecare@catilizehealth.com
Out-of-Pocket Co-Ins Maximums-Single In Network[2]	**$4,000**	**$5,500**	**$6,350**	**$6,350**	**$6,350**	**$6,350**	**$3,000**	**$9,100 Single per year 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	**$18,200 Family per year 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	No out of network coverage	For more information on this plan contact your District Benefit Representative
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)*	40%	50%	50%	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	
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	No Coverage	
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	
Chiropractic Care - CHPC.com (in-network only)	**$10 copay**						No Coverage	
Surgery Benefit Management Program	**100% w/Transcarent Surgery Care (888) 387-3909**						Transcarent 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
[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