

MUNICIPALITIES-COLLEGES-SCHOOLS INSURANCE GROUP
2018-19 Medical Plan Comparison

Carmel Unified Employee Premiums	Effective 01/01/19	11 monthly premiums						
Employee Only	\$454.73	\$72.91	\$26.00	\$4.18	0	0	0	0
*Employee & 1	\$1,434.09	\$668.27	\$574.45	\$529.73	\$482.82	\$380.27	\$218.82	\$72.64
*Full Family	\$1,902.55	\$907.64	\$786.55	\$726.55	\$666.55	\$533.45	\$325.09	\$133.09
Participant's share of (You Pay):	PPO \$20	PPO \$25	PPO \$30	PPO \$35	PPO \$40	PPO \$50	PPO \$60	EPO *
Network	Prudent Buyer (formerly PPO Option I)	Prudent Buyer (formerly PPO Option III)	Prudent Buyer	Prudent Buyer	Prudent Buyer	Prudent Buyer	Prudent Buyer	Southern California Prudent Provider <i>*No coverage for Monterey County Hospitals</i>
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 Ded Per Person 30%	\$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
Out-of-Pocket Co-Ins Maximums - Single In Network	\$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 x Individual	2 x Individual	2 x Individual	2 x Individual	2 x Individual	2 x Individual	2 x Individual	2 x Individual
Out-Network Co-Insurance Maximums	\$4,000 / 2 x Ind	\$7,000 / 2 x Ind.	\$11,000 / 2 x Ind	\$12,000 / 2 x Ind	\$12,700 / 2 x Ind	\$12,700 / 2 x Ind	No out of network coverage	No out of network coverage
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	No out of network coverage
Separate Hospital ER Co-Pay (applies only if non-emergent)	\$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%
Ground/Air Ambulance								
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%
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 only -Chiropractic HealthPlan Network only	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay
Mental Health/Substance Abuse - MHN	Outpnt: \$15/visit network; 40% out-of-network Inpatient: 100% in-network; 40% out-of-network	Outpnt: \$15/visit network; 40% out-of-network Inpatient: 100% in-network; 40% out-of-network	Outpnt: \$15/visit network; 40% out-of-network Inpatient: 100% in-network; 40% out-of-network	Outpnt: \$15/visit network; 40% out-of-network Inpatient: 100% in-network; 40% out-of-network	Outpnt: \$15/visit network; 40% out-of-network Inpatient: 100% in-network; 40% out-of-network	Outpnt: \$15/visit network; 40% out-of-network Inpatient: 100% in-network; 40% out-of-network	Outpnt: \$15/visit network; 40% out-of-network Inpatient: 100% in-network; 40% out-of-network	Outpnt: \$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* up to 365 days/Lifetime	0% to 365 days	20% to 365 days	30% / 50%	30% / 50%	30% / 50%	30% / 50%	30%	20%
Home Health Care* up to 120 days per illness	0%, to 120 days	20%, to 120 days	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 max per calendar year	\$2,000 max per calendar year	\$2,000 max per calendar year	\$2,000 max per calendar year	\$2,000 max per calendar year	\$2,000 max per calendar year	30%	\$2,000 per year calendar year
Durable Medical Equipment*	20% / 40%	20% / 40%	30% / 50%	30% / 50%	30% / 50%	30% / 50%	30%	20%
Outpatient surgery @ Ambulatory Surgery Center*	10% / 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%	EPO plans do not have out of network coverage; exception: Ambulance and MHN services
Prescription Drugs								
Retail - Generic/Preferred/Brand (NonFormulary)	\$7 / \$20 / \$35 per 30 day supply	\$7 / \$20 / \$35 per 30 day supply	\$10 / \$25 / \$40 per 30 day supply	\$10 / \$25 / \$40 per 30 day supply	\$10 / \$25 / \$40 per 30 day supply	\$10 / \$25 / \$40 per 30 day supply	25 ^o	\$10 / \$25 / \$40 per 30 day supply
Retail/Mtce. - Gen./Pref./Brand (NonFormulary)	\$9.50 / \$29 / \$44 per 30 day supply	\$9.50 / \$29 / \$44 per 30 day supply	\$13 / \$35 / \$50 per 30 day supply	\$13 / \$35 / \$50 per 30 day supply	\$13 / \$35 / \$50 per 30 day supply	\$13 / \$35 / \$50 per 30 day supply	50 ^o	\$13 / \$35 / \$50 per 30 day supply
Mail - Generic/Preferred/Brand (NonFormulary)	\$0 / \$40 / \$70 - per 90 day supply	\$0 / \$40 / \$70 - per 90 day supply	\$0 / \$50 / \$80 - per 90 day supply	\$0 / \$50 / \$80 - per 90 day supply	\$0 / \$50 / \$80 - per 90 day supply	\$0 / \$50 / \$80 - per 90 day supply	75 ^o	\$0 / \$50 / \$80 - per 90 day supply
Specialty	\$21 / \$60 / \$100 per 30 day supply	\$21 / \$60 / \$100 per 30 day supply	\$21 / \$60 / \$100 per 30 day supply	\$21 / \$60 / \$100 per 30 day supply	\$21 / \$60 / \$100 per 30 day supply	\$21 / \$60 / \$100 per 30 day supply	200 ^o	\$21 / \$60 / \$100 per 30 day supply
HCR Actuarial Value	95%	90.50%	85%	81%	81%	74%	62%	

Co-pays do not apply toward deductibles or out-of-pocket maximums

**ANNUAL DISTRICT CONTRIBUTION CAP
APPLIED TOWARDS HEALTH INSURANCE PREMIUMS**
EMPLOYEE \$ 9,410.00
EMPLOYEE & 1 \$13,025.00
FULL FAMILY \$16,488.00

EPO*
County hospitals
that are included are:
Watsonville Community Hospital
Dignity Dominican Hospital
Sutter Maternity & Surgical Center
Hazel Hawkins Memorial in Hollister
EPO*
Hospitals
not included:
CHOMP
Salinas Valley Memorial
Natividad Hospital

Deductibles apply toward out-of-pocket maximums
*Subject to deductible ¹Applies to OOP Maximums Includes deductible
Rates in effect January 1, 2019 through December 31, 2019 unless otherwise noted

¹Co-pays apply after annual deductible met
Out of Network: All charges over the C&R (Customary & Reasonable) is the participants responsibility