



Municipalities, Colleges, Schools Insurance Group
2026 Medical Comparison Chart

Participant's share of (You Pay):	PPO \$25	PPO \$40	PPO \$60	PPO Select	Trio HMO	CompleteCare	Kaiser High Plan
Network: Blue Shield / Claims Processing: Delta Health Systems			High Deductible Health Plan			Medical Expense Reimbursement Plan	Network: Kaiser Permanente (provider search kp.org)
Deductibles (Individual/Family) ¹	\$1,000 / 2x	\$1,650 / 2x	\$6,000 Integrated with Med/Rx Deductible, Per Person	\$1,300 / 2x	\$1,500 / 2x Applies Only to Inpatient and Outpatient Hospital and Ambulatory Surgical Center	Contact your Benefit Representative for more information	\$0
Coinsurance - Network	25%	30%	30%	25%	15% -25%		\$0
Coinsurance - Out Network	40%	50%	No out of network coverage. Deducible must be met first.	No out of network coverage. No coverage for Monterey County hospitals and their owned facilities (except SVMH)	No out of network coverage.	(877) 872-4232 or email completecare@catilizehealth.com	No out of network coverage.
Out-of-Pocket Co-Ins Maximums-Single In Network ²	\$6,000	\$6,500	\$7,500	\$7,500	\$3,000	\$10,600 Single per year Annual Reimbursement	\$1,500
Out-of-Pocket Co-Ins Maximums - Family In Network ²	2 x Individual	2 x Individual	Per person	2 x Individual	2 x Individual	\$21,200 Family per year Annual Reimbursement	2 x Individual
Out-Network Co-Insurance Maximums ²	\$7,000 / 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	No out of network coverage
Inpatient Hospital Coinsurance (In-Network)*	\$250 copay + 25%	\$250 copay + 30%	\$250 copay + 30%	25%	25%		\$0
Inpatient Hospital Coinsurance (Out-Network)*	40%	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		No out of network coverage
Separate Hospital ER Co-Pay (waived if admitted)	\$500 ER Room	\$500 ER Room	\$500 ER Room	\$500 ER Room	\$150 ER Room		\$50 (waived if admitted - inpatient cost share applies)
Ground/Air Ambulance*	25%	30%	30%	25%	\$100 Copay		\$50 / Trip
Physician Benefits	In-Net/Out-Net	In-Net/Out-Net	In-Network Only	In-Network Only	In-Network Only		In-Network Only
Surgery/Anesthesia*	25% / 40%	30% / 50%	30%	25%	15% - 30% ³		Inpatient \$0 /
Hospital Visits*	25% / 40%	30% / 50%	30%	25%	0%		Outpatient \$20 / Procedure
Office Visits	\$25 / 40%	\$40 / 50%	\$60	\$25	\$20		\$0
Specialist Visits	\$40 / 40%	\$60 / 50%	\$70	\$40	\$20		\$20
Physical Exams	0% /40%	0% /50%	0%	0%	0%		\$0
Mental Health/Substance Abuse							\$20 individual.
Outpatient Diagnostic X-ray and Lab Work	25% / 40%	30% / 50%	30%	25%	\$20 visit / \$0 for some services		Mental Health: \$10 / group visit;
Radiology at Free standing facilities (non-hospital owned)	25% / 40%	30% / 50%	30%	25%	\$0		Substance Abuse: \$5 / group visit.
Acupuncture (Any Licensed Acupuncturist)	\$0 / 40%	\$0 / 50%	\$0	\$0	\$0		\$0
Prescription Drugs	\$2,000 per year	\$2,000 per year	\$2,000 per year	\$2,000 per year	No Coverage		No Coverage
Out-of-Pocket Copay Max - Single In Network	\$1,800	\$1,800	\$1,800	\$1,800	Included with OOP Max above		
Out-of-Pocket Copay Max - Family In Network	\$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	\$75	\$0 / \$50 / \$90	\$20 / \$60 / \$100		(100 Day Supply) \$10 / \$10
Retail-Generic/Preferred/Brand (NonFormulary), 30 Day Supply	\$10 / \$25 / \$45	\$10 / \$25 / \$45	\$25	\$10 / \$25 / \$45	\$10 / \$30 / \$50		(100 Day Supply) \$10 / \$10
Retail/Maint.-Gen./Pref./Brand (NonFormulary), 60 Day Supply	\$15 / \$40 / \$60	\$15 / \$40 / \$60	\$50	\$15 / \$40 / \$60	(90 Day Supply) \$30 / \$90 /\$150		(100 Day Supply) \$10 / \$10
Specialty, 30 Day Supply	\$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		(30 Day Supply) \$10
Chiropractic Care - CHPC.com (in-network only)			\$10 copay		No Coverage		No Coverage
Translucent Surgery Benefit Management Program (required for PPO25, PPO40, PPO60, and Select Plan)	Members must coordinate their surgeries with Translucent at (855) 586-2744. Non-compliance will result in 100% claim denial. Surgeries under Translucent are covered at 100%. This requirement does not apply to surgeries resulting from an emergency room visit.						Translucent benefits not included

Chart is for Comparison only; Plan 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