Participant's share of (You Pay):		NO OUT OF NETWORK COVERAGE PPO Select	Trio HMO	CompleteCare Medical Expense Reimbursement Plan
Network: **Blue Shield** (provider search blueshieldca.com/mcsig)		(formerly known as EPO)		
Deductibles (Individual / Family)[1]	$650 / 2x	$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%	20%	15% - 25% for Certain Services[3]	
Coinsurance - Out Network	40%	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	$6,350	$3,000	$9,450 Single per year Annual Reimbursement
Out-of-Pocket Co-Ins Maximums - Family In Network[2]	2 x Individual	2 x Individual	2 x Individual	$18,900 Family per year Annual Reimbursement
Out-Network Co-Insurance Maximums[2]	$7,000 / 2 x Ind.	No out of network coverage	No out of network coverage	For more information
Inpatient Hospital Coinsurance (In-Network)*	$250 copay + 20%	20%	25%	on this plan contact your
Inpatient Hospital Coinsurance (Out-Network)*	40%	No out of network coverage Emergency Services Only	No out of network coverage Emergency Services Only	District Benefit Representative
Hospital ER Co-Pay (waived if admitted)	$250 ER Room	$500 ER Room**	$150 ER Room	
Ground/Air Ambulance*	20%/20%	20%/20%	$100 Copay	
Physician Benefits-5.oth(-5.88 (.3(r Ambul)-5.3(ance*)-284) oth(8($100 58 2525daT9l*)- .3889ETr1ee/)-o28-5. .48($5 481058o542a8fP4i 58o542ae/)-gurs)-.9881 f6-5.08 TJAiForIn-Network Only				
Surgery/Anesthesia*	20% / 40%	20%	15% - 30%[3]	
Hospital Visits*	20% / 40%	0%	0%	
Office Visits	**$25 / 40%**	**$25**	**$20**	