

# North Coast Schools Medical Insurance Group



## Plan Comparison July 1, 2025

Plan Type	Oak & Oak PLUS <sup>+</sup> PPO Plan		Spruce & Spruce PLUS <sup>+</sup> PPO Plan		Pine & Pine PLUS <sup>+</sup> PPO HDHP (HSA Compatible)		Maple & Maple PLUS <sup>+</sup> PPO Plan	
Medical Benefits	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network
Network	Blue Shield of California PPO		Blue Shield of California PPO		Blue Shield of California PPO		Blue Shield of California PPO	
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited	
Annual Deductible	Annual Deductible is embedded Annual Deductible applies unless indicated otherwise		Annual Deductible is embedded Annual Deductible applies unless indicated otherwise		Annual Deductible is embedded Annual Deductible applies unless indicated otherwise		Annual Deductible is embedded Annual Deductible applies unless indicated otherwise	
Individual	\$350		\$500		\$1,600		\$5,000	
Family	\$1,050		\$1,500		\$3,200		\$10,000	
Out-of-Pocket Maximum (OOPM)	Allows In Network (INN) OOPM to accrue to Out of Network (OON) OOPM and vice versa. If the OON OOPM is met before the INN OOPM is met the OON OOPM can satisfy the plan's OOPM and benefits would be paid at 100% for both INN and OON services.		Allows In Network (INN) OOPM to accrue to Out of Network (OON) OOPM and vice versa. If the OON OOPM is met before the INN OOPM is met the OON OOPM can satisfy the plan's OOPM and benefits would be paid at 100% for both INN and OON services.		Allows In Network (INN) OOPM to accrue to Out of Network (OON) OOPM and vice versa. If the OON OOPM is met before the INN OOPM is met the OON OOPM can satisfy the plan's OOPM and benefits would be paid at 100% for both INN and OON services.		Allows In Network (INN) OOPM to accrue to Out of Network (OON) OOPM and vice versa. If the OON OOPM is met before the INN OOPM is met the OON OOPM can satisfy the plan's OOPM and benefits would be paid at 100% for both INN and OON services.	
	Individual OOPM is Embedded in the Family OOPM		Individual OOPM is Embedded in the Family OOPM		Individual OOPM is Embedded in the Family OOPM		Individual OOPM is Embedded in the Family OOPM	
Individual	\$2,000		\$3,000		\$7,000		\$6,350	
Family	\$4,000		\$6,000		\$14,000		\$12,700	
Professional								
Primary Care Physician (PCP)	\$20 copay; Deductible waived	30%	\$20 copay; Deductible waived	40%	\$0 copay	30%	\$60 copay, Annual Deductible applies after first 3 visits either PCP or Specialist	PLUS <sup>+</sup> \$60 Annual Deductible Applies 50%
Specialist	\$30 / PLUS <sup>+</sup> \$20 copay; Deductible waived	30%	\$30 / PLUS <sup>+</sup> \$20 copay; Deductible waived	40%	\$0 copay	30%	\$70 copay, Annual Deductible applies after first 3 visits either PCP or Specialist	PLUS <sup>+</sup> \$60 Annual Deductible Applies 50%
Physical Therapy	10%	30%; Limited to \$25/visit	20%	40%; Limited to \$25/visit	20%	30%; Limited to \$25/visit	30%	50%; Limited to \$25/visit
Home Health Care	10%	Not Covered	20%	Not Covered	20%	Not Covered	30%	Not Covered
	120-day annual maximum		120-day annual maximum		120-day annual maximum		120-day annual maximum	
Preventive Care								
Baby	\$0 copay; Deductible waived	30%	\$0 copay; Deductible waived	40%	\$0 copay; Deductible waived	30%	\$0 copay; Deductible waived	50%
Adult	\$0 copay; Deductible waived	30%	\$0 copay; Deductible waived	40%	\$0 copay; Deductible waived	30%	\$0 copay; Deductible waived	50%
Hearing Test	20%		20%		20%		20%	
	\$5,000 Maximum; every 24 months		\$5,000 Maximum; every 24 months		\$5,000 Maximum; every 24 months		\$5,000 Maximum; every 24 months	

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	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network
<b>Medical Benefits</b>								
<b>Hospital Services</b>								
Inpatient	10%	\$500/admission then 30%	20%	\$500/admission then 40%	20%	30%	30%	50%
Outpatient	10%	30%	20%	40%	20%	30%	30%	50%
Urgent Care	\$20 copay; Deductible waived	30%	\$20 copay; Deductible waived	40%	\$0 copay	30%	\$60/PCP copay for the first 3 visits, before the deductible	50%
Emergency Room	\$100 copay, then 10% Copay waived if admitted		\$100 copay, then 20% Copay waived if admitted		\$100 copay, then 20% Copay waived if admitted		<i>Note, Maple PLUS<sup>+</sup> Urgent Care visits are considered in the same manner as any other PCP or Specialist Visit.</i> \$100 copay, then 30% Copay waived if admitted	
<b>Lab &amp; X-Ray</b>								
Diagnostic Lab	10%	30%	20%	40%	20%	30%	30%	50%
X-Ray	10%	30%	20%	40%	20%	30%	30%	50%
<b>Durable Medical Equipment</b>	10%	30%	20%	40%	20%	30%	30%	50%
<b>Maternity</b>								
Office Visits	\$20 copay; Deductible waived	30%	\$20 copay; Deductible waived	40%	\$0 copay	30%	\$60/PCP or \$70/Specialist copay, Annual Deductible applies after first 3 visits	PLUS <sup>+</sup> \$60 Annual Deductible Applies
Hospitalization	10%	\$500/admission then 30%	20%	\$500/admission then 40%	20%	30%	30%	50%
<b>Mental Health &amp; Chemical Dependency</b>								
Inpatient	10%	\$500/admission then 30%	20%	\$500/admission then 40%	20%	30%	30%	50%
Outpatient	\$20 copay; Deductible waived	30%	\$20 copay; Deductible waived	40%	\$0 copay	30%	\$60 copay, Annual Deductible applies after first 3 visits either PCP or Specialist	PLUS <sup>+</sup> \$60 Annual Deductible Applies
<b>Teladoc Telehealth Visits</b>								
General Visits	<i>Note: Not Applicable to PLUS<sup>+</sup> Plans</i> \$10 copay; Deductible waived		<i>Note: Not Applicable to PLUS<sup>+</sup> Plans</i> \$10 copay; Deductible waived		<i>Note: Not Applicable to PLUS<sup>+</sup> Plans</i> \$0 copay		<i>Note: Not Applicable to PLUS<sup>+</sup> Plans</i> \$10 copay; Deductible waived	
Behavioral Health Visits	\$10 copay; Deductible waived		\$10 copay; Deductible waived		\$0 copay		\$10 copay; Deductible waived	

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Medical Benefits	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network
<b>Chiropractic</b>								
Office Visits	10%	30% limited to \$25/visit	20%	40% limited to \$25/visit	20%	30% limited to \$25/visit	30%	50% limited to \$25/visit
	24 visit annual maximum		24 visit annual maximum		24 visit annual maximum		24 visit annual maximum	
<b>Prescription Drug Benefit</b>	<b>Carved out to CVS/Caremark</b>		<b>Carved out to CVS/Caremark</b>		<b>Carved out to CVS/Caremark</b>		<b>Carved out to CVS/Caremark</b>	
Annual Deductible	Not Applicable		Not Applicable		Integrated; See Medical Deductible		Not Applicable	
Out of Pocket Maximum (OOPM):	The individual OOPM is embedded in the family OOPM		The individual OOPM is embedded in the family OOPM		Integrated; See Medical OOPM		The individual OOPM is embedded in the family OOPM	
Individual Member	\$4,600		\$3,600				\$250	
Family Member / Family	\$4,600 / \$9,200		\$3,600 / \$7,200				\$250 / \$500	
Retail:	Maximum 30-day supply		Maximum 30-day supply		Maximum 30-day supply		Maximum 30-day supply	
	Note, 90-day supply of maintenance prescriptions for discounted copays thru Maintenance Choice program		Note, 90-day supply of maintenance prescriptions for discounted copays thru Maintenance Choice program		Note, 90-day supply of maintenance prescriptions for discounted copays thru Maintenance Choice program		Note, 90-day supply of maintenance prescriptions for discounted copays thru Maintenance Choice program	
Tier 1 (Normally Generic)	\$10	Not Covered	\$10	Not Covered	\$10	Not Covered	\$19	Not Covered
Tier 2 (Normally Preferred)	\$30	Not Covered	\$30	Not Covered	\$30	Not Covered	\$50	Not Covered
Tier 3 (Normally Non-Preferred)	\$40	Not Covered	\$40	Not Covered	\$40	Not Covered	\$75	Not Covered
Mail Order:	Maximum 90-day supply		Maximum 90-day supply		Maximum 90-day supply		Maximum 90-day supply	
Tier 1 (Normally Generic)	\$15	Not Covered	\$15	Not Covered	\$15	Not Covered	\$38	Not Covered
Tier 2 (Normally Preferred)	\$45	Not Covered	\$45	Not Covered	\$45	Not Covered	\$100	Not Covered
Tier 3 (Normally Non-Preferred)	\$80	Not Covered	\$80	Not Covered	\$80	Not Covered	\$150	Not Covered
Specialty Drugs	Prior Authorization may be required; Must be Dispensed by a CVS/Caremark Specialty facility.		Prior Authorization may be required; Must be Dispensed by a CVS/Caremark Specialty facility.		Prior Authorization may be required; Must be Dispensed by a CVS/Caremark Specialty facility.		Prior Authorization may be required; Must be Dispensed by a CVS/Caremark Specialty facility.	
	0% if enrolled in PrudentRX;	Not Covered	0% if enrolled in PrudentRX;	Not Covered	0% if enrolled in PrudentRX;	Not Covered	0% if enrolled in PrudentRX; 30% otherwise	Not Covered
	30% otherwise		30% otherwise		30% up to a \$150 coinsurance per Rx otherwise			
	NOTE: If a Specialty Drug is not on the PrudentRX Specialty Drug list, see Caremark.com, and the normal Tier copay applies.		NOTE: If a Specialty Drug is not on the PrudentRX Specialty Drug list, see Caremark.com, and the normal Tier copay applies.		NOTE: If a Specialty Drug is not on the PrudentRX Specialty Drug list, see Caremark.com, and the normal Tier copay applies.		NOTE: If a Specialty Drug is not on the PrudentRX Specialty Drug list, see Caremark.com, and the normal Tier copay applies.	

### Notes & Assumptions

#### Deductible Definitions:

- Embedded: In a health plan with an embedded deductible no individual on a family plan will pay higher than the individual deductible amount.
- Aggregate: In a health plan with an aggregate deductible, benefits are not covered for any individual on a family plan until the family deductible amount has been met.

**Disclaimer:** This information is intended as a summary only; benefits may contain limitations and exclusions. Refer to your Summary Plan Description for detailed information.