North Coast Schools Medical Insurance Group

Plan Comparison July 1, 2026

Plan Type	Oak & Oak *PLUS*+ PPO Plan		Spruce & Spruce *PLUS*+ PPO Plan		Pine & Pine *PLUS*+ PPO HDHP (HSA Compatible)		Maple & Maple *PLUS*+ 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		$1,700		$5,000		
Family	$1,050		$1,500		$3,400		$10,000		
Out-of-Pocket Maximum (OOPM)	*Allows In Network (INN) OOPM to accrue to Out of Network (OON) OOPM and visa 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*		*Allows In Network (INN) OOPM to accrue to Out of Network (OON) OOPM and visa 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*		*Allows In Network (INN) OOPM to accrue to Out of Network (OON) OOPM and visa 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*		*Allows In Network (INN) OOPM to accrue to Out of Network (OON) OOPM and visa 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	$2,000	$4,350	$3,000	$10,000	$7,000	$7,000	$6,350		$10,000
Family	$4,000	$8,700	$6,000	$20,000	$14,000	$14,000	$12,700		$20,000
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*+ $60 Annual Deductible Applies	50%
Specialist	$30 / PLUS+ $20 copay; Deductible waived	30%	$30 / PLUS+ $20 copay; Deductible waived	40%	$0 copay	30%	$70 copay, Annual Deductible applies after first 3 visits either PCP or Specialist	*PLUS*+ $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% *120-day annual maximum*	Not Covered	20% *120-day annual maximum*	Not Covered	20% *120-day annual maximum*	Not Covered	30% *120-day annual maximum*		Not Covered
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% $5,000 Maximum; every 24 months		20% $5,000 Maximum; every 24 months		20% $5,000 Maximum; every 24 months		20% $5,000 Maximum; every 24 months		

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

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Medical Benefits	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network
Chiropractic								
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*	
Prescription Drug Benefit	Carved out to CVS/Caremark		Carved out to CVS/Caremark		Carved out to CVS/Caremark		Carved out to CVS/Caremark	
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; 30% otherwise	Not Covered	0% if enrolled in PrudentRX; 30% otherwise	Not Covered	0% if enrolled in PrudentRX; 30% up to a $150 coinsurance per Rx otherwise	Not Covered	0% if enrolled in PrudentRX; 30% otherwise	Not Covered
	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.