

EFFECTIVE July 1, 2018

North Coast Schools' Medical Ins. Group

Medical Plan Overview

DESCRIPTION	REDWOOD Blue Shield of California PPO		OAK Blue Shield of California PPO	
	Network	Non Network	Network	Non Network
Lifetime Maximum	Unlimited		Unlimited	
Annual Deductible • Individual Member • Family Member/Family	Embedded Deductible \$250 \$250/\$750		Embedded Deductible \$350 \$350/\$1,050	
Medical Out of Pocket Maximum (OOPM) • Individual Member • Family	<ul style="list-style-type: none"> OOPM includes Medical Deductibles, Copays & Coinsurance The Individual OOPM is Embedded in the Family OOPM \$1,000 \$2,250 \$3,000 \$6,750		<ul style="list-style-type: none"> OOPM includes Medical Deductibles, Copays & Coinsurance The Individual OOPM is Embedded in the Family OOPM \$2,000 \$4,350 \$4,000 \$8,700	
Professional • Primary Care Physician (PCP) • Specialist • Physical Therapy • Home Health Care • Urgent Care Visit	\$20 copay, deductible waived \$30 copay, deductible waived 100% 100% <i>120 day annual maximum</i> \$20 copay, deductible waived	80% 80% 80% limited to \$25/visit Not Covered 80%	\$20 copay, deductible waived \$30 copay, deductible waived 90% 90% <i>120 day annual maximum</i> \$20 copay, deductible waived	70% 70% 70% limited to \$25/visit Not Covered 70%
Hospital Services • Inpatient • Outpatient • Emergency Room	100% 100%	\$500/admission then 80% 80% \$100/visit, then 100% <i>ER copay waived if admitted</i>	90% 90%	\$500/admission then 70% 70% \$100/visit, then 90% <i>ER copay waived if admitted</i>
Lab & X-Ray: • Non-Hospital • Hospital	100% 100%	80% 80%	90% 90%	70% 70%
Durable Medical Equipment	100%	80%	90%	70%
Chiropractic	100%	80% limited to \$25/visit <i>24 visit calendar year maximum</i>	90%	70% limited to \$25/visit <i>24 visit calendar year maximum</i>
Preventative Care • Baby • Adult	100%, deductible waived 100%, deductible waived	80% 80%	100%, deductible waived 100%, deductible waived	70% 70%

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DESCRIPTION	REDWOOD Blue Shield of California PPO		OAK Blue Shield of California PPO	
	Network	Non Network	Network	Non Network
Maternity				
• Inpatient	100%	\$500/admission then 80%	90%	\$500/admission then 70%
• Office Visits	\$20 copay, deductible waived	80%	\$20 copay, deductible waived	70%
Mental Health				
• Inpatient	100%	\$500/admission then 80%	90%	\$500/admission then 70%
• Outpatient	\$20 copay, deductible waived	80%	\$20 copay, deductible waived	70%
Chemical Dependency				
• Inpatient	100%	\$500/admission then 80%	90%	\$500/admission then 70%
• Outpatient	\$20 copay, deductible waived	80%	\$20 copay, deductible waived	70%
Telemedicine	Administered by Teladoc \$15 Copay		Administered by Teladoc \$15 Copay	
Minute Clinic	Administered by CVS See Prescription Drug Benefit		Administered by CVS See Prescription Drug Benefit	
Hearing Benefit	80% \$5,000 Maximum per member every 24 months		80% Effective 7/1/2018 \$5,000 Maximum per member every 24 months	
Prescription Drug	Carved out to CVS/Caremark Generic/Preferred/Non-Preferred Not Applicable		Carved out to CVS/Caremark Generic/Preferred/Non-Preferred Not Applicable	
Annual Deductible	\$5,600		\$4,600	
Out of Pocket Maximum (OOPM)	\$5,600/\$10,200		\$4,600/\$9,200	
• Individual Member				
• Family Member/Family				
Copays & Maximum Day Supply				
• Retail	\$10 /\$30 /\$40	Not Covered	\$10 /\$30 /\$40	Not Covered
	30-Day Maximum Supply	Not Covered	30-Day Maximum Supply	Not Covered
• Mail Order	\$15 /\$45 /\$80	Not Covered	\$15 /\$45 /\$80	Not Covered
	90-Day Maximum Supply	Not Covered	90-Day Maximum Supply	Not Covered
• Specialty Drugs	Prior Authorization may be required; and Must be Dispensed by a CVS/Caremark Specialty facility		Prior Authorization may be required; and Must be Dispensed by a CVS/Caremark Specialty facility	
	\$15 /\$45 /\$80	Not Covered	\$15 /\$45 /\$80	Not Covered
Minute Clinic	\$15 Copay		\$15 Copay	

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North Coast Schools' Medical Ins. Group

Medical Plan Overview

DESCRIPTION	SPRUCE Blue Shield of California PPO		PINE BCS HDHP PPO (HSA Compatible)	
	Network	Non Network	Network	Non Network
Lifetime Maximum	Unlimited		Unlimited	
Annual Deductible	Embedded Deductible		Embedded Deductible	
<ul style="list-style-type: none"> Individual Member Family Member/Family 	\$500 \$500/\$1,500		\$1,500 <i>Feb. 1, 2017: \$2,600/\$3,000</i> <i>July 1, 2018: \$2,700/\$3,000</i>	
Medical Out of Pocket Maximum (OOPM)	<ul style="list-style-type: none"> OOPM includes Medical Deductibles, Copays & Coinsurance The Individual OOPM is Embedded in the Family OOPM 		<ul style="list-style-type: none"> Includes Medical and RX Deductibles, Copays & Coinsurance The Individual OOPM is Embedded in the Family OOPM 	
<ul style="list-style-type: none"> Individual Member Family 	\$3,000 \$6,000	\$10,000 \$20,000	\$4,000 \$8,000	\$5,786 \$11,572
Professional				
<ul style="list-style-type: none"> Primary Care Physician (PCP) 	\$20 copay, deductible waived	60%	100%	70%
<ul style="list-style-type: none"> Specialist 	\$30 copay, deductible waived	60%	100%	70%
<ul style="list-style-type: none"> Physical Therapy Home Health Care 	80% 80%	60% limited to \$25/visit Not Covered	80% 80%	70% limited to \$25/visit Not Covered
<ul style="list-style-type: none"> Urgent Care Visit 	\$20 copay, deductible waived	60%	100%	70%
	<i>120 day annual maximum</i>		<i>120 day annual maximum</i>	
Hospital Services				
<ul style="list-style-type: none"> Inpatient 	80%	\$500/admission then 60%	80%	70%
<ul style="list-style-type: none"> Outpatient Emergency Room 	80%	60% \$100/visit, then 80% <i>ER copay waived if admitted</i>	80%	70% \$100/visit, then 80% <i>ER copay waived if admitted</i>
Lab & X-Ray:				
<ul style="list-style-type: none"> Non-Hospital Hospital 	80% 80%	60% 60%	80% 80%	70% 70%
Durable Medical Equipment	80%	60%	80%	70%
Chiropractic	80%	60% limited to \$25/visit <i>24 visit calendar year maximum</i>	80%	70% limited to \$25/visit <i>24 visit calendar year maximum</i>
Preventative Care				
<ul style="list-style-type: none"> Baby Adult 	100%, deductible waived 100%, deductible waived	60% 60%	100%, deductible waived 100%, deductible waived	70%, deductible waived 70%, deductible waived

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DESCRIPTION	SPRUCE Blue Shield of California PPO		PINE BCS HDHP PPO (HSA Compatible)	
	Network	Non Network	Network	Non Network
Maternity				
• Inpatient	80%	\$500/admission then 60%	80%	70%
• Office Visits	\$20 copay, deductible waived	60%	100%	70%
Mental Health				
• Inpatient	80%	\$500/admission then 60%	80%	70%
• Outpatient	\$20 copay, deductible waived	60%	100%	70%
Chemical Dependency				
• Inpatient	80%	\$500/admission then 60%	80%	70%
• Outpatient	\$20 copay, deductible waived	60%	100%	70%
Telemedicine	Administered by Teladoc \$15 Copay		Administered by Teladoc 100%	
Minute Clinic	Administered by CVS See Prescription Drug Benefit		Treated like another Office Visit	
Hearing Benefit	80% \$5,000 Maximum per member every 24 months		80% \$5,000 Maximum per member every 24 months	
Prescription Drug	Carved out to CVS/Caremark Generic / Preferred / Non-Preferred Not Applicable		Administered by Blue Shield of California Generic / Preferred / Non-Preferred Annual Deductible Applies, See Medical Plan	
Annual Deductible	\$3,600		See Medical OOPM	
Out of Pocket Maximum (OOPM)	\$3,600/\$7,200			
• Individual Member	\$10 / \$30 / \$40	Not Covered	\$10 / \$30 / \$40	Copay + 25%
• Family Member/Family	30-Day Maximum Supply	Not Covered	30-Day Maximum Supply	
Copays & Maximum Day Supply	\$15 / \$45 / \$80	Not Covered	\$15 / \$45 / \$80	Not Covered
• Retail	90-Day Maximum Supply	Not Covered	90-Day Maximum Supply	
• Mail Order	Prior Authorization may be required; and Must be Dispensed by a CVS/Caremark Specialty facility		Require Prior Authorization; and Must be Dispensed by an Approved Specialty facility	
• Specialty Drugs	\$15 / \$45 / \$80	Not Covered	30% up to a \$150 out-of-pocket maximum/prescription See Medical Plan	
Minute Clinic	\$15 Copay			

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North Coast Schools' Medical Ins. Group

Medical Plan Overview

DESCRIPTION	SEQUOIA (Eff 7/1/2018) Blue Shield of California PPO		MAPLE BSC PPO (Bronze Look-a-Like)	
	Network	Non Network	Network	Non Network
Lifetime Maximum	Unlimited		Unlimited	
Annual Deductible	Embedded Deductible		Embedded Deductible	
<ul style="list-style-type: none"> Individual Member Family Member/Family 	\$2,500 \$2,500/\$7,500		\$5,000 \$5,000/\$10,000	
Medical Out of Pocket Maximum (OOPM)	<ul style="list-style-type: none"> OOPM includes Medical Deductibles, Copays & Coinsurance The Individual OOPM is Embedded in the Family OOPM 		<ul style="list-style-type: none"> OOPM includes Medical Deductibles, Copays & Coinsurance The Individual OOPM is Embedded in the Family OOPM 	
<ul style="list-style-type: none"> Individual Member Family 	\$5,000 \$15,000	\$10,000 \$30,000	\$6,350 \$12,700	\$10,000 \$20,000
Professional				
<ul style="list-style-type: none"> Primary Care Physician (PCP) 	\$20 copay, deductible waived	50%	\$60 copay, Annual Deductible applies after first 3 visits either PCP or Specialist	50%
<ul style="list-style-type: none"> Specialist 	\$30 copay, deductible waived	50%	\$70 copay, Annual Deductible applies after first 3 visits either PCP or Specialist	50%
<ul style="list-style-type: none"> Physical Therapy Home Health Care 	80% 80%	50% limited to \$25/visit Not Covered	70% 70%	50% limited to \$25/visit Not Covered
<ul style="list-style-type: none"> Urgent Care Visit 	\$20 copay, deductible waived	50%	\$60/PCP or \$70/Specialist copay for the first 3 visits, before the deductible	50%
Hospital Services				
<ul style="list-style-type: none"> Inpatient 	80%	\$500/admission then 50%	70%	50%
<ul style="list-style-type: none"> Outpatient Emergency Room 	80%	50% \$100/visit, then 100% <i>ER copay waived if admitted</i>	70%	50%
Lab & X-Ray:				
<ul style="list-style-type: none"> Non-Hospital Hospital 	80% 80%	50% 50%	70% 70%	50% 50%
Durable Medical Equipment	80%	50%	70%	Not Covered
Chiropractic	80%	50% limited to \$25/visit <i>24 visit calendar year maximum</i>	70%	50% limited to \$25/visit <i>24 visit calendar year maximum</i>
Preventative Care				
<ul style="list-style-type: none"> Baby Adult 	100%, deductible waived 100%, deductible waived	50% 50%	100%, deductible waived 100%, deductible waived	50% 50%

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Medical Plan Overview

DESCRIPTION	SEQUOIA (Eff 7/1/2018) Blue Shield of California PPO		MAPLE BSC PPO (Bronze Look-a-Like)	
	Network	Non Network	Network	Non Network
Maternity				
• Inpatient	80%	\$500/admission then 50%	70%	50%
• Office Visits	\$20 copay, deductible waived	50%	\$60/PCP or \$70/Specialist copay, Annual Deductible applies after first 3 visits	50%
Mental Health				
• Inpatient	80%	\$500/admission then 50%	70%	50%
• Outpatient	\$20 copay, deductible waived	50%	\$60 copay, Annual Deductible applies after first 3 visits either PCP or Specialist	50%
Chemical Dependency				
• Inpatient	80%	\$500/admission then 50%	70%	50%
• Outpatient	\$20 copay, deductible waived	50%	\$60 copay, Annual Deductible applies after first 3 visits either PCP or Specialist	50%
Telemedicine	Administered by Teladoc \$15 Copay		Administered by Teladoc \$15 Copay	
Minute Clinic	Administered by CVS See Prescription Drug Benefit		Administered by CVS See Prescription Drug Benefit	
Hearing Benefit	80% \$5,000 Maximum per member every 24 months		80% - Effective 7/1/2018 \$5,000 Maximum per member every 24 months	
Prescription Drug	Carved out to CVS/Caremark Generic/Preferred/Non-Preferred Not Applicable		Carved out to CVS/Caremark Generic/Preferred/Non-Preferred Not Applicable	
Annual Deductible				
Out of Pocket Maximum (OOPM)				
• Individual Member		\$1,650		\$250
• Family Member/Family		\$4,950		\$250/\$500
Copays & Maximum Day Supply				
• Retail	\$10 /\$30 /\$40	Not Covered	\$19 /\$50 /\$75	Not Covered
• Mail Order	30-Day Maximum Supply \$15 /\$45 /\$80	Not Covered	30-Day Maximum Supply \$38 /\$100 /\$150	Not Covered
• Specialty Drugs	90-Day Maximum Supply Prior Authorization may be required; and Must be Dispensed by a CVS/Caremark Specialty facility	Not Covered	90-Day Maximum Supply Prior Authorization may be required; and Must be Dispensed by a CVS/Caremark Specialty facility	Not Covered
Minute Clinic		\$15 Copay		\$15 Copay