2024-2025	Blue Shield	Blue Shield	Blue Shield	Blue Shield	Blue Shield	Blue Shield	Blue Shield
RESIG Regional Employee School Insurance Group Serving Schools Since 1979	100-B $20	90-E $20 (Non-Marketed)	80-G $30	HSA $1700 - Single	HSA-$3400	Two Tier HSA $5000 (Formerly Anchor Bronze)	2-Tier MEC $9000
MEDICAL - CALENDAR YEAR Deductibles & Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	$100/$300	$300/$600	$500/$1,000	$1,700*	$3,400/$6,800*	$5,000/$10,000*	$9,000/$18,000*
Individual/Family Out-of-Pocket (OOP) Max (includes medical deductibles, co-insurance and co-pays)	$1,000/$3,000	$1,000/$3,000	$2,000/$4,000	$3,400*	$6,000/$12,000*	$6,350/$12,700*	$9,000/$18,000*
				*Includes Rx	*Includes Rx	*Includes Rx	*Includes Rx
PROFESSIONAL SERVICES							
Office Visit (OV) co-pay ($0 Copay for 1st 3 cal yr Primary Care OV on Non-HSA PPO plans)	$20	$20	$30	Deductible, then 10%	Deductible, then 10%	Deductible, then 30%	Deductible, then 0%
Urgent Care co-pay	$20	$20	$30	10%	10%	30%	0%
Specialists/Consultants co-pay	$20	$20	$30	10%	10%	30%	0%
Prenatal, postnatal office visit co-pay	$20	$20	$30	10%	10%	30%	0%
Scans: CT, CAT, MRI, PET etc.	0%	10%	20%	10%	10%	30%	0%
Diagnostic X-ray & Laboratory Procedures	0%	10%	20%	10%	10%	30%	0%
Infertility (Refer to Plan Document)	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Preventive Care (includes physical exams & screenings)	0% Ded Waived	0% Ded Waived	0% Ded Waived	0% Ded Waived	0% Ded Waived	0% Ded Waived	0% Ded Waived
HOSPITAL & SKILLED NURSING FACILITY SERVICES							
Emergency Room visit (copay waived if admitted)	0% $100 co-pay	10% $100 co-pay	20% $100 co-pay	10% $100 co-pay	10% $100 co-pay	30% $100 co-pay	$0
Inpatient Hospital (preauthorization required) - limits may apply	0%	10%	20%	10%	10%	30%	0%
Outpatient Hospital	0%	10%	20%	10%	10%	30%	0%
Surgery, Outpatient (performed in Surgery Center)	0%	10%	20%	10%	10%	30%	0%
Surgery, Outpatient (performed in a Hospital) - limits may apply	0%	10%	20%	10%	10%	30%	0%
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT							
INPATIENT: Facility Based Care (preauth required)	0%	10%	20%	10%	10%	30%	0%
OUTPATIENT: Facility Based Care (preauth required)	0%	10%	20%	10%	10%	30%	0%
OTHER SERVICES							
Ambulance (Ground or Air)	0% $100 co-pay	10% $100 co-pay	20% $100 co-pay	10% $100 co-pay	10% $100 co-pay	30% $100 co-pay	0%
Acupuncture - Limits apply	0%	10%	20%	10%	10%	30%	0%
Chiropractic - Limits apply	0%	10%	20%	10%	10%	30%	0%
Durable Medical Equipment (DME)	0%	10%	20%	10%	10%	30%	0%
Physical and Occupational Therapy - Limits apply	0%	10%	20%	10%	10%	30%	0%

RESIG Serving Schools Since 1979	100-B $20	90-E $20 (Non-Marketed)	80-G $30	HSA $1700 - Single	HSA-$3400	Two Tier HSA $5000 (Formerly Anchor Bronze)	2-Tier MEC $9000
Hearing Aids	Amount in excess of $700 allowance/24 months	10% and Amount in excess of $700 allowance/24 months	20% and Amount in excess of $700 allowance/24 months	10% and Amount in excess of $700 allowance/24 months	10% and Amount in excess of $700 allowance/24 months	30% and Amount in excess of $700 allowance/24 months	Amount in excess of $700 allowance/24 months

PHARMACY BENEFITS

Plan	7-25	7-25	9-35	HSA Rx	HSA Rx	HSA Rx	2-Tier MEC $9000 Rx
Pharmacy Benefit Manager	Navitus	Navitus	Navitus	Navitus	Navitus	Navitus	Navitus
Individual/Family Brand & Specialty Rx Deductibles	none	none	none	Included w/ Medical ded	Included w/ Medical ded	Included w/ Medical ded	Included w/ Medical ded
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	$1,500/$2,500	$1,500/$2,500	$2,500/$3,500	Included w/ Med OOP Max	Included w/ Med OOP Max	Included w/ Med OOP Max	Included w/ Med OOP Max
Generic co-pay/30 days supply	$0 at Costco $7 at Other Network	$0 at Costco $7 at Other Network	$0 at Costco $9 at Other Network	Deductible, then $0 at Costco or $9 at Other Network	Deductible, then $0 at Costco or $9 at Other Network	Deductible, then $0 at Costco or $9 at Other Network	Deductible, then $0 at Costco or $9 at Other Network
Brand co-pay/30 days supply	$25	$25.00	$35.00	Deductible, then $35	Deductible, then $35	Deductible, then $35	Deductible, then $35
Specialty co-pay/up to 30 days supply	$25 Must Use Navitus Mail	$25 Must Use Navitus Mail	$35 Must Use Navitus Mail	Deductible, then $35 (Must Use Navitus Mail)	Deductible, then $35 (Must Use Navitus Mail)	Deductible, then $35 (Must Use Navitus Mail)	Deductible, then $35 (Must Use Navitus Mail)
Mail Order (Generic-Brand co-pay/90 days supply)	$0-$60	$0-$60	$0-$90	Deductible, then $18-$90	Deductible, then $18-$90	Deductible, then $18-$90	Deductible, then $18-$90
Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy	Costco Mail Order Pharmacy

This sheet is only a brief summary of In-Network patient costs. Please refer to the plan documents available through your district for applicable details, limitations, and exclusions. Out-of-Network services may not be covered. Employee cost/payroll deduction, if applicable, can be requested from the district.

*Coverage stages apply, see benefit summary for details