Stockbridge Community Schools 10-1-2022 to 9-30-2023		
Medical/Rx - Plan Highlights $100 Deductible HRA - BCBSM/EHIM		
Partial listing of covered services	**In Network**	**Out of Network**
Deductible and Out-of-Pocket		
Annual Deductible	$100 per person $200 per family	$10,000 per person $20,000 per family
Annual medical out-of-pocket maximum	$100 per person $200 per family	$12,700 per person $25,400 per family
Annual Rx out-of-pocket maximum	$800 per person $1,600 per family	Member could pay more due to U&C restrictions
Preventive Healthcare		
Annual physical	you pay nothing	Most preventative services not covered. Mammography and Colonoscopy covered at 40% member cost-share. See benefit summary or contact BCBSM for more details.
Immunizations and Prenatal		
Postnatal, family planning & screenings		
Preventative Care Drugs		
Office Visits		
Illness or injury	$20 Co-pay	you pay 40% after deductible
Physical, occupational therapy, speech therapy		
Chiropractic care		
Mental / Chemical health care		
Retail Clinic		
Emergency Care		
Care at an urgent care clinic or medical center	$40 Co-pay	you pay 40% after deductible
Emergency care at a hospital ER	$250 Co-pay	$250 Co-pay
Inpatient Hospital Care		
Illness or injury	you pay nothing after deductible	you pay 40% after deductible
Mental / Chemical health care		
Outpatient Care		
Scheduled outpatient procedures	you pay nothing after deductible	you pay 40% after deductible
MRI/CT		
Durable Medical Equipment (DME)		
Hearing Aids	$1,684 limit per ear for hearing aid, plus $250 for other services	
DME & prosthetic devices	you pay nothing after deductible	you pay 20% after deductible
Pharmacy Highlights		
Partial listing of covered services		
	Retail Pharmacy	
Generic preferred	$10 copay	$10 copay (member must pay in advance and then submit for reimbursement at usual and customary). Member may not be fully reimbursed based on Usual & Customary.
Brand preferred	$40 copay	$40 copay (member must pay in advance and then submit for reimbursement at usual and customary). Member may not be fully reimbursed based on Usual & Customary.
Non-preferred	$80 copay	$80 copay (member must pay in advance and then submit for reimbursement at usual and customary). Member may not be fully reimbursed based on Usual & Customary.
	Mail Order Pharmacy (up to a 90-day supply)	
Generic preferred	$20 copay	Not covered
Brand preferred	$80 copay	
Non-preferred	$160 copay	