Stockbridge Community Schools 10-1-2020 to 9-30-2021

Medical/Rx - Plan Highlights

Partial listing of covered services	$100 Deductible HRA - BCBSM/EHIM		$4,000 Deductible HSA - BCBSM		$6,350 Deductible HSA - BCBSM	
	In Network	Out of Network	In Network	Out of Network	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	$4,000 per person $8,000 per family	$8,000 per person $16,000 per family	$6,350 per person $12,700 per family	$12,700 per person $25,400 per family
Annual medical out-of-pocket maximum	$100 per person $200 per family	$12,700 per person $25,400 per family	$6,350 per person $12,700 per family	$12,700 per person $25,400 per family	$6,350 per person $12,700 per family	$15,000 per person $30,000 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						
Annual physical Immunizations and Prenatal Postnatal, family planning & screenings	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.	you pay nothing	Most preventative services not covered. Mammography and Colonoscopy covered at 50% member cost-share. See benefit summary or contact BCBSM for more details.	you pay nothing (deductible waived)	Not covered
Preventative Care Drugs						
Office Visits						
Illness or injury Physical, occupational therapy, speech Chiropractic care Mental / Chemical health care Retail Clinic	$20 Co-pay	you pay 40% after deductible	you pay 50% after deductible	you pay 50% after deductible	you pay nothing after deductible	you pay 20% after deductible; you pay nothing for outpatient mental health
Emergency Care						
Care at an urgent care clinic or medical	$40 Co-pay	you pay 40% after deductible	you pay 50% after deductible	you pay 50% after deductible	you pay nothing after deductible	you pay nothing after deductible for ER; you pay 20% after deductible for urgent
Emergency care at a hospital ER	$250 Co-pay	$250 Co-pay			you pay nothing after deductible	
Inpatient Hospital Care						
Illness or injury Mental / Chemical health care	you pay nothing after deductible	you pay 40% after deductible	you pay 50% after deductible	you pay 50% after deductible	you pay nothing after deductible	you pay 20% after deductible
Outpatient Care						
Scheduled outpatient procedures MRI/CT	you pay nothing after deductible	you pay 40% after deductible	you pay 50% after deductible	you pay 50% after deductible	you pay nothing after deductible	you pay 20% after deductible
Durable Medical Equipment (DME)						
Hearing Aids	$1,684 limit per ear for hearing aid, plus $250 for other services		Not covered	Not covered	Not covered	Not covered
DME & prosthetic devices	you pay nothing after deductible	you pay 20% after deductible	you pay 50% after deductible	you pay 50% after deductible	you pay nothing after deductible	you pay nothing after deductible
Pharmacy Highlights						
Partial listing of covered services						
	Retail Pharmacy		**Retail Pharmacy**		**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.	you pay 50% after deductible	you pay 50% after deductible plus an additional 20%	you pay nothing after deductible	you pay 20% after deductible
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)		**Mail Order Pharmacy (up to a 90-day supply)**		**Mail Order Pharmacy (up to a 90-day supply)**	
Generic preferred	$20 copay	Not covered	you pay 50% after deductible	Not covered	you pay nothing after deductible	you pay 20% after deductible
Brand preferred	$80 copay					
Non-preferred	$160 copay					