Brookfield Schools - Medical and Precsription Plan Options 2024-2025

	AH PPO HSA $1,600	EPO HSA $1,600/50%	AH POS NG $10/$20 $0 Day	EPO $30/$50 $1,000
In-Network Benefits	**In Network**	**In Network**	**In Network**	**In Network**
	Member Costs	Member Costs	Member Costs	Member Costs
Deductible	$1,600 Indiv/ $3,200 Family (Aggregate)	$1,600 Indiv/ $3,200 Family (Aggregate)	$0 Indiv/ $0 Family	$1,000 Indiv/$2,000 Family (Embedded)
Out of Pocket Limit	$1,650 Indiv/$3,300 Family (Aggregate)	$2,500 Indiv/$5,000 Family (Aggregate)	$1,500 Indiv/$3,000 Family (Embedded)	$3,500 Indiv/$7,000 Family (Embedded)
PCP Election Required	No	No	No	No
Referrals Required	No	No	No	No
Preventive	No Charge (No Deductible)	No Charge (No Deductible)	No Charge	No Charge (No Deductible)
Primary Care (Office & Telemedicine Visit)	No Charge After Deductible	50% After Deductible	$10 copay	$30 copay (No Deductible)
Specialist (Office & Telemedicine Visit)	No Charge After Deductible	50% After Deductible	$20 copay	$50 copay (No Deductible)
Urgent Care	No Charge After Deductible	50% After Deductible	$75 copay	$75 copay (No Deductible)
Therapy Services (visit limits apply)	No Charge After Deductible (Speech Therapy: 20 Visit Limit; Physical and Occupational Therapy: 30 Visit Limit)	50% After Deductible (Physical, Occupational, and Speech Therapies Combined: 60 Visit Limit)	$20 copay (Speech Therapy: 20 Visit Limit; Physical and Occupational Therapy: Combined 30 Visit Limit)	$50 copay (No Deductible) (Physical, Occupational, and Speech Therapies Combined: 60 Visit Limit)
Emergency Room	No Charge After Deductible	50% After Deductible	$100	$100 copay (No Deductible)
Emergency Transportation	No Charge After Deductible	50% After Deductible	No Charge	50% after Deductible
Hospital Stay	No Charge After Deductible	50% After Deductible	No Charge	$500/Day; max of 5 copays per admission after Deductible
Outpatient Surgery	No Charge After Deductible	50% After Deductible	No Charge	$300 after Deductible
Diagnostic Medical/Routine Radiology	No Charge After Deductible	50% After Deductible	$20 copay	$50 after Deductible
Imaging (CT/PET scans, MRIs)	No Charge After Deductible	50% After Deductible	$40 copay	$100 after Deductible
Outpatient Lab and Pathology	No Charge After Deductible	No Charge After deductible	No Charge	No Charge No Deductible
Durable Medical Equipment	50% after Deductible	50% after Deductible	50% coinsurance	50% after Deductible
Eye Exam	Not Covered	Not covered	$20 copay (1 Exam/24 Months)	Not Covered
Out of Network Benefits	**Out of Network**	**Out of Network**	**Out of Network**	**Out of Network**
Deductible	$3,000 Ind/$6,000 Family (Aggregate)	Coverage for Emergency Services Only	$500 Ind/$1,500 Family (Embedded)	Coverage for Emergency Services Only
Coinsurance	40% after deductible		20%	
Out of Pocket Limit	$15,000 Ind/$30,000 Family (Aggregate)		$4,500 Ind/$9,000 Family (Embedded)	
Prescription Benefits	**Rx Retail $10/$40/$60**	**Rx Retail $7/50%/$125**	**Rx Retail $15/$35/$50**	**Rx Retail $25/$50/$75**
Retail Copays				
Generic	$10 Copay after deductible	$7 Copay	$15	$25 Copay
Preferred Brand	$40 Copay after deductible	50% Coinsurance ($125 Max/Fill)	$35	$50 Copay
Non-Preferred Brand	$60 Copay after deductible	N/A	$50	$75 Copay
Retail Dispensing Limitation	30 day supply	90 day max	90 day max	90 day max
Mail Order - 90 Day Supply				
Generic	$20 Copay after deductible	$7 Copay	$30	$50 Copay
Preferred Brand	$80 Copay after deductible	50% Coinsurance ($250 Max/Fill)	$70	$100 Copay
Non-Preferred Brand	$120 Copay after deductible	N/A	$100	$150 Copay

This overview is being provided as a convenient reference tool and is not a complete list of the benefits or any plan or visit limitations that may apply. Please refer to the plan documents provided by your carriers for detailed plan information. If there is any discrepancy between the descriptions of the program elements in this overview and the official plan documents, the language of the official plan documents shall prevail as accurate.