

# Quartz HMO Benefit Overview

SCHOOL DISTRICT OF BOSCOBEL AREA SCHOOLS  
HMO1-3

Annual Deductible	\$2,000/\$4,000 (Single/Family)
Coinsurance	0% Coinsurance
Annual Maximum Out of Pocket	\$4,000/\$8,000 (Single/Family)
Lifetime Maximum	Unlimited
Annual Maximum for Essential Benefits	Unlimited
Preventive Services	Unlimited
Dependent Age	26/26

Physician Services	
Office Visit	Subject to Deductible and Coinsurance
Chiropractor Visits	Subject to Deductible and Coinsurance
Hearing Examination	Subject to Deductible and Coinsurance
Podiatry Services	Subject to Deductible and Coinsurance
Vision Services	Subject to Deductible and Coinsurance
Weight Loss/Nutritional Counseling	Subject to Deductible and Coinsurance

Hospital Services	
General Inpatient	Subject to Deductible and Coinsurance
Delivery & Newborn Charges	Subject to Deductible and Coinsurance
Outpatient Services	Subject to Deductible and Coinsurance

Emergency Services	
Emergency Room	\$125 Copayment
Urgent Care	Subject to Deductible and Coinsurance
Ambulance	Subject to Deductible and Coinsurance

Pharmacy Benefits	
Tier 1/Tier 2/Tier 3	\$10/\$25/\$50 Copay
Value Tier	\$5 Rx Outcomes
Max Out-of-Pocket (Single/Family)	\$2,000/\$4,000

Behavioral Health	
Inpatient	Subject to Deductible and Coinsurance
Transitional	Subject to Deductible and Coinsurance
Outpatient	
Psychiatrist or Psychologist	Subject to Deductible and Coinsurance
Other Mental Health Professional	Subject to Deductible and Coinsurance

Diagnostic Services	
Lab	Subject to Deductible and Coinsurance
X-Ray	Subject to Deductible and Coinsurance
MRI/MRA Scan	Subject to Deductible and Coinsurance
PET Scan	Subject to Deductible and Coinsurance
CAT Scan	Subject to Deductible and Coinsurance

Other Services	
Anesthesia for Dental	Subject to Deductible and Coinsurance
Autism Spectrum Disorder	See Specific Benefit Category for Applicable Coverage
Durable Medical Equipment	20% Coinsurance
Home Health Care Services	Subject to Deductible and Coinsurance
Hospice Services	Subject to Deductible and Coinsurance
Kidney Disease Treatment	See Specific Benefit Category for Applicable Coverage
Oral Surgery	100% Coverage
Skilled Nursing Care Facility	Subject to Deductible and Coinsurance
Therapy Services	Subject to Deductible and Coinsurance
TMJ Benefits	Subject to Deductible and Coinsurance

This Benefits Summary is intended to highlight the benefits provided in policy listed above. Please see your policy, including the Certificate of Coverage and Schedule of Benefits (SOB), for limitations and exclusions.



# POS Benefit Overview

SCHOOL DISTRICT OF BOSCOBEL AREA SCHOOLS  
POS1-3

	In-Network	Out-of-Network
Annual Deductible	\$2,000/\$4,000 (Single/Family)	\$4,000/\$8,000 (Single/Family)
Coinsurance	0% Coinsurance	20% Coinsurance
Annual Maximum Out of Pocket	\$4,000/\$8,000 (Single/Family)	\$8,000/\$16,000 (Single/Family)
Lifetime Maximum	Unlimited	Unlimited
Annual Maximum for Essential Benefits	Unlimited	Unlimited
Preventive Services	Unlimited	Subject to Deductible and Coinsurance
Dependent Age	26/26	26/26
<b>Physician Services</b>		
Office Visit	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Chiropractor Visits	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Hearing Examination	Subject to Deductible and Coinsurance	No Benefit
Podiatry Services	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Vision Services	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Weight Loss/Nutritional Counseling	Subject to Deductible and Coinsurance	No Benefit
<b>Hospital Services</b>		
General Inpatient	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Delivery & Newborn Charges	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Outpatient Services	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
<b>Emergency Services</b>		
Emergency Room	\$125 Copayment	\$125 Copayment
Urgent Care	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Ambulance	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
<b>Pharmacy Benefits</b>		
Tier 1/Tier 2/Tier 3	\$10/\$25/\$50 Copay	\$10/\$25/\$50 Copay
Value Tier	\$5 Rx Outcomes	\$5 Rx Outcomes
Max Out-of-Pocket (Single/Family)	\$2,000/\$4,000	\$2,000/\$4,000
<b>Behavioral Health</b>		
Inpatient	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Transitional	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Outpatient	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Psychiatrist or Psychologist	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Other Mental Health Professional	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
<b>Diagnostic Services</b>		
Lab	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
X-Ray	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
MRI/MRA Scan	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
PET Scan	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
CAT Scan	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
<b>Other Services</b>		
Anesthesia for Dental	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Autism Spectrum Disorder	See Specific Benefit Category for Applicable Coverage	See Specific Benefit Category for Applicable Coverage
Durable Medical Equipment	20% Coinsurance	20% Coinsurance
Home Health Care Services	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Hospice Services	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Kidney Disease Treatment	See Specific Benefit Category for Applicable Coverage	See Specific Benefit Category for Applicable Coverage
Oral Surgery	100% Coverage	20% Coinsurance
Skilled Nursing Care Facility	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Therapy Services	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
TMJ Benefits	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance

This Benefits Summary is intended to highlight the benefits provided in policy listed above. Please see your policy, including the Certificate of Coverage and Schedule of Benefits (SOB), for limitations and exclusions.



# PPO Benefit Overview

SCHOOL DISTRICT OF BOSCOBEL AREA SCHOOLS  
PPO1-3

	In-Network	Out-of-Network
Annual Deductible	\$2,000/\$4,000 (Single/Family)	\$4,000/\$8,000 (Single/Family)
Coinsurance	0% Coinsurance	20% Coinsurance
Annual Maximum Out of Pocket	\$4,000/\$8,000 (Single/Family)	\$8,000/\$16,000 (Single/Family)
Lifetime Maximum	Unlimited	Unlimited
Annual Maximum for Essential Benefits	Unlimited	Unlimited
Preventive Services	Unlimited	Subject to Deductible and Coinsurance
Dependent Age	26/26	26/26
<b>Physician Services</b>		
Office Visit	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Chiropractor Visits	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Hearing Examination	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Podiatry Services	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Vision Services	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Weight Loss/Nutritional Counseling	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
<b>Hospital Services</b>		
General Inpatient	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Delivery & Newborn Charges	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Outpatient Services	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
<b>Emergency Services</b>		
Emergency Room	\$125 Copayment	\$125 Copayment
Urgent Care	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Ambulance	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
<b>Pharmacy Benefits</b>		
Tier 1/Tier 2/Tier 3	\$10/\$25/\$50 Copay	\$10/\$25/\$50 Copay
Value Tier	\$5 Rx Outcomes	\$5 Rx Outcomes
Max Out-of-Pocket (Single/Family)	\$2,000/\$4,000	\$2,000/\$4,000
<b>Behavioral Health</b>		
Inpatient	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Transitional	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Outpatient		
Psychiatrist or Psychologist	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Other Mental Health Professional	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
<b>Diagnostic Services</b>		
Lab	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
X-Ray	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
MRI/MRA Scan	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
PET Scan	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
CAT Scan	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
<b>Other Services</b>		
Anesthesia for Dental	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Autism Spectrum Disorder	See Specific Benefit Category for Applicable Coverage	See Specific Benefit Category for Applicable Coverage
Durable Medical Equipment	20% Coinsurance	30% Coinsurance
Home Health Care Services	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Hospice Services	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
Kidney Disease Treatment	See Specific Benefit Category for Applicable Coverage	See Specific Benefit Category for Applicable Coverage
Oral Surgery	100% Coverage	20% Coinsurance
Skilled Nursing Care Facility	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance
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TMJ Benefits	Subject to Deductible and Coinsurance	Subject to Deductible and Coinsurance

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**RICHARDS BENEFITS**  
**2018-2019 PREMIUMS WITH AN HRA**  
**Deductible: \$2000/\$4000**

Health Insurance		HMO			POS/PPO		
		Per Paycheck	Per Month	Annual	Per Paycheck	Per Month	Annual
Single	Employee	\$42.90	\$85.79	\$1,029.54	\$70.11	\$140.22	\$1,682.70
	District	\$297.56	\$595.12	\$7,141.38	\$297.56	\$595.12	\$7,141.38
	Total	\$340.46	\$680.91	\$8,170.92	\$367.67	\$735.34	\$8,824.08
Family	Employee	\$111.53	\$223.07	\$2,676.80	\$182.29	\$364.58	\$4,374.92
	District	\$773.65	\$1,547.30	\$18,567.64	\$773.65	\$1,547.30	\$18,567.64
	Total	\$885.19	\$1,770.37	\$21,244.44	\$955.94	\$1,911.88	\$22,942.56

Dental Insurance		Per Paycheck	Per Month	Annual
Single	Employee	\$2.32	\$4.64	\$55.66
	District	\$20.87	\$41.74	\$500.90
	Total	\$23.19	\$46.38	\$556.56
Family	Employee	\$6.09	\$12.18	\$146.12
	District	\$54.80	\$109.59	\$1,315.12
	Total	\$60.89	\$121.77	\$1,461.24

12.18

59.69  
119.38  
121.7676  
60.8838  
54.79542