

This plan is offered by Quartz Health Benefit Plans Corporation



Schedule of Benefits

Prepared for:  
RIO COMMUNITY SCHOOL  
DISTRICT

9082016 - HMO Deductible  
Coverage Period: 9/1/2022 - 8/31/2023

Medical Benefits	
Annual Deductible	Single: \$500 per Benefit Year Family: \$500/individual or \$1,000/family per Benefit Year
Coinsurance	0% coinsurance
Annual Maximum Out-of-Pocket	Single: \$1,500 per Benefit Year Family: \$1,500/individual or \$3,000/family per Benefit Year
Preventive Services	No Charge
Dependent Age	26
Deductible Information	This plan has an embedded deductible. If you have other family members on the plan, each family member must meet their own Single Annual Deductible until the total amount of deductible expenses paid by all family members meets the Family Annual Deductible.
Out-of-Pocket Limit	If you have other family members on the plan, they each must meet the Single Annual Maximum Out-of-Pocket limit until the Family limit has been met.
HSA Qualified Plan	No
Prior Authorization	Prior authorization may be required for certain services. See <a href="http://QuartzBenefits.com/WIPAList">QuartzBenefits.com/WIPAList</a> or call Customer Service for additional information

Physician Services	
Office Visit	\$10 copay/visit
Telehealth Services	Same as Office Visit
Virtual Visit	\$5 copay/visit; Specialist: Same as Office Visit
Chiropractor Visits	\$10 copay/visit
Hearing Examination	\$10 copay/visit
Podiatry Services	\$10 copay/visit
Vision Examination	\$10 copay/visit; One Routine Vision exam is covered with no charge

Hospital Services *	
General Inpatient	No charge after deductible
Delivery & Newborn Charges	No charge after deductible
Outpatient Services	No charge after deductible

Emergency Services	
Emergency Room	\$100 copay/visit

Questions? Visit us at [QuartzBenefits.com](http://QuartzBenefits.com) or call (800) 362-3310.

QA00997 (0521)

Tracking ID: N9TR82P9

HMO

<b>Emergency Room Waiver</b>	Copay waived if admitted.
<b>Urgent Care</b>	\$25 copay/visit
<b>Ambulance</b>	No charge after deductible

<b>Pharmacy Benefits</b>	
<b>Value Tier</b>	No charge
<b>Generic/Preferred/Non-Preferred</b>	\$5/\$20/\$40 copay
<b>Tier 4</b>	\$20 copay for Preferred \$40 copay for Non-Preferred
<b>Pharmacy Max Out-of-Pocket</b>	\$2,000 Single/ \$4,000 Family per Benefit Year

<b>Behavioral Health</b>	
<b>Inpatient</b>	No charge after deductible
<b>Transitional</b>	No charge after deductible
<b>Outpatient</b>	\$10 copay/visit

<b>Diagnostic Services</b>	
<b>Lab</b>	No charge after deductible
<b>X-Ray</b>	No charge after deductible
<b>MRI/MRA Scan</b>	No charge after deductible
<b>PET Scan</b>	No charge after deductible
<b>CAT Scan</b>	No charge after deductible

<b>Other Services</b>	
<b>Durable Medical Equipment</b>	No charge after deductible
<b>Home Health Care Services</b>	No charge after deductible
<b>Home Health Care Limit</b>	60 visits per Benefit Year
<b>Hospice Services</b>	No charge after deductible
<b>Skilled Nursing Care Facility</b>	No charge after deductible
<b>Skilled Nursing Care Limit</b>	90 days per confinement
<b>Therapy Services</b>	No charge after deductible
<b>Therapy Limit</b>	40 visits combined for Physical, Speech, and Occupational therapy and Pulmonary Rehab
<b>TMJ Benefits</b>	\$10 copay/visit

\* Hospital Services – Includes daily hospital room and board, surgical, anesthesia and miscellaneous hospital services.

This plan is offered by Quartz Health Benefit Plans Corporation



Schedule of Benefits

Prepared for:

RIO COMMUNITY SCHOOL  
DISTRICT

9076769 - POS

Coverage Period: 9/1/2022 - 8/31/2023

Medical Benefits	In Network	Out of Network
<b>Annual Deductible</b>	Single: \$500 per Benefit Year Family: \$500/individual or \$1,000/family per Benefit Year	\$1,000 Single/\$2,000 Family per Benefit Year
<b>Coinsurance</b>	0% coinsurance	20% coinsurance
<b>Annual Maximum Out-of-Pocket</b>	Single: \$1,500 per Benefit Year Family: \$1,500/Individual or \$3,000/family per Benefit Year	\$3,000 Single/\$6,000 Family per Benefit Year
<b>Preventive Services</b>	No Charge	20% coinsurance after deductible
<b>Dependent Age</b>	26	26
<b>Deductible Information</b>	This plan has an embedded deductible. If you have other family members on the plan, each family member must meet their own Single Annual Deductible until the total amount of deductible expenses paid by all family members meets the Family Annual Deductible.	
<b>Out-of-Pocket Limit</b>	If you have other family members on the plan, they each must meet the Single Annual Maximum Out-of-Pocket limit until the Family limit has been met.	
<b>HSA Qualified Plan</b>	No	
<b>Prior Authorization</b>	Prior authorization may be required for certain services. See <a href="http://QuartzBenefits.com/WIPAList">QuartzBenefits.com/WIPAList</a> or call Customer Service for additional information	

Physician Services	In Network	Out of Network
<b>Office Visit</b>	\$10 copay/visit	20% coinsurance after deductible
<b>Telehealth Services</b>	Same as Office Visit	Same as Office Visit
<b>Virtual Visit</b>	\$5 copay/visit; Specialist: Same as Office Visit	\$5 copay/visit; Specialist: Same as Office Visit
<b>Chiropractor Visits</b>	\$10 copay/visit	20% coinsurance after deductible
<b>Hearing Examination</b>	\$10 copay/visit	Not Covered
<b>Podiatry Services</b>	\$10 copay/visit	20% coinsurance after deductible
<b>Vision Examination</b>	\$10 copay/visit; One Routine Vision exam is covered with no charge	20% coinsurance after deductible

Hospital Services *	In Network	Out of Network
<b>General Inpatient</b>	No charge after deductible	20% coinsurance after deductible
<b>Delivery &amp; Newborn Charges</b>	No charge after deductible	20% coinsurance after deductible

Questions? Visit us at [QuartzBenefits.com](http://QuartzBenefits.com) or call (800) 362-3310.

QA00998 (0521)

Tracking ID: XWRIEV35F

POS

<b>Outpatient Services</b>	No charge after deductible	20% coinsurance after deductible
<b>Emergency Services</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Emergency Room</b>	\$100 copay/visit	\$100 copay/visit
<b>Emergency Room Waiver</b>	Copay waived if admitted.	
<b>Urgent Care</b>	\$25 copay/visit	20% coinsurance after deductible
<b>Ambulance</b>	No charge after deductible	No charge after deductible
<b>Pharmacy Benefits</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Value Tier</b>	No charge	Not Covered
<b>Generic/Preferred/Non-Preferred</b>	\$5/\$20/\$40 copay	Not Covered
<b>Tier 4</b>	\$20 copay for Preferred \$40 copay for Non-Preferred	Not Covered
<b>Pharmacy Max Out-of-Pocket</b>	\$2,000 Single/ \$4,000 Family per Benefit Year	Not Covered
<b>Behavioral Health</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Inpatient</b>	No charge after deductible	20% coinsurance after deductible
<b>Transitional</b>	No charge after deductible	20% coinsurance after deductible
<b>Outpatient</b>	\$10 copay/visit	20% coinsurance after deductible
<b>Diagnostic Services</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Lab</b>	No charge after deductible	20% coinsurance after deductible
<b>X-Ray</b>	No charge after deductible	20% coinsurance after deductible
<b>MRI/MRA Scan</b>	No charge after deductible	20% coinsurance after deductible
<b>PET Scan</b>	No charge after deductible	20% coinsurance after deductible
<b>CAT Scan</b>	No charge after deductible	20% coinsurance after deductible
<b>Other Services</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Durable Medical Equipment</b>	No charge after deductible	20% coinsurance
<b>Home Health Care Services</b>	No charge after deductible	20% coinsurance after deductible
<b>Home Health Care Limit</b>	60 visits per Benefit Year	
<b>Hospice Services</b>	No charge after deductible	20% coinsurance after deductible
<b>Skilled Nursing Care Facility</b>	No charge after deductible	20% coinsurance after deductible
<b>Skilled Nursing Care Limit</b>	90 days per confinement	
<b>Therapy Services</b>	No charge after deductible	20% coinsurance after deductible
<b>Therapy Limit</b>	40 visits combined for Physical, Speech, and Occupational therapy and Pulmonary Rehab	
<b>TMJ Benefits</b>	\$10 copay/visit	20% coinsurance after deductible

\* Hospital Services – Includes daily hospital room and board, surgical, anesthesia and miscellaneous hospital services.