This plan is offered by Quartz Health Benefit Plans Corporation

Quartz

Prepared for:
RIO COMMUNITY SCHOOL DISTRICT

Schedule of Benefits
9082016 - HMO Deductible
Coverage Period: 9/1/2023 - 8/31/2024

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. Manufacturer-funded cost-sharing assistance for your prescriptions will not be credited to your Annual Maximum Out-of-Pocket Limit.
HSA Qualified Plan	No
Prior Authorization	Prior authorization may be required for certain services. See www.QuartzBenefits.com/WIPAList or call (800) 362-3310 for additional information

Physician Services	
Office Visit	$10 copay/visit
Telehealth Services	Same as Office Visit
Virtual Visit	$5 copay/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
Emergency Room Waiver	Copay waived if admitted.
Urgent Care	$25 copay/visit
Ambulance	No charge after deductible

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

Behavioral Health	
Inpatient	No charge after deductible
Transitional	No charge after deductible
Outpatient	$10 copay/visit

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

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

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

EXCLUSIONS AND LIMITATIONS

THIS IS A SUMMARY ONLY. FOR A COMPLETE LIST OF EXCLUSIONS, PLEASE SEE YOUR CERTIFICATE OF COVERAGE.

SURGICAL SERVICES

- Procedures to correct obesity. This exclusion does not apply to bariatric surgery services covered in the Certificate of Coverage.
- Plastic or cosmetic surgery
- Reconstructive surgery unless the purpose is to correct a functional defect
- Breast augmentation (This does not apply to reconstruction of affected tissue incident to mastectomy.)
- Refractive eye surgery for vision correction

MEDICAL SERVICES

- Examinations required for employment, licensing, or insurance; or any third-party request, including court-ordered treatment that does not otherwise qualify for coverage
- Immunizations covered by an employer, educational institution or other third party
- Expenses for the preparation and presentation of medical reports and records
- Weight control programs
- Psychological and Neuropsychological testing for educational purposes
- Custodial care and Maintenance and Supportive care and / or therapy

AMBULANCE SERVICES

- Travel and transportation for a consultation or to receive non-emergent treatment

THERAPIES

- Maintenance and Supportive Care and / or Therapy for chronic conditions
- Relationship counseling
- Vocational rehabilitation, including work-hardening programs
- Massage therapy

DENTAL SERVICES

- Routine dental procedures (e.g., cleanings, extraction of teeth, root canals, and filling or recapping of teeth), unless dental benefits are purchased.

REPRODUCTIVE SERVICES

- Reversal of voluntary sterilization procedures and related procedures
- Home delivery for childbirth
- Charges related to surrogate mother services when the surrogate is not a Quartz member

OUTPATIENT PRESCRIPTION DRUGS

- Prescription drugs prescribed for cosmetic purposes or for conditions or treatments that are not covered
- Prescription drugs not approved by the Federal Food and Drug Administration

DURABLE MEDICAL EQUIPMENT & DISPOSABLE MEDICAL SUPPLIES

- Foot pads, bunion covers, batteries, antiseptics, tape, over-the-counter shoe inserts, supports and elastic bandages; orthopedic shoes
- Comfort or convenience items (e.g., home monitoring devices, blood pressure cuffs, etc.); back-up supplies, equipment or prosthesis
- Customization of vehicles and / or lifts for wheelchairs and scooters; any and all modifications to a member's home and items associated with home modifications
- Repair or replacement of supplies, equipment or prosthesis if lost, stolen or nonfunctional due to misuse, abuse or neglect

GENERAL

- Any service, supply or equipment that is Experimental, Investigative or not Medically Necessary
- Services obtained without prior authorization or services that exceed the prior authorization granted
- Charges for services or items that the member has no legal obligation to pay
- Hypnotherapy
- Services rendered by a masseuse or massage therapist
- Coma Stimulation programs
- Orthoptics (eye exercise / training)
- Any condition, disability or charge resulting from or sustained as a result of being engaged in an illegal occupation or the commission or attempted commission of an assault or a criminal act

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Proof of Claim

A Member must submit proof of claim within 90 days of the date of service. Circumstances beyond the Member's control might make this time limit unreasonable. If so, the Member must file the claim as soon as possible.

Provider Limitations

Each member of an HMO or POS plan is required to select a Primary Care Physician (PCP) found in the Provider Directory. To access this directory online, visit our website at QuartzBenefits.com/findadoctor. There is no PCP requirement for PPO plan members.

For Behavioral Health (Mental Health) Services, please contact UW Health - Behavioral Health Care Management at (800) 683-2300 to connect with an in-network provider.