SUMMARY OF BENEFITS

Baraboo School District | **Quartz HMO Plan** | **EFFECTIVE 7/1/2021**

TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAYS	QUARTZ BENEFIT
DEDUCTIBLE & COINSURANCE			
In-Network Individual Deductible	$500	$7,400	$7,900
In-Network Family Deductible	$1,000	$14,800	$15,800
Out-of-Network Individual Deductible	N/A		
Out-of-Network Family Deductible			
Prescription Individual Deductible	$0	$0	$0
Prescription Family Deductible	$0	$0	$0
In-Network Coinsurance %	0%	0%	0%
In-Network Individual Coinsurance Limit	$0	$0	$0
In-Network Family Coinsurance Limit	$0	$0	$0
Out-of-Network Coinsurance %	N/A		
Out-of-Network Individual Coinsurance Limit			
Out-of-Network Family Coinsurance Limit			
PHYSICIAN SERVICES			
Primary Care Office Visit Copay	$0	$45	$45
Specialist Office Visit Copay	$80	$45	$125
Other (Chiro) Office Copay	$0	$45	$45
PREVENTIVE CARE			
Preventive Care / Screening / Immunization	No Charge		
DIAGNOSTIC PROCEDURES			
Diagnostic Test X-Ray	Deductible	Remaining Amount	Deductible
Diagnostic Test- Lab Bloodwork	Deductible	Remaining Amount	Deductible
Imaging (CT/Pet Scans, MRIs)	Deductible	Remaining Amount	Deductible
PHARMACY			
Tier 1 RX Retail Copay	$0.00	$20.00	$20.00
Tier 1 RX Mail Order Copay	N/A		
Tier 2 RX Retail Copay	$40.00	$20.00	$60.00
Tier 2 RX Mail Order Copay	N/A		
Tier 3 RX Retail Copay	$100.00	$20.00	$120.00
Tier 3 RX Mail Order Copay	N/A		
Tier 4 RX Retail Copay	$155.00	$20.00	$175.00
Tier 4 RX Mail Order Copay	N/A		
MAJOR MEDICAL SERVICES			
Outpatient Surgery Facility Fee	Deductible	Remaining Amount	Deductible
Outpatient Surgery Physician / Surgeon Fee	Deductible	Remaining Amount	Deductible
Emergency Room Care	$200	$300	$500
Emergency Medical Transportation	Deductible	Remaining Amount	Deductible
Urgent Care	$100	$25	$125
Inpatient Hospital Facility Fee	Deductible	Remaining Amount	Deductible
Inpatient Surgery Physician / Surgeon Fee	Deductible	Remaining Amount	Deductible
Mental - Behavioral Health / Substance Use Disorder Outpatient Services	$0	$45	$45
Mental - Behavioral Health / Substance Use Disorder Inpatient Services	Deductible	Remaining Amount	Deductible
Prenatal and Postnatal Care	Deductible	Remaining Amount	Deductible
Delivery and All Inpatient Services	Deductible	Remaining Amount	Deductible
Home Health Care	Deductible	Remaining Amount	Deductible
Rehabilitation Services	Deductible	Remaining Amount	Deductible
Habilitative Services	Deductible	Remaining Amount	Deductible
Skilled Nursing Care	Deductible	Remaining Amount	Deductible
Durable Medical Equipment	Deductible	Remaining Amount	Deductible
Hospice Service	Deductible	Remaining Amount	Deductible

Family Multiplier 2

Deductibles are determined on a Plan year basis.

All claims must be submitted within 3 months of the end of the plan year.

Deductible is Embedded

Information on this document based on carrier SBC

Terminated members must submit claims within 3 months of the termination date.

Please have your provider swipe the Difference Card for the following amounts:

Primary Care Swipe -	$45
Specialist Swipe -	$45
ER Visit Swipe -	$300
Urgent Care Swipe -	$25
RX Swipe -	$20

Call 888.343.2110 with any questions.

CONTACT US

Monday – Friday

8AM to 8PM Eastern

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