To locate an Aetna Choice Point of Service (POS) II network provider:
http://www.aetna.com/docfind/custom/mymeritain/

This rate chart applies to ALL eligible employees of the School District

Welcome to Quantum Health Your Health Care Coordinators	**Gold Plan - PPO**		**Silver Plan - PPO**		**Bronze Plan - HMO**	
call: 855-497-1307	**Aetna Choice POS II Network**		**Aetna Choice POS II Network**		**Aetna Choice POS II Network**	
	Employee Cost	Board Cost	Employee cost	Board Cost	Employee cost	Board Cost
Premiums per Pay Check	22-paychecks	22-paychecks	22-paychecks	22-paychecks	22-paychecks	22-paychecks
Employee Only	$55.64	$275.45	$34.91	$276.55	$17.45	$268.91
Employee + Spouse	$303.27	$424.91	$259.09	$426.00	$212.18	$418.36
Employee + Child(ren)	$200.73	$394.91	$158.18	$402.00	$87.27	$429.27
Family	$448.36	$544.36	$382.36	$551.45	$280.91	$578.73
Calendar Year Deductible (CYD)						
In-Network (per person/family)	$1,000 / $2,000		$1,500 / $3,000		$2,500 / $5,000	
Out-of Network (per person/family)	$2,000 / $4,000		$3,000 / $6,000		**N/A**	
Co-Insurance (Amount owed after CYD met)						
In-Network	10% of allowable charges		20% of allowable charges		30% of allowable charges	
Out-of Network	50% of allowable charges		50% of allowable charges		**N/A**	
Out of Pocket Maximum - Includes CYD, Co-Insurance & all copays for services and prescriptions						
In-Network	$3,000 / $6,000		$4,000 / $8,000		$5,000 / $10,000	
Out-of Network	$6,000 / $12,000		$8,000 / $16,000		**N/A**	
Office Services						
Primary Care Physician	$10		$25		$30	
Specialist & Urgent Care	$20		$50		$60	
Acupuncture	26 visits per calendar year / follows Specialist co-pay amounts					
PT/OT/Speech/Chiropractic	35 visits combined per calendar year / follows Specialist co-pay amounts					
Emergency/Facility Services						
ER Copay (not to exceed billed amount)	$800		$1,000		$1,200	
Inpatient Admission Copay	$200		$250		$300	
Preventive Services (including Dermatology)	100% Coverage		100% Coverage		100% Coverage-in network	
Any Benefit not specified is covered at deductible then coinsurance						
Pharmacy-prescriptions - Low cost pharmacies such as Publix, Walmart and CVS are encouraged. WALGREENS is an excluded pharmacy.						
Generic 30-day / 90-day	$10 / $25		$10 / $25		$10 / $25	
Preferred 30-day / 90-day	$30 / $75		$30 / $75		$30 / $75	
Non-Preferred 30-day / 90-day	$60 / $150		$60 / $150		$60 / $150	

***** Do not elect medical coverage that your paycheck cannot support *****

MyQHealth. by QUANTUM HEALTH

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as of 12/7/2021