

Individual & Family Plan Options – Wisconsin 2021

Beloit One Network

(Rock County)

Gold Plans

These plans will cover about 80% of your service and you are responsible for the other 20%

YOUR QUOTE INFORMATION

County:

Individuals Covered:

Benefits	Beloit One Gold I401	Beloit One Gold I402 Maintenance	Beloit One Gold I403 HSA*	Beloit One Gold I404 HSA*	Beloit One Gold I405
Deductible (Single / Family)	\$2,000 / \$4,000	\$1,500 / \$3,000	\$3,000 / \$6,000	\$2,000 / \$4,000	\$2,000 / \$4,000
Coinsurance	30%	0%	0%	10%	40%
Maximum Out-of-Pocket	\$7,000 / \$14,000	\$7,900 / \$15,800	\$3,000 / \$6,000	\$6,650 / \$13,300	\$6,500 / \$13,000
e-Visits	\$20	\$30	Deductible & Coinsurance	Deductible & Coinsurance	\$20
Office Visit Copay (PCP / Specialist)	\$30 / \$70	\$40 / \$90	Deductible & Coinsurance	Deductible & Coinsurance	\$30 / \$60
Urgent Care Copay	\$70	\$90	Deductible & Coinsurance	Deductible & Coinsurance	\$60
Emergency Room Copay	\$250	\$500	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Mental Health Outpatient Copay	\$30	\$40	Deductible & Coinsurance	Deductible & Coinsurance	\$30
Hospital Copay (Inpatient / Outpatient)	Deductible & Coinsurance	\$2,500 per diem IP / Ded & Coins	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Pharmacy Copay	\$10 / \$40 / \$80 / 45%	\$10 / \$75 / \$150 / \$450	Deductible & Coinsurance	Deductible & Coinsurance	\$35 / \$150 / \$250 / 45%
Dental Coverage Available for an Additional Charge?	Yes	Yes	No	No	Yes
HSA Eligible?	No	No	Yes*	Yes*	No
Summary of Benefits of Coverage (SBC) Tracking ID	B1G215110400	B1G215109300	B1G215404900	B1G215401400	B1G215114000
Monthly Premium (no Dental)					
Monthly Premium (with Dental)			N / A	N / A	

*Quartz HSA and Deductible family plans have an aggregate deductible. Aggregate means that if more than one person is covered by the plan, the “per person” deductible does not apply. The family deductible must be met before Quartz will pay benefits. One person’s claims may satisfy the entire family deductible. Likewise, the “per person” Maximum-Out-of-Pocket Limit does not apply to family plans. However, to comply with Health Care Reform rules, one member of a family will never pay more than \$8,550.

Quartz is a Qualified Health Plan issuer in the Health Insurance Marketplace.

Quartz does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

Individual & Family Plan Options – Wisconsin 2021

Beloit One Network

(Rock County)

Silver Plans

These plans will cover about 70% of your service and you are responsible for the other 30%

YOUR QUOTE INFORMATION

County:

Individuals Covered:

Benefits	Beloit One Silver I301	Beloit One Silver I302	Beloit One Silver I303	Beloit One Silver I304 HSA*
Deductible (Single / Family)	\$4,400 / \$8,800	\$5,000 / \$10,000	\$8,500 / \$17,000	\$5,250 / \$10,500
Coinsurance	40%	50%	50%	0%
Maximum Out-of-Pocket	\$8,150 / \$16,300	\$7,900 / \$15,800	\$8,550 / \$17,100	\$5,250 / \$10,500
e-Visits	\$30	\$30	\$30	Deductible & Coinsurance
Office Visit Copay (PCP / Specialist)	\$50 / \$90	\$50 / \$100	\$75 / \$160	Deductible & Coinsurance
Urgent Care Copay	\$90	\$100	\$300	Deductible & Coinsurance
Emergency Room Copay	\$550	\$500	\$700	Deductible & Coinsurance
Mental Health Outpatient Copay	\$50	\$50	\$75	Deductible & Coinsurance
Hospital Copay (Inpatient / Outpatient)	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Pharmacy Copay	\$20 / \$85 / \$150 / 45%	\$20 / \$75 / \$150 / 45%	\$35 / \$125 / \$250 / 45%	Deductible & Coinsurance
Dental Coverage Available for an Additional Charge?	Yes	Yes	Yes	No
HSA Eligible?	No	No	No	Yes*
Summary of Benefits of Coverage (SBC) Tracking ID	B1S215112600	B1S215112700	B1S215112800	B1S215405900
Monthly Premium (no Dental)				
Monthly Premium (with Dental)				N / A

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Beloit One Network

(Rock County)

Bronze Plans

These plans will cover about 60% of your service and you are responsible for the other 40%

YOUR QUOTE INFORMATION

County:

Individuals Covered:

Benefits	Beloit One Bronze I201	Beloit One Bronze I202	Beloit One Bronze I203 HSA *	Beloit One Bronze I204
Deductible (Single / Family)	\$8,000 / \$16,000	\$8,200 / \$16,400	\$6,850 / \$13,700	\$2,450 / \$4,900
Coinsurance	50%	0%	0%	50%
Maximum Out-of-Pocket	\$8,250 / \$16,500	\$8,200 / \$16,400	\$6,850 / \$13,700	\$8,550 / \$17,100
e-Visits	\$30	\$30	Deductible & Coinsurance	Deductible & Coinsurance
Office Visit Copay (PCP / Specialist)	\$80 / \$160	\$50 / \$100	Deductible & Coinsurance	Deductible & Coinsurance
Urgent Care Copay	\$160	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Room Copay	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Mental Health Outpatient Copay	\$80	\$50	Deductible & Coinsurance	Deductible & Coinsurance
Hospital Copay (Inpatient / Outpatient)	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Pharmacy Copay	\$35 / \$160 / \$250 / 45%	Deductible & Coinsurance	Deductible & Coinsurance	\$30 / \$160 / Deductible & 70% / \$600
Dental Coverage Available for an Additional Charge?	Yes	Yes	No	Yes
HSA Eligible?	No	No	Yes*	No
Summary of Benefits of Coverage (SBC) Tracking ID	B1B215114400	B1B215110700	B1B215401000	B1B215114300
Monthly Premium (no Dental)				
Monthly Premium (with Dental)			N / A	

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(Rock County)

Catastrophic

Only individuals under 30 years old or with a hardship exemption qualify for Catastrophic Plans

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County:

Individuals Covered:

Benefits	Beloit One Catastrophic I101
Deductible (Single / Family)	\$8,550 / \$17,100
Coinsurance	0%
Maximum Out-of-Pocket	\$8,550 / \$17,100
e-Visits	Deductible & Coinsurance
Office Visit Copay (PCP / Specialist)	\$0* / Deductible & Coinsurance
Urgent Care Copay	Deductible & Coinsurance
Emergency Room Copay	Deductible & Coinsurance
Mental Health Outpatient Copay	Deductible & Coinsurance
Hospital Copay (Inpatient / Outpatient)	Deductible & Coinsurance
Pharmacy Copay	Deductible & Coinsurance
Dental Coverage Available for an Additional Charge?	No
HSA Eligible?	No
Summary of Benefits of Coverage (SBC) Tracking ID	B1C215401100
Monthly Premium (no Dental)	
Monthly Premium (with Dental)	N / A

*Only applies to the first three office visits with PCP, then deductible and coinsurance apply.

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