

2019 Small Group Plan Options Wisconsin – HMO



Platinum Plans

These plans will cover about 90% of your service and you are responsible for the other 10%

Benefits	P1901: Platinum \$0	P1902: Platinum \$500	P1903: Platinum \$1,000	P1904: Platinum Maintenance
Deductible (Single / Family)	\$0 / \$0	\$500 / \$1,000	\$1,000 / \$2,000	\$0 / \$0
Coinsurance	0%	20%	10%	0%
Maximum Out-of-Pocket	\$4,500 / \$9,000	\$1,250 / \$2,500	\$1,500 / \$3,000	\$7,900 / \$15,800
e-Visits	\$30	\$15	\$10	\$10
Office Visit Copay (PCP / Specialist)	\$40 / \$60	\$25 / \$50	\$20 / \$40	\$20 / \$40
Urgent Care Copay	\$60	\$50	\$40	\$40
Emergency Room Copay	\$350	\$100	\$150	\$500
Mental Health Outpatient Copay	\$40	\$25	\$20	\$20
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	\$2,500 per diem IP / Ded & Coins
Pharmacy Copay	\$5 / \$10 / \$40 / \$80 / \$200	\$5 / \$10 / \$40 / \$80 / \$200	\$5 / \$10 / \$40 / \$80 / \$200	\$5 / \$10 / \$40 / \$80 / \$200
Pharmacy Maximum Out-of-Pocket (Single / Family)	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical
Dental Coverage Available for an Additional Charge?	Yes	Yes	Yes	Yes
HSA Eligible?	No	No	No	No
Embedded / Aggregate	Embedded	Embedded	Embedded	Embedded
Creditable Coverage	Creditable	Creditable	Creditable	Creditable
SBC	TA1F30V29	FGM3HXM	B4N1LC3	UAZK4Q

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Offered by Quartz Health Benefit Plans Corporation.

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Gold Plans

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

Benefits	G1901: Gold \$1,500	G1902: Gold \$2,000	G1903: Gold \$3,500	G1904: Gold Maintenance	G1905: Gold HSA \$3,000 Embedded
Deductible (Single / Family)	\$1,500 / \$3,000	\$2,000 / \$4,000	\$3,500 / \$7,000	\$1,500 / \$3,000	\$3,000 / \$6,000
Coinsurance	30%	30%	0%	0%	0%
Maximum Out-of-Pocket	\$5,000 / \$10,000	\$5,000 / \$10,000	\$3,500 / \$7,000	\$7,900 / \$15,800	\$3,000 / \$6,000
e-Visits	\$15	\$20	Deductible then Coinsurance	\$15	Deductible then Coinsurance
Office Visit Copay (PCP / Specialist)	\$25 / \$50	\$30 / \$60	Deductible then Coinsurance	\$25 / \$50	Deductible then Coinsurance
Urgent Care Copay	\$50	\$60	Deductible then Coinsurance	\$50	Deductible then Coinsurance
Emergency Room Copay	\$200	\$250	Deductible then Coinsurance	\$500	Deductible then Coinsurance
Mental Health Outpatient Copay	\$25	\$30	Deductible then Coinsurance	\$25	Deductible then Coinsurance
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	\$4,000 per diem IP / Ded & Coins	Deductible then Coinsurance
Pharmacy Copay	\$5 / \$10 / \$40 / \$80 / \$200	\$5 / \$10 / \$40 / \$80 / \$200	\$5 / \$10 / \$40 / \$80 / \$200	\$5 / \$10 / \$40 / \$80 / \$200	Deductible then Coinsurance
Pharmacy Maximum Out-of-Pocket (Single / Family)	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical
Dental Coverage Available for an Additional Charge?	Yes	Yes	Yes	Yes	No
HSA Eligible?	No	No	No	No	Yes
Embedded / Aggregate	Embedded	Embedded	Embedded	Embedded	Embedded
Creditable Coverage	Creditable	Creditable	Creditable	Creditable	Creditable
SBC	URL9ZR3KN	XJSHAGN1	G19KL9FQ8N	JZ2VN3	RGX140

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Silver Plans

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

Benefits	S1901: Silver \$2,000	S1902: Silver \$4,500	S1903: Silver \$5,000	S1904: Silver HSA \$4,000 Embedded	S1905: Silver HSA \$5,000 Embedded
Deductible (Single / Family)	\$2,000 / \$4,000	\$4,500 / \$9,000	\$5,000 / \$10,000	\$4,000 / \$8,000	\$5,000 / \$10,000
Coinsurance	40%	30%	50%	0%	0%
Maximum Out-of-Pocket	\$7,000 / \$14,000	\$7,900 / \$15,800	\$7,900 / \$15,800	\$4,000 / \$8,000	\$5,000 / \$10,000
e-Visits	Deductible then Coinsurance	Deductible then Coinsurance	\$30	Deductible then Coinsurance	Deductible then Coinsurance
Office Visit Copay (PCP / Specialist)	Deductible then Coinsurance	Deductible then Coinsurance	\$40 / \$60	Deductible then Coinsurance	Deductible then Coinsurance
Urgent Care Copay	Deductible then Coinsurance	Deductible then Coinsurance	\$60	Deductible then Coinsurance	Deductible then Coinsurance
Emergency Room Copay	Deductible then Coinsurance	Deductible then Coinsurance	\$450	Deductible then Coinsurance	Deductible then Coinsurance
Mental Health Outpatient Copay	Deductible then Coinsurance	Deductible then Coinsurance	\$40	Deductible then Coinsurance	Deductible then Coinsurance
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Copay	\$5 / \$10 / \$55 / \$125 / \$225	\$5 / \$10 / \$55 / \$125 / \$225	\$10 / \$20 / \$70 / \$150 / \$300	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Maximum Out-of-Pocket (Single / Family)	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical
Dental Coverage Available for an Additional Charge?	Yes	Yes	Yes	No	No
HSA Eligible?	No	No	No	Yes	Yes
Embedded / Aggregate	Embedded	Embedded	Embedded	Embedded	Embedded
Creditable Coverage	Creditable	Creditable	Creditable	Creditable	Not Creditable
SBC	FMXUORHV	OC5KH933	MIL212HUC8	UND5IHVC3P	Y741K1R7

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Bronze Plans

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

Benefits	B1901: Bronze \$6,500	B1902: Bronze HSA \$6,750 Embedded
Deductible (Single / Family)	\$6,500 / \$13,000	\$6,750 / \$13,500
Coinsurance	50%	0%
Maximum Out-of-Pocket	\$7,900 / \$15,800	\$6,750 / \$13,500
e-Visits	\$30	Deductible then Coinsurance
Office Visit Copay (PCP / Specialist)	\$85 / \$170	Deductible then Coinsurance
Urgent Care Copay	\$170	Deductible then Coinsurance
Emergency Room Copay	Deductible then Coinsurance	Deductible then Coinsurance
Mental Health Outpatient Copay	\$85	Deductible then Coinsurance
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Copay	\$10 / \$20 / \$80 / \$175 / \$300	Deductible then Coinsurance
Pharmacy Maximum Out-of-Pocket (Single / Family)	Subject to Medical	Subject to Medical
Dental Coverage Available for an Additional Charge?	Yes	No
HSA Eligible?	No	Yes
Embedded / Aggregate	Embedded	Embedded
Creditable Coverage	Creditable	Not Creditable
SBC	BQN1DH	CF2Z6Y9

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2019 Small Group Plan Options Wisconsin – POS



Platinum Plans

These plans will cover about 90% of your service and you are responsible for the other 10%

Benefits	P1901: Platinum \$0		P1902: Platinum \$500	
	In Network	Out-of-Network	In Network	Out-of-Network
Deductible (Single / Family)	\$0 / \$0	\$1,000 / \$2,000	\$500 / \$1,000	\$1,000 / \$2,000
Coinsurance	0%	20%	20%	40%
Maximum Out-of-Pocket	\$4,500 / \$9,000	\$5,000 / \$10,000	\$1,250 / \$2,500	\$2,500 / \$5,000
e-Visits	\$30	N / A	\$15	N / A
Office Visit Copay (PCP / Specialist)	\$40 / \$60	Deductible then Coinsurance	\$25 / \$50	Deductible then Coinsurance
Urgent Care Copay	\$60	Deductible then Coinsurance	\$50	Deductible then Coinsurance
Emergency Room Copay	\$350	\$350	\$100	\$100
Mental Health Outpatient Copay	\$40	Deductible then Coinsurance	\$25	Deductible then Coinsurance
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Copay	\$5 / \$10 / \$40 / \$80 / \$200	\$5 / \$10 / \$40 / \$80 / \$200	\$5 / \$10 / \$40 / \$80 / \$200	\$5 / \$10 / \$40 / \$80 / \$200
Pharmacy Maximum Out-of-Pocket (Single / Family)	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical
Dental Coverage Available for an Additional Charge?	Yes		Yes	
HSA Eligible?	No		No	
Embedded / Aggregate	Embedded		Embedded	
Creditable Coverage	Creditable		Creditable	
SBC	MF7G7C6		J1OP3E	

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Platinum Plans

These plans will cover about 90% of your service and you are responsible for the other 10%

Benefits	P1903: Platinum \$1,000		P1904: Platinum Maintenance	
	In Network	Out-of-Network	In Network	Out-of-Network
Deductible (Single / Family)	\$1,000 / \$2,000	\$2,000 / \$4,000	\$0 / \$0	\$1,000 / \$2,000
Coinsurance	10%	30%	0%	20%
Maximum Out-of-Pocket	\$1,500 / \$3,000	\$3,000 / \$6,000	\$7,900 / \$15,800	\$8,000 / \$16,000
e-Visits	\$10	N / A	\$10	N / A
Office Visit Copay (PCP / Specialist)	\$20 / \$40	Deductible then Coinsurance	\$20 / \$40	Deductible then Coinsurance
Urgent Care Copay	\$40	Deductible then Coinsurance	\$40	Deductible then Coinsurance
Emergency Room Copay	\$150	\$150	\$500	\$500
Mental Health Outpatient Copay	\$20	Deductible then Coinsurance	\$20	Deductible then Coinsurance
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	\$2,500 per diem IP / Ded & Coins	Deductible then Coinsurance
Pharmacy Copay	\$5 / \$10 / \$40 / \$80 / \$200	\$5 / \$10 / \$40 / \$80 / \$200	\$5 / \$10 / \$40 / \$80 / \$200	\$5 / \$10 / \$40 / \$80 / \$200
Pharmacy Maximum Out-of-Pocket (Single / Family)	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical
Dental Coverage Available for an Additional Charge?	Yes		Yes	
HSA Eligible?	No		No	
Embedded / Aggregate	Embedded		Embedded	
Creditable Coverage	Creditable		Creditable	
SBC	AVHOLHK		VRDR4BU	

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Gold Plans

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

Benefits	G1901: Gold \$1,500		G1902: Gold \$2,000		G1903: Gold \$3,500	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
Deductible (Single / Family)	\$1,500 / \$3,000	\$3,000 / \$6,000	\$2,000 / \$4,000	\$4,000 / \$8,000	\$3,500 / \$7,000	\$5,000 / \$10,000
Coinsurance	30%	50%	30%	50%	0%	20%
Maximum Out-of-Pocket	\$5,000 / \$10,000	\$8,000 / \$16,000	\$5,000 / \$10,000	\$10,000 / \$20,000	\$3,500 / \$7,000	\$10,000 / \$20,000
e-Visits	\$15	N / A	\$20	N / A	Deductible then Coinsurance	N / A
Office Visit Copay (PCP / Specialist)	\$25 / \$50	Deductible then Coinsurance	\$30 / \$60	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Urgent Care Copay	\$50	Deductible then Coinsurance	\$60	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Emergency Room Copay	\$200	\$200	\$250	\$250	Deductible then Coinsurance	Deductible then Coinsurance
Mental Health Outpatient Copay	\$25	Deductible then Coinsurance	\$30	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Copay	\$5 / \$10 / \$40 / \$80 / \$200	\$5 / \$10 / \$40 / \$80 / \$200	\$5 / \$10 / \$40 / \$80 / \$200	\$5 / \$10 / \$40 / \$80 / \$200	\$5 / \$10 / \$40 / \$80 / \$200	\$5 / \$10 / \$40 / \$80 / \$200
Pharmacy Maximum Out-of- Pocket (Single / Family)	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical
Dental Coverage Available for an Additional Charge?	Yes		Yes		Yes	
HSA Eligible?	No		No		No	
Embedded / Aggregate	Embedded		Embedded		Embedded	
Creditable Coverage	Creditable		Creditable		Creditable	
SBC	XGG06J04		GCXCAI		COQS4NGIN	

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2019 Small Group Plan Options Wisconsin – POS



Gold Plans

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

Benefits	G1904: Gold Maintenance		G1905: Gold HSA \$3,000 Embedded	
	In Network	Out-of-Network	In Network	Out-of-Network
Deductible (Single / Family)	\$1,500 / \$3,000	\$7,000 / \$14,000	\$3,000 / \$6,000	\$6,000 / \$12,000
Coinsurance	0%	20%	0%	20%
Maximum Out-of-Pocket	\$7,900 / \$15,800	\$14,000 / \$28,000	\$3,000 / \$6,000	\$12,000 / \$24,000
e-Visits	\$15	N / A	Deductible then Coinsurance	N / A
Office Visit Copay (PCP / Specialist)	\$25 / \$50	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Urgent Care Copay	\$50	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Emergency Room Copay	\$500	\$500	Deductible then Coinsurance	Deductible then Coinsurance
Mental Health Outpatient Copay	\$25	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Hospital Copay (Inpatient / Outpatient)	\$4,000 per diem IP / Ded & Coins	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Copay	\$5 / \$10 / \$40 / \$80 / \$200	\$5 / \$10 / \$40 / \$80 / \$200	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Maximum Out-of-Pocket (Single / Family)	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical
Dental Coverage Available for an Additional Charge?	Yes		No	
HSA Eligible?	No		Yes	
Embedded / Aggregate	Embedded		Embedded	
Creditable Coverage	Creditable		Creditable	
SBC	Z9RISTI		EJYTC7	

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2019 Small Group Plan Options Wisconsin – POS



Silver Plans

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

Benefits	S1901: Silver \$2,000		S1902: Silver \$4,500		S1903: Silver \$5,000	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
Deductible (Single / Family)	\$2,000 / \$4,000	\$4,000 / \$8,000	\$4,500 / \$9,000	\$7,000 / \$14,000	\$5,000 / \$10,000	\$7,000 / \$14,000
Coinsurance	40%	50%	30%	50%	50%	50%
Maximum Out-of-Pocket	\$7,000 / \$14,000	\$14,000 / \$28,000	\$7,900 / \$15,800	\$14,000 / \$28,000	\$7,900 / \$15,800	\$14,000 / \$28,000
e-Visits	Deductible then Coinsurance	N / A	Deductible then Coinsurance	N / A	\$30	N / A
Office Visit Copay (PCP / Specialist)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	\$40 / \$60	Deductible then Coinsurance
Urgent Care Copay	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	\$60	Deductible then Coinsurance
Emergency Room Copay	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	\$450	\$450
Mental Health Outpatient Copay	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	\$40	Deductible then Coinsurance
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Copay	\$5/\$10/\$55/\$125/\$225	\$5/\$10/\$55/\$125/\$225	\$5/\$10/\$55/\$125/\$225	\$5/\$10/\$55/\$125/\$225	\$10/\$20/\$70/\$150/\$300	\$10/\$20/\$70/\$150/\$300
Pharmacy Maximum Out-of- Pocket (Single / Family)	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical
Dental Coverage Available for an Additional Charge?	Yes		Yes		Yes	
HSA Eligible?	No		No		No	
Embedded / Aggregate	Embedded		Embedded		Embedded	
Creditable Coverage	Creditable		Creditable		Creditable	
SBC	I07A50BLGK		KDD2305		KSN2PD550	

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Silver Plans

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Benefits	S1904: Silver HSA \$4,000 Embedded		S1905: Silver HSA \$5,000 Embedded	
	In Network	Out-of-Network	In Network	Out-of-Network
Deductible (Single / Family)	\$4,000 / \$8,000	\$8,000 / \$16,000	\$5,000 / \$10,000	\$10,000 / \$20,000
Coinsurance	0%	20%	0%	20%
Maximum Out-of-Pocket	\$4,000 / \$8,000	\$16,000 / \$32,000	\$5,000 / \$10,000	\$20,000 / \$40,000
e-Visits	Deductible then Coinsurance	N / A	Deductible then Coinsurance	N / A
Office Visit Copay (PCP / Specialist)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Urgent Care Copay	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Emergency Room Copay	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Mental Health Outpatient Copay	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Copay	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Maximum Out-of-Pocket (Single / Family)	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical
Dental Coverage Available for an Additional Charge?	No		No	
HSA Eligible?	Yes		Yes	
Embedded / Aggregate	Embedded		Embedded	
Creditable Coverage	Creditable		Not Creditable	
SBC	BM3I32T1		SUYIUB	

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Bronze Plans

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

Benefits	B1901: Bronze \$6,500		B1902: Bronze HSA \$6,750 Embedded	
	In Network	Out-of-Network	In Network	Out-of-Network
Deductible (Single / Family)	\$6,500 / \$13,000	\$9,000 / \$18,000	\$6,750 / \$13,500	\$10,000 / \$20,000
Coinsurance	50%	50%	0%	20%
Maximum Out-of-Pocket	\$7,900 / \$15,800	\$12,000 / \$24,000	\$6,750 / \$13,500	\$20,000 / \$40,000
e-Visits	\$30	N / A	Deductible then Coinsurance	N / A
Office Visit Copay (PCP / Specialist)	\$85 / \$170	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Urgent Care Copay	\$170	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Emergency Room Copay	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Mental Health Outpatient Copay	\$85	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Copay	\$10 / \$20 / \$80 / \$175 / \$300	\$10 / \$20 / \$80 / \$175 / \$300	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Maximum Out-of-Pocket (Single / Family)	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical
Dental Coverage Available for an Additional Charge?	Yes		No	
HSA Eligible?	No		Yes	
Embedded / Aggregate	Embedded		Embedded	
Creditable Coverage	Creditable		Not Creditable	
SBC	GZQ6X2U3D8		WTX2XK8	

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Platinum Plans

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Benefits	P1901: Platinum \$0		P1902: Platinum \$500	
	In Network	Out-of-Network	In Network	Out-of-Network
Deductible (Single / Family)	\$0 / \$0	\$1,000 / \$2,000	\$500 / \$1,000	\$1,000 / \$2,000
Coinsurance	0%	20%	20%	40%
Maximum Out-of-Pocket	\$4,500 / \$9,000	\$5,000 / \$10,000	\$1,250 / \$2,500	\$2,500 / \$5,000
e-Visits	\$30	N / A	\$15	N / A
Office Visit Copay (PCP / Specialist)	\$40	Deductible then Coinsurance	\$25	Deductible then Coinsurance
Urgent Care Copay	\$60	Deductible then Coinsurance	\$50	Deductible then Coinsurance
Emergency Room Copay	\$350	\$350	\$100	\$100
Mental Health Outpatient Copay	\$40	Deductible then Coinsurance	\$25	Deductible then Coinsurance
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Copay	\$10 / \$40 / \$80 / \$200	\$10 / \$40 / \$80 / \$200	\$10 / \$40 / \$80 / \$200	\$10 / \$40 / \$80 / \$200
Pharmacy Maximum Out-of-Pocket (Single / Family)	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical
Dental Coverage Available for an Additional Charge?	Yes		Yes	
HSA Eligible?	No		No	
Embedded / Aggregate	Embedded		Embedded	
Creditable Coverage	Creditable		Creditable	
SBC	N16JR2		S1F0405NR	

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2019 Small Group Plan Options Wisconsin – PPO



Platinum Plans

These plans will cover about 90% of your service and you are responsible for the other 10%

Benefits	P1903: Platinum \$1,000		P1904: Platinum Maintenance	
	In Network	Out-of-Network	In Network	Out-of-Network
Deductible (Single / Family)	\$1,000 / \$2,000	\$2,000 / \$4,000	\$0 / \$0	\$1,000 / \$2,000
Coinsurance	10%	30%	0%	20%
Maximum Out-of-Pocket	\$1,500 / \$3,000	\$3,000 / \$6,000	\$7,900 / \$15,800	\$8,000 / \$16,000
e-Visits	\$10	N / A	\$10	N / A
Office Visit Copay (PCP / Specialist)	\$20	Deductible then Coinsurance	\$20	Deductible then Coinsurance
Urgent Care Copay	\$40	Deductible then Coinsurance	\$40	Deductible then Coinsurance
Emergency Room Copay	\$150	\$150	\$500	\$500
Mental Health Outpatient Copay	\$20	Deductible then Coinsurance	\$20	Deductible then Coinsurance
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	\$2,500 per diem IP / Ded & Coins	Deductible then Coinsurance
Pharmacy Copay	\$10 / \$40 / \$80 / \$200	\$10 / \$40 / \$80 / \$200	\$10 / \$40 / \$80 / \$200	\$10 / \$40 / \$80 / \$200
Pharmacy Maximum Out-of-Pocket (Single / Family)	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical
Dental Coverage Available for an Additional Charge?	Yes		Yes	
HSA Eligible?	No		No	
Embedded / Aggregate	Embedded		Embedded	
Creditable Coverage	Creditable		Creditable	
SBC	F6ETCGCHPQ		C8D7D84	

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2019 Small Group Plan Options Wisconsin – PPO



Gold Plans

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

Benefits	G1901: Gold \$1,500		G1902: Gold \$2,000		G1903: Gold \$3,500	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
Deductible (Single / Family)	\$1,500 / \$3,000	\$3,000 / \$6,000	\$2,000 / \$4,000	\$4,000 / \$8,000	\$3,500 / \$7,000	\$5,000 / \$10,000
Coinsurance	30%	50%	30%	50%	0%	20%
Maximum Out-of-Pocket	\$5,000 / \$10,000	\$8,000 / \$16,000	\$5,000 / \$10,000	\$10,000 / \$20,000	\$3,500 / \$7,000	\$10,000 / \$20,000
e-Visits	\$15	N / A	\$20	N / A	Deductible then Coinsurance	N / A
Office Visit Copay (PCP / Specialist)	\$25	Deductible then Coinsurance	\$30	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Urgent Care Copay	\$50	Deductible then Coinsurance	\$60	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Emergency Room Copay	\$200	\$200	\$250	\$250	Deductible then Coinsurance	Deductible then Coinsurance
Mental Health Outpatient Copay	\$25	Deductible then Coinsurance	\$30	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Copay	\$10/\$40/\$80/\$200	\$10/\$40/\$80/\$200	\$10/\$40/\$80/\$200	\$10/\$40/\$80/\$200	\$10/\$40/\$80/\$200	\$10/\$40/\$80/\$200
Pharmacy Maximum Out-of- Pocket (Single / Family)	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical
Dental Coverage Available for an Additional Charge?	Yes		Yes		Yes	
HSA Eligible?	No		No		No	
Embedded / Aggregate	Embedded		Embedded		Embedded	
Creditable Coverage	Creditable		Creditable		Creditable	
SBC	XMRB74		D2P28KSR		MHB2RYHJ7	

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2019 Small Group Plan Options Wisconsin – PPO



Gold Plans

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

Benefits	G1904: Gold Maintenance		G1905: Gold HSA \$3,000 Embedded	
	In Network	Out-of-Network	In Network	Out-of-Network
Deductible (Single / Family)	\$1,500 / \$3,000	\$7,000 / \$14,000	\$3,000 / \$6,000	\$6,000 / \$12,000
Coinsurance	0%	20%	0%	20%
Maximum Out-of-Pocket	\$7,900 / \$15,800	\$14,000 / \$28,000	\$3,000 / \$6,000	\$12,000 / \$24,000
e-Visits	\$15	N / A	Deductible then Coinsurance	N / A
Office Visit Copay (PCP / Specialist)	\$25	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Urgent Care Copay	\$50	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Emergency Room Copay	\$500	\$500	Deductible then Coinsurance	Deductible then Coinsurance
Mental Health Outpatient Copay	\$25	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Hospital Copay (Inpatient / Outpatient)	\$4,000 per diem IP / Ded & Coins	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Copay	\$10 / \$40 / \$80 / \$200	\$10 / \$40 / \$80 / \$200	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Maximum Out-of-Pocket (Single / Family)	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical
Dental Coverage Available for an Additional Charge?	Yes		No	
HSA Eligible?	No		Yes	
Embedded / Aggregate	Embedded		Embedded	
Creditable Coverage	Creditable		Creditable	
SBC	HISP7KBO		HJGW14X	

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2019 Small Group Plan Options Wisconsin – PPO



Silver Plans

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

Benefits	S1901: Silver \$2,000		S1902: Silver \$4,500		S1903: Silver \$5,000	
	In Network	Out-of-Network	In Network	Out-of-Network	In Network	Out-of-Network
Deductible (Single / Family)	\$2,000 / \$4,000	\$4,000 / \$8,000	\$4,500 / \$9,000	\$7,000 / \$14,000	\$5,000 / \$10,000	\$7,000 / \$14,000
Coinsurance	40%	50%	30%	50%	50%	50%
Maximum Out-of-Pocket	\$7,000 / \$14,000	\$14,000 / \$28,000	\$7,900 / \$15,800	\$14,000 / \$28,000	\$7,900 / \$15,800	\$14,000 / \$28,000
e-Visits	Deductible then Coinsurance	N / A	Deductible then Coinsurance	N / A	\$30	N / A
Office Visit Copay (PCP / Specialist)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	\$40	Deductible then Coinsurance
Urgent Care Copay	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	\$60	Deductible then Coinsurance
Emergency Room Copay	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	\$450	\$450
Mental Health Outpatient Copay	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	\$40	Deductible then Coinsurance
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Copay	\$10/\$55/\$125/\$225	\$10/\$55/\$125/\$225	\$10/\$55/\$125/\$225	\$10/\$55/\$125/\$225	\$20/\$70/\$150/\$300	\$20/\$70/\$150/\$300
Pharmacy Maximum Out-of- Pocket (Single / Family)	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical
Dental Coverage Available for an Additional Charge?	Yes		Yes		Yes	
HSA Eligible?	No		No		No	
Embedded / Aggregate	Embedded		Embedded		Embedded	
Creditable Coverage	Creditable		Creditable		Creditable	
SBC	X1136BHFBG		RKC1672		V9FOILC	

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2019 Small Group Plan Options Wisconsin – PPO



Silver Plans

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

Benefits	S1904: Silver HSA \$4,000 Embedded		S1905: Silver HSA \$5,000 Embedded	
	In Network	Out-of-Network	In Network	Out-of-Network
Deductible (Single / Family)	\$4,000 / \$8,000	\$8,000 / \$16,000	\$5,000 / \$10,000	\$10,000 / \$20,000
Coinsurance	0%	20%	0%	20%
Maximum Out-of-Pocket	\$4,000 / \$8,000	\$16,000 / \$32,000	\$5,000 / \$10,000	\$20,000 / \$40,000
e-Visits	Deductible then Coinsurance	N / A	Deductible then Coinsurance	N / A
Office Visit Copay (PCP / Specialist)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Urgent Care Copay	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Emergency Room Copay	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Mental Health Outpatient Copay	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Copay	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Maximum Out-of-Pocket (Single / Family)	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical
Dental Coverage Available for an Additional Charge?	No		No	
HSA Eligible?	Yes		Yes	
Embedded / Aggregate	Embedded		Embedded	
Creditable Coverage	Creditable		Not Creditable	
SBC	Z4EV4MBF2U		QGDXTH83S	

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Bronze Plans

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

Benefits	B1901: Bronze \$6,500		B1902: Bronze HSA \$6,750 Embedded	
	In Network	Out-of-Network	In Network	Out-of-Network
Deductible (Single / Family)	\$6,500 / \$13,000	\$9,000 / \$18,000	\$6,750 / \$13,500	\$10,000 / \$20,000
Coinsurance	50%	50%	0%	20%
Maximum Out-of-Pocket	\$7,900 / \$15,800	\$12,000 / \$24,000	\$6,750 / \$13,500	\$20,000 / \$40,000
e-Visits	\$30	N / A	Deductible then Coinsurance	N / A
Office Visit Copay (PCP / Specialist)	\$85	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Urgent Care Copay	\$170	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Emergency Room Copay	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Mental Health Outpatient Copay	\$85	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Copay	\$20 / \$80 / \$175 / \$300	\$20 / \$80 / \$175 / \$300	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Maximum Out-of-Pocket (Single / Family)	Subject to Medical	Subject to Medical	Subject to Medical	Subject to Medical
Dental Coverage Available for an Additional Charge?	Yes		No	
HSA Eligible?	No		Yes	
Embedded / Aggregate	Embedded		Embedded	
Creditable Coverage	Creditable		Not Creditable	
SBC	QB27Z2C		QABB2CA	

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