

2019 Individual & Family Plan Options – Wisconsin Prime Network – Cost Share Reduction Plans



(Columbia, Dane, Dodge, Green, Iowa, Jefferson and Sauk Counties)

100 - 150% of Federal Poverty Level

Benefits	Prime Silver Deductible 425*	Prime Silver 75 – Copay \$5 / \$10	Prime Silver 150 – Copay \$10 / \$20	Prime Silver 575 – Copay \$5 / \$10
Deductible (Single / Family)	\$425 / \$850	\$75 / \$150	\$150 / \$300	\$575 / \$1,150
Coinsurance	0%	10%	20%	0%
Maximum Out-of-Pocket	\$425 / \$850	\$1,300 / \$2,600	\$700 / \$1,400	\$575 / \$1,150
e-Visits	Deductible then Coinsurance	\$3	\$5	\$3
Office Visit Copay (PCP / Specialist)	Deductible then Coinsurance	\$5 / \$10	\$10 / \$20	\$5 / \$10
Urgent Care Copay	Deductible then Coinsurance	\$10	\$20	\$10
Emergency Room Copay	Deductible then Coinsurance	\$90	\$65	\$50
Mental Health Outpatient Copay	Deductible then Coinsurance	\$5	\$10	\$5
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Copay	Deductible then Coinsurance	\$5 / \$10 / \$70 / 40%	\$5 / \$10 / \$70 / 40%	\$5 / \$10 / \$70 / 40%
Dental Coverage Available for an Additional Charge?	No	Yes	Yes	Yes
HSA Eligible?	No	No	No	No
Summary of Benefits of Coverage (SBC) Tracking ID	PS185403506	PS185109706	PS185100806	PS185100906

* Quartz HSA 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 \$2,600.

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.

Offered by Quartz Health Benefit Plans Corporation.

UH01446 (0519)

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(Columbia, Dane, Dodge, Green, Iowa, Jefferson and Sauk Counties)

150 - 200% of Federal Poverty Level

Benefits	Prime Silver Deductible 1150*	Prime Silver 375 – Copay \$15 / \$30	Prime Silver 450 – Copay \$20 / \$40	Prime Silver 1900 – Copay \$5 / \$10
Deductible (Single / Family)	\$1,150 / \$2,300	\$375 / \$750	\$450 / \$900	\$1,900 / \$3,800
Coinsurance	0%	30%	30%	0%
Maximum Out-of-Pocket	\$1,150 / \$2,300	\$2,600 / \$5,200	\$2,475 / \$4,950	\$1,900 / \$3,800
e-Visits	Deductible then Coinsurance	\$10	\$10	\$3
Office Visit Copay (PCP / Specialist)	Deductible then Coinsurance	\$15 / \$30	\$20 / \$40	\$5 / \$10
Urgent Care Copay	Deductible then Coinsurance	\$30	\$40	\$10
Emergency Room Copay	Deductible then Coinsurance	\$250	\$200	\$300
Mental Health Outpatient Copay	Deductible then Coinsurance	\$15	\$20	\$5
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Copay	Deductible then Coinsurance	\$10 / \$30 / \$70 / 40%	\$5 / \$25 / \$70 / 45%	\$10 / \$30 / \$70 / 40%
Dental Coverage Available for an Additional Charge?	No	Yes	Yes	Yes
HSA Eligible?	No	No	No	No
Summary of Benefits of Coverage (SBC) Tracking ID	PS185403505	PS185109705	PS185100805	PS185100905

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2019 Individual & Family Plan Options – Wisconsin Prime Network – Cost Share Reduction Plans



(Columbia, Dane, Dodge, Green, Iowa, Jefferson and Sauk Counties)

200 - 250% of Federal Poverty Level

Benefits	Prime Silver HSA 3375*	Prime Silver 3975 – Copay \$35 / \$70	Prime Silver 4950 – Copay \$40 / \$80	Prime Silver 6300 – Copay \$35 / \$70
Deductible (Single / Family)	\$3,375 / \$6,750	\$3,975 / \$7,950	\$4,950 / \$9,900	\$6,300 / \$12,600
Coinsurance	0%	40%	30%	0%
Maximum Out-of-Pocket	\$3,375 / \$6,750	\$6,300 / \$12,600	\$6,300 / \$12,600	\$6,300 / \$12,600
e-Visits	Deductible then Coinsurance	\$25	\$30	\$25
Office Visit Copay (PCP / Specialist)	Deductible then Coinsurance	\$35 / \$70	\$40 / \$80	\$35 / \$70
Urgent Care Copay	Deductible then Coinsurance	\$70	\$80	\$70
Emergency Room Copay	Deductible then Coinsurance	\$450	\$300	\$550
Mental Health Outpatient Copay	Deductible then Coinsurance	\$35	\$40	\$35
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Copay	Deductible then Coinsurance	\$20 / \$75 / \$150 / 45%	\$15 / \$50 / \$100 / 45%	\$20 / \$75 / \$150 / 45%
Dental Coverage Available for an Additional Charge?	No	Yes	Yes	Yes
HSA Eligible?	Yes*	No	No	No
Summary of Benefits of Coverage (SBC) Tracking ID	PS185403504	PS185109704	PS185100804	PS185100904

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Optional Family Dental

Adult Benefits	In-Network	Out-of-Network	Benefit Maximum
Cleanings / X-rays (Class A) Includes exams, X-rays, bitewings, cleanings and fluoride.	100% Coverage	No Coverage	1 Visit per 6 Months
Basic Restorative (Class B) Includes therapeutic pulpotomy, repair / adjustment of dentures and oral surgery procedures such as wisdom tooth or other tooth extractions. Benefit limits may apply to posterior composite fillings.	20% Coinsurance	No Coverage	\$1,000 Benefit Maximum per Year
Major Restorative (Class C) Includes such services as crowns, root canals, apicoectomy, gingivectomy, dentures, implants and occlusal guards.	50% Coinsurance	No Coverage	
Orthodontics	Not Covered	Not Covered	Not Covered

Pediatric (up to age 19) Benefits	In-Network	Out-of-Network	Benefit Maximum
Cleanings / X-rays (Class A) Includes exams, X-rays, bitewings, cleanings, fluoride, sealants and space maintainers.	100% Coverage	No Coverage	1 Visit per 6 Months
Basic Restorative (Class B) Includes therapeutic pulpotomy, repair / adjustment of dentures and oral surgery procedures such as wisdom tooth or other tooth extractions. Benefit limits may apply to posterior composite fillings; age limits may apply to certain procedures.	30% Coinsurance	No Coverage	No Benefit Maximum
Major Restorative (Class C) Includes such services as crowns, root canals, apicoectomy, gingivectomy, dentures, implants and occlusal guards.	50% Coinsurance	No Coverage	No Benefit Maximum
Orthodontics Covered only when medically necessary and a 24-month wait period is satisfied.	50% Coinsurance	No Coverage	No Benefit Maximum

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