

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



(Adams, Crawford, Fond Du Lac, Green Lake, Juneau, Lafayette, Marquette, Richland, Rock, Vernon, Walworth and Waushara Counties)

100 - 150% of Federal Poverty Level

Benefits	Elite Silver Deductible 425*	Elite Silver 75 – Copay \$5 / \$10	Elite Silver 150 – Copay \$10 / \$20	Elite 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	ES185403606	ES185110106	ES185101806	ES185101906

* 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

UH01448 (0519)

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150 - 200% of Federal Poverty Level

Benefits	Elite Silver Deductible 1150*	Elite Silver 375 – Copay \$15 / \$30	Elite Silver 450 – Copay \$20 / \$40	Elite 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	ES185403605	ES185110105	ES185101805	ES185101905

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200 - 250% of Federal Poverty Level

Benefits	Elite Silver HSA 3375*	Elite Silver 3975 – Copay \$35 / \$70	Elite Silver 4950 – Copay \$40 / \$80	Elite 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	ES185403604	ES185110104	ES185101804	ES185101904

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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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