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

(Rock County)

100 – 150% of Federal Poverty Level

Benefits	Beloit One Silver Deductible 425*	Beloit One Silver 75 – Copay $5 / $10	Beloit One Silver 150 – Copay $10 / $20	Beloit One 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	B1S185403706	B1S185110506	B1S185104406	B1S185102406

** 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.

Underwritten by Unity Health Plans Insurance Corporation.

UH01450 (0618)

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

(Rock County)

150 - 200% of Federal Poverty Level

Benefits	Beloit One Silver Deductible 1150*	Beloit One Silver 375 – Copay $15 / $30	Beloit One Silver 450 – Copay $20 / $40	Beloit One 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	B1S185403705	B1S185110505	B1S185104405	B1S185102405

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UH01450 (0618)

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

(Rock County)

200 – 250% of Federal Poverty Level

Benefits	Beloit One Silver HSA 3375*	Beloit One Silver 3975 – Copay $35 / $70	Beloit One Silver 4950 – Copay $40 / $80	Beloit One 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	B1S185403704	B1S185110504	B1S185104404	B1S185102404

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

(Rock County)

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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