2019 Individual & Family Plan Options – Wisconsin
ProHealth on the Elite Network

(Waukesha County)

Gold Plans

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

Benefits	ProHealth Gold HSA 3000*	ProHealth Gold HSA 2000*	ProHealth Gold 2000 – Copay $30 / $70	ProHealth Gold Maintenance – Copay $40 / $90
Deductible (Single / Family)	$3,000 / $6,000	$2,000 / $4,000	$2,000 / $4,000	$1,500 / $3,000
Coinsurance	0%	10%	30%	0%
Maximum Out-of-Pocket	$3,000 / $6,000	$6,650 / $13,300	$7,900 / $15,800	$7,900 / $15,800
e-Visits	Deductible then Coinsurance	Deductible then Coinsurance	$20	$30
Office Visit Copay (PCP / Specialist)	Deductible then Coinsurance	Deductible then Coinsurance	$30 / $70	$40 / $90
Urgent Care Copay	Deductible then Coinsurance	Deductible then Coinsurance	$70	$90
Emergency Room Copay	Deductible then Coinsurance	Deductible then Coinsurance	$250	$500
Mental Health Outpatient Copay	Deductible then Coinsurance	Deductible then Coinsurance	$30	$40
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance	$2,500 per diem IP / Ded & Coins
Pharmacy Copay	Deductible then Coinsurance	Deductible then Coinsurance	$10 / $40 / $80 / 45%	$10 / $75 / $150 / $450
Dental Coverage Available for an Additional Charge?	No	No	Yes	Yes
HSA Eligible?	Yes*	Yes*	No	No
Summary of Benefits of Coverage (SBC) Tracking ID	PHG185405100	PHG185401500	PHG185110800	PHG185109400

** 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 $7,900.*

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.

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2019 Individual & Family Plan Options – Wisconsin
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(Waukesha County)

Silver Plans

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

Benefits	ProHealth Silver HSA 5250*	ProHealth Silver 4000 – Copay $45 / $90	ProHealth Silver 5000 – Copay $50 / $100	ProHealth Silver 7900 – Copay $80 / $160
Deductible (Single / Family)	$5,250 / $10,500	$4,000 / $8,000	$5,000 / $10,000	$7,900 / $15,800
Coinsurance	0%	40%	50%	0%
Maximum Out-of-Pocket	$5,250 / $10,500	$7,900 / $15,800	$7,900 / $15,800	$7,900 / $15,800
e-Visits	Deductible then Coinsurance	$30	$30	$30
Office Visit Copay (PCP / Specialist)	Deductible then Coinsurance	$45 / $90	$50 / $100	$80 / $160
Urgent Care Copay	Deductible then Coinsurance	$90	$100	$160
Emergency Room Copay	Deductible then Coinsurance	$450	$500	$700
Mental Health Outpatient Copay	Deductible then Coinsurance	$45	$50	$80
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%	$20 / $75 / $150 / 45%	$35 / $150 / $250 / 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	PHS185406000	PHS185112900	PHS185113000	PHS185113100

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(Waukesha County)

Bronze Plans

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

Benefits	ProHealth Bronze HSA 6750*	ProHealth Bronze 7500 – Copay $80 / $160	ProHealth Bronze 7900 – Copay $50 / $100
Deductible (Single / Family)	$6,750 / $13,500	$7,500 / $15,000	$7,900 / $15,800
Coinsurance	0%	50%	0%
Maximum Out-of-Pocket	$6,750 / $13,500	$7,900 / $15,800	$7,900 / $15,800
e-Visits	Deductible then Coinsurance	$30	$30
Office Visit Copay (PCP / Specialist)	Deductible then Coinsurance	$80 / $160	$50 / $100
Urgent Care Copay	Deductible then Coinsurance	$160	Deductible then Coinsurance
Emergency Room Copay	Deductible then Coinsurance	$800	Deductible then Coinsurance
Mental Health Outpatient Copay	Deductible then Coinsurance	$80	$50
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance	Deductible then Coinsurance	Deductible then Coinsurance
Pharmacy Copay	Deductible then Coinsurance	$35 / $150 / $250 / 45%	Deductible then Coinsurance
Dental Coverage Available for an Additional Charge?	No	Yes	Yes
HSA Eligible?	Yes*	No	No
Summary of Benefits of Coverage (SBC) Tracking ID	PHB185401900	PHB185111000	PHB185111100

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(Waukesha County)

Catastrophic Plans

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

Benefits	ProHealth Catastrophic
Deductible (Single / Family)	$7,900 / $15,800
Coinsurance	0%
Maximum Out-of-Pocket	$7,900 / $15,800
e-Visits	Deductible then Coinsurance
Office Visit Copay (PCP / Specialist)	$0** / Deductible then Coinsurance
Urgent Care Copay	Deductible then Coinsurance
Emergency Room Copay	Deductible then Coinsurance
Mental Health Outpatient Copay	Deductible then Coinsurance
Hospital Copay (Inpatient / Outpatient)	Deductible then Coinsurance
Pharmacy Copay	Deductible then Coinsurance
Dental Coverage Available for an Additional Charge?	No
HSA Eligible?	No
Summary of Benefits of Coverage (SBC) Tracking ID	PHC185402100

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

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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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