The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact ETF at [www.etf.wi.gov](http://www.etf.wi.gov).

For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other terms see the Glossary. You can view the Glossary at [https://www.healthcare.gov/glossary/essential-health-benefits/](https://www.healthcare.gov/glossary/essential-health-benefits/) or call 1-877-533-5020 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$ 1,500 Individual / $3,000 Family Combined medical and prescription drug deductible.</td>
<td>You must pay all the costs up to the deductible amount before the policy begins to pay for covered services you use, with the exception of federally required preventive services. The deductible starts over with each plan year beginning January 1st. For family coverage, the full family deductible must be met. See the chart starting on page 2 for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care and primary care services are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No</td>
<td>There are no other deductibles.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$2,500 Individual / $5,000 Family Combined medical and prescription drug out-of-pocket limit.</td>
<td>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. The federal maximum out-of-pocket is $8,150 person/$16,300 family. This applies to all essential health benefits. See <a href="https://www.healthcare.gov/glossary/essential-healthbenefits/">https://www.healthcare.gov/glossary/essential-healthbenefits/</a> for details.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Coinsurance paid by adults for hearing aids, premiums and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.ChooseQuartz.com">www.ChooseQuartz.com</a> or call 1-844-644-3455 for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a <strong>referral</strong> to see a <strong>specialist</strong>?</td>
<td>No, you don’t need a <strong>referral</strong> to see a <strong>specialist</strong></td>
<td>You can see the <strong>specialist</strong> you choose without permission from the health plan. However, you should get a <strong>referral</strong> to an orthopedist or neurosurgeon for low back pain.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.etf.wi.gov](http://www.etf.wi.gov)
## All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least): $15 copay/visit after deductible</td>
<td>Out-of-Network Provider (You will pay the most): Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$25 copay/visit after deductible</td>
<td>Not covered unless prior authorized</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$15 copay/visit after deductible (includes chiropractic visits)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>After deductible $15 primary care visit copay and 10% coinsurance for related services.</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have a test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Level 1: Preferred generic drugs and certain lower cost preferred brand name drugs</td>
<td>In-network covers most up to a 30-day supply (90-day for certain prescriptions) retail and mail order. Out-of-network care allowed but if your ID card is not used, you will pay more than the copay. Full coverage if required by federal law.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Level 2: Preferred brand drugs and certain higher cost preferred generic drugs</td>
<td>In-network covers most up to a 30-day supply (90-day for certain prescriptions) retail and mail order. Out-of-network care allowed but if your ID card is not used, you will pay more than the copay. Full coverage if required by federal law.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Level 3: Non-preferred brand name and certain high cost</td>
<td>Federal out-of-pocket limit applies. Out-of-network care allowed, but if your ID card is not</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td><strong>generic drugs</strong></td>
<td></td>
<td>after deductible.</td>
<td>Used, you will pay more than the copay. Full coverage if required by federal law.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Member must pay the cost difference between the non-preferred brand drug and the preferred generic equivalent drug if not medically necessary.</td>
<td></td>
</tr>
<tr>
<td><strong>Level 4: Specialty drugs at preferred specialty pharmacy provider</strong></td>
<td></td>
<td>$50 copay per prescription after deductible for preferred drugs</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>40% coinsurance ($200 max) per prescription after deductible for non-preferred drugs</td>
<td></td>
</tr>
<tr>
<td><strong>Level 4: Specialty drugs at non-participating pharmacy provider</strong></td>
<td></td>
<td>40% coinsurance ($200 max) per prescription after deductible for preferred and non-preferred drugs</td>
<td></td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$15 copay for primary doctor office visit after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$25 copay for specialist office visit after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency room care</td>
<td>$75 copay after deductible</td>
<td>Copay is waived if admitted.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical</td>
<td>10% coinsurance after</td>
<td>---------------NONE---------------</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.etf.wi.gov](http://www.etf.wi.gov)
<table>
<thead>
<tr>
<th>Common Medical Event</th>
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<th>Limitations, Exceptions, &amp; Other Important Information</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>deductible</td>
<td>deductible</td>
</tr>
<tr>
<td>transportation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td></td>
<td>$25 copay/visit after deductible</td>
<td>$25 copay/visit after deductible</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$15 copay/visit after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>10% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$15 copay/visit after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>10% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$15 copay/visit after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$15 copay/visit after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$15 copay/visit after deductible</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>10% coinsurance after deductible</td>
<td>Not covered</td>
<td>Facility coverage is limited to 120 days per benefit period.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% coinsurance after deductible (child’s hearing aids 10%)</td>
<td>Not covered</td>
<td>Hearing aids (adults) plan maximum payment $1,000 per ear every 3 years.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>10% coinsurance after deductible</td>
<td>Not covered</td>
<td>---------------------- NONE ----------------------</td>
</tr>
</tbody>
</table>

If your child needs dental or eye care

| Children’s eye exam | $25 copay after deductible | Not covered | Limited to one per individual per year. Contact lens fitting not covered. Full coverage if required by federal law. |
| Children’s glasses | Not covered | Not covered | Excluded service. |
| Children’s dental check-up | Not covered | Not covered | Excluded service. |

Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Dental Cleanings
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside US
- Private duty nursing
- Routine foot care

**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)**

- Bariatric surgery and weight loss services for participants with a body mass index of 35 or greater
- Hearing aids
- Telemedicine
- Telehealth
- Dental care, limited to certain oral surgical services and treatment of injuries
- Routine eye care, limited to one eye exam per calendar year by a plan provider
- E-visit services
- Chiropractic care

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Kate Salveson at Quartz Health Benefit Plans Corporation at 1-844-644-3455, TTY 711 / 1-800-877-8973 or ETF at 1-877-533-5020 or www.etf.wi.gov.

* For more information about limitations and exceptions, see the plan or policy document at www.etf.wi.gov
Does this plan provide Minimum Essential Coverage? Yes
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-644-3455, TTY 711 / 1-800-877-8973.


注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-644-3455, TTY 711 / 1-800-877-8973.


ЧУ й: Нёу бьен ной Тиён Вьет, ко ц́ачь вьют то тро нёгь мёйн фи дхань cho bàn. Gọi số 1-844-644-3455, TTY 711 / 1-800-877-8973.


โปรดทราบ: ชู้อุ่น ทมansion ภาษา ทม. ทมบุกิวิทยาธุรกิจหลักภาษา, ไยเยี่ยงวิช, ประเมินใหม่มาใช้ต่ําส่ง. ได้ 1-844-644-3455, TTY 711 / 1-800-877-8973.

ATTENTION : Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-844-644-3455, TTY 711 / 1-800-877-8973.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-644-3455, TTY 711 / 1-800-877-8973.

* For more information about limitations and exceptions, see the plan or policy document at www.etf.wi.gov
For more information about limitations and exceptions, see the plan or policy document at www.etf.wi.gov

*For more information about limitations and exceptions, see the plan or policy document at www.etf.wi.gov*
About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
<tr>
<td>- The plan’s overall deductible $1500</td>
<td>- The plan’s overall deductible $1500</td>
<td>- The plan’s overall deductible $1500</td>
</tr>
<tr>
<td>- Specialist copayment $25</td>
<td>- Specialist copayment $25</td>
<td>- Specialist copayment $25</td>
</tr>
<tr>
<td>- Hospital (facility) coinsurance 10%</td>
<td>- Hospital (facility) coinsurance 10%</td>
<td>- Hospital (facility) coinsurance 10%</td>
</tr>
<tr>
<td>- Other coinsurance 10%</td>
<td>- Other coinsurance 10%</td>
<td>- Other coinsurance 10%</td>
</tr>
<tr>
<td><strong>This EXAMPLE event includes services like:</strong></td>
<td><strong>This EXAMPLE event includes services like:</strong></td>
<td><strong>This EXAMPLE event includes services like:</strong></td>
</tr>
<tr>
<td>Specialist office visits (prenatal care)</td>
<td>Primary care physician office visits (including disease education)</td>
<td>Emergency room care (including medical supplies)</td>
</tr>
<tr>
<td>Childbirth/Delivery Professional Services</td>
<td>Diagnostic tests (blood work)</td>
<td>Diagnostic test (x-ray)</td>
</tr>
<tr>
<td>Childbirth/Delivery Facility Services</td>
<td>Prescription drugs</td>
<td>Durable medical equipment (crutches)</td>
</tr>
<tr>
<td>Diagnostic tests (ultrasounds and blood work)</td>
<td>Durable medical equipment (glucose meter)</td>
<td>Rehabilitation services (physical therapy)</td>
</tr>
<tr>
<td>Specialist visit (anesthesia)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Example Cost** $12,731

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$30</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

**What isn’t covered**

<table>
<thead>
<tr>
<th>Limits or exclusions</th>
<th>$10</th>
</tr>
</thead>
</table>

**The total Peg would pay** $2,540

**Total Example Cost** $7,389

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$800</td>
</tr>
</tbody>
</table>

**What isn’t covered**

<table>
<thead>
<tr>
<th>Limits or exclusions</th>
<th>$0</th>
</tr>
</thead>
</table>

**The total Joe would pay** $2,500

**Total Example Cost** $1,925

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$60</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$10</td>
</tr>
</tbody>
</table>

**What isn’t covered**

<table>
<thead>
<tr>
<th>Limits or exclusions</th>
<th>$0</th>
</tr>
</thead>
</table>

**The total Mia would pay** $1,570

The plan would be responsible for the other costs of these EXAMPLE covered services.