


Offered by Quartz Health Benefit Plans Corporation



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/> or call 1-877-533-5020 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$ 1,500 Individual / \$3,000 Family Combined medical and prescription drug <a href="#">deductible</a> .	You must pay all the costs up to the <a href="#">deductible</a> 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 1 <sup>st</sup> . 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.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan covers some items and services even if you haven't yet met the deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	There are no other <a href="#">deductibles</a> .
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$2,500 Individual / \$5,000 Family Combined medical and prescription drug <a href="#">out-of-pocket limit</a> .	The <a href="#">out-of-pocket limit</a> 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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Coinsurance</a> paid by adults for hearing aids, <a href="#">premiums</a> and health <b>care this plan doesn't cover.</b>	<b>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</b>
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.ChooseQuartz.com">www.ChooseQuartz.com</a> or call 1-844-644-3455 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider in the plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider for the difference between the provider's charge and what your plan pays (balance billing)</a> . Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	<b>No, you don't need a referral</b> to see a <a href="#">specialist</a>	You can see the <a href="#">specialist</a> you choose without permission from the health plan. However, you should get a <a href="#">referral</a> to an orthopedist or neurosurgeon for low back pain.
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 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$15 <a href="#">copay</a> /visit after <a href="#">deductible</a>	Not covered	Additional services (e.g. labs, x-rays, etc.) during the visit are subject to applicable <a href="#">coinsurance</a> .
	<a href="#">Specialist</a> visit	\$25 <a href="#">copay</a> /visit after <a href="#">deductible</a>	Not covered unless prior authorized	Additional services (e.g. labs, x-rays, etc.) during the visit are subject to applicable <a href="#">coinsurance</a> .
	Other practitioner office visit	\$15 <a href="#">copay</a> /visit after <a href="#">deductible</a> (includes chiropractic visits)	Not covered	Maintenance care and acupuncture not covered. Additional services (e.g. labs, x-rays, etc.) during the visit are subject to applicable <a href="#">coinsurance</a> .
	<a href="#">Preventive care/screening/immunization</a>	After <a href="#">deductible</a> \$15 primary care visit <a href="#">copay</a> and 10% <a href="#">coinsurance</a> for related services.	Not covered	Full coverage if required by federal law. For details, visit: <a href="https://www.healthcare.gov/preventive-care-benefits/">https://www.healthcare.gov/preventive-care-benefits/</a>
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	Full coverage if required by federal law.
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	Prior approval required or benefits not payable.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.navitus.com">www.navitus.com</a>	Level 1: Preferred generic drugs and certain lower cost preferred brand name drugs	\$5/prescription after deductible. (2 <a href="#">copays</a> apply to certain 90-day supply mail orders)	Not covered	<a href="#">In-network</a> covers most up to a 30-day supply (90-day for certain prescriptions) retail and mail order. <a href="#">Out-of-network</a> care allowed but if your ID card is not used, you will pay more than the copay. Full coverage if required by federal law.
	Level 2: <a href="#">Preferred</a> brand drugs and certain higher cost preferred generic drugs	20% <a href="#">coinsurance</a> (\$50 max) per prescription after <a href="#">deductible</a> (2 <a href="#">copays</a> apply to certain 90-day supply mail order)	Not covered	<a href="#">In-network</a> covers most up to a 30-day supply (90-day for certain prescriptions) retail and mail order. <a href="#">Out-of-network</a> care allowed but if your ID card is not used, you will pay more than the copay. Full coverage if required by federal law.
	Level 3: <a href="#">Non-preferred</a> brand name and certain high cost	40% <a href="#">coinsurance</a> (\$150 max) per prescription	Not covered	Federal <a href="#">out-of-pocket limit</a> applies. <a href="#">Out-of-network</a> care allowed, but if your ID card is not

\* For more information about limitations and exceptions, see the plan or policy document at [www.etf.wi.gov](http://www.etf.wi.gov)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	generic drugs	after deductible. Member must pay the cost difference between the non-preferred brand drug and the preferred generic equivalent drug if not medically necessary.		used, you will pay more than the copay. Full coverage if required by federal law.
	Level 4: Specialty drugs at preferred specialty pharmacy provider	\$50 copay per prescription after deductible for preferred drugs  40% coinsurance (\$200 max) per prescription after deductible for non-preferred drugs	Not covered	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.
	Level 4: Specialty drugs at non-participating pharmacy provider	40% coinsurance (\$200 max) per prescription after deductible for preferred and non-preferred drugs		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	Not covered	----- NONE -----
	Physician/surgeon fees	\$15 copay for primary doctor office visit after deductible  \$25 copay for specialist office visit after deductible	Not covered	Additional services provided (e.g. costs of surgery, equipment, etc.) are subject to applicable deductible and coinsurance. Prior approval required for low back surgeries and MRI, CT and PET scans.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$75 copay after deductible	\$75 copay after deductible	Copay is waived if admitted.
	<a href="#">Emergency medical</a>	10% coinsurance after	10% coinsurance after	-----NONE-----

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">transportation</a>	deductible	deductible	
	<a href="#">Urgent care</a>	\$25 copay/visit after deductible	\$25 copay/visit after deductible	Additional services (e.g. labs, x-rays, etc.) during the visit are subject to applicable deductibles and coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	Not covered	Prior approval recommended
	Physician/surgeon fees	10% coinsurance after deductible	Not covered	Prior approval required for low back surgeries and MRI, CT and PET scans
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	\$15 copay/visit after deductible	Not covered	-----NONE-----
	Mental/Behavioral health inpatient services	10% coinsurance after deductible	Not covered	-----NONE-----
	Substance use disorder outpatient services	\$15 copay/visit after deductible	Not covered	-----NONE-----
	Substance use disorder inpatient services	10% coinsurance after deductible	Not covered	-----NONE-----
If you are pregnant	Office visits	\$15 copay/visit after deductible	Not covered	Deductible and 10% coinsurance apply if prenatal and/or postnatal care billed as a package. Full coverage if required by federal law.
	Childbirth/delivery professional services	10% coinsurance after deductible	Not covered	-----NONE-----
	Childbirth/delivery facility services	10% coinsurance after deductible	Not covered	-----NONE-----
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% coinsurance after deductible	Not covered	Limited to 50 visits per year. Plan may approve 50 more per year.
	<a href="#">Rehabilitation services</a>	\$15 copay/visit after deductible	Not covered	Physical, speech and occupational therapy limited to 50 visits per year, combined rehabilitation and habilitation services. Plan may approve 50 more per year.
	<a href="#">Habilitation services</a>	\$15 copay/visit after deductible	Not covered	Physical, speech and occupational therapy limited to 50 visits per year, combined rehabilitation and habilitation services. Plan may approve 50 more per year.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Skilled nursing care</a>	10% <b>coinsurance</b> after <b>deductible</b>	Not covered	Facility coverage is limited to 120 days per benefit period.
	<a href="#">Durable medical equipment</a>	20% <b>coinsurance</b> after <b>deductible</b> ( <b>child's</b> hearing aids 10%)	Not covered	Hearing aids (adults) plan maximum payment \$1,000 per ear every 3 years.
	<a href="#">Hospice services</a>	10% <b>coinsurance</b> after <b>deductible</b>	Not covered	-----NONE-----
If your child needs dental or eye care	<b>Children's eye exam</b>	\$25 <b>copay</b> after <b>deductible</b>	Not covered	Limited to one per individual per year. Contact lens fitting not covered. Full coverage if required by federal law.
	<b>Children's glasses</b>	Not covered	Not covered	Excluded service.
	<b>Children's dental check-up</b>	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](#).)

- |   |   |   |
|---|---|---|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental Cleanings</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside US</li> </ul> | <ul style="list-style-type: none"> <li>• Private duty nursing</li> <li>• Routine foot care</li> </ul> |
|---|---|---|

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

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Bariatric surgery and weight loss services for participants with a body mass index of 35 or greater</li> <li>• Vaccines at in-network retail pharmacies</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Telemedicine</li> <li>• Telehealth</li> <li>• Dental care, limited to certain oral surgical services and treatment of injuries</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care, limited to one eye exam per calendar year by a plan provider</li> <li>• E-visit services</li> <li>• Chiropractic care</li> </ul> |
|---|--|---|

**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](http://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](http://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](http://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 Salvesson 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](http://www.etf.wi.gov).

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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.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 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.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-644-3455, TTY 711 / 1-800-877-8973.

لهجوة: إذا التفتت حديثاً لكرال غة ف إن خدم انتل مس اعداة لغوة 1-5543-446-448-1 telephone # (قم  
هتف لل ص مو الهاتف مت وف ل ر ل ا ب ا ل م ج ان تباص له ب رقم: 1-3798-778-008-1). (TTY #

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-644-3455, TTY 711 / 1-800-877-8973.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-644-3455, TTY 711 / 1-800-877-8973 번으로 전화해 주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-644-3455, TTY 711 / 1-800-877-8973.

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: 1-844-644-3455, TTY 711 / 1-800-877-8973.

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີຮ່ວມໃຫ້ທ່ານ. ໂທສ 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](http://www.etf.wi.gov)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-644-3455, TTY 711 / 1-800-877-8973 पर कॉल करें।

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-844-644-3455, TTY 711 / 1-800-877-8973.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-644-3455, TTY 711 / 1-800-877-8973.

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next section.* —————



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.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$1500
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:  
Specialist office visits (*prenatal care*)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

Total Example Cost	\$12,731
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$30
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Peg would pay is	\$2,540

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$1500
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:  
Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,389
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$200
Coinsurance	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2,500

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1500
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:  
Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,925
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$60
Coinsurance	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,570