

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

This health plan is offered by Quartz Health Benefit Plans Corporation



9030372 - QUARTZ ONE WITH AURORA HEALTH
CARE GOLD I401

Coverage Period: 1/1/2022 - 12/31/2022

Coverage for: Single/Family | Plan Type: HMO



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, visit www.QuartzBenefits.com/certlookup. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-800-362-3310 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall deductible ? | Single: \$2,000 per Benefit Year Family: \$2,000 /individual or \$4,000 /family per Benefit Year | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible ? | Yes. Preventive care services are covered before you meet your deductible . | 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 https://www.healthcare.gov/coverage/preventive-care-benefits . |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | Single: \$7,000 per Benefit Year Family: \$7,000 /individual or \$14,000 /family per Benefit Year | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit ? | Premiums , balance billing charges, dental coinsurance , and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Will you pay less if | Yes. | This plan uses a provider network . You will pay less if you use a provider in |

| | | |
|---|---|---|
| <p>you use a network provider?</p> | <p>See www.QuartzBenefits.com/FindADoctor or call 1-800-362-3310 for a list of network providers.</p> | <p>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.</p> |
| <p>Do you need a referral to see a specialist?</p> | <p>In-Network providers: No. Out-of-Network providers: Yes, written referral is required.</p> | <p>In-Network: You can see the specialist you choose without a referral. Out-of-Network: This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.</p> |



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 |
|--|---|--|--|---|
| | | In Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| <p>If you visit a health care provider's office or clinic</p> | <p>Primary care visit to treat an injury or illness</p> | <p>\$35 copay/visit; deductible does not apply</p> | <p>Not covered</p> | <p>Virtual Visits and Telehealth Visits are covered at no charge. Deductible and/or coinsurance may apply for additional services performed at your visit.</p> |
| | <p>Specialist visit</p> | <p>\$70 copay/visit; deductible does not apply</p> | <p>Not covered</p> | <p>A covered Telehealth visit applies the same cost-sharing as an in-person visit. Deductible and/or coinsurance may apply for additional services performed at your visit.</p> |
| | <p>Other practitioner office visit</p> | <p>Chiro/Non-Routine Adult Vision: \$35 copay/visit; deductible does not apply</p> | <p>Not covered</p> | <p>Benefits are not available for care that is Maintenance and Supportive Care. Routine Adult Vision exams are not covered. Glasses/contacts for Adult Routine Vision are not covered. Deductible and/or coinsurance may apply for additional services performed at your visit.</p> |
| | <p>Preventive care/screening/immunization</p> | <p>No charge; deductible does not apply</p> | <p>Not covered</p> | <p>Coverage is limited to preventive services as defined by the Affordable Care Act. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</p> |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|---|---|--|
| | | In Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| If you have a test | Diagnostic test (x-ray, blood work) | 30% coinsurance | Not covered | -----none----- |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | Not covered | -----none----- |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.QuartzBenefits.com/formulary | Preferred Generics Tier 1 | \$10 copay /prescription | Not covered | Multiple copays will apply for claims of greater than 30 day supply when covered; for claims of 31 to 60 days supply, two copays will apply, and for claims of 61 to 90 days supply, three copays will apply. Coverage restrictions may apply to some medications. See the Quartz Formulary for details |
| | Preferred Brands Tier 2 | \$40 copay /prescription | Not covered | |
| | Non-Preferred Brands & Generics Tier 3 | 50% coinsurance | Not covered | |
| | Tier 4 | 50% coinsurance | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | Not covered | Prior authorization may be required. See www.QuartzBenefits.com/WIPAList or call Customer Service for additional information. Oral Surgery: Not covered |
| | Physician/surgeon fees | 30% coinsurance | Not covered | |
| If you need immediate medical attention | Emergency room care | \$250 copay /visit; deductible does not apply | \$250 copay /visit; deductible does not apply | Emergency room copay waived if admitted. |
| | Emergency medical transportation | 30% coinsurance | 30% coinsurance | -----none----- |
| | Urgent care | \$70 copay /visit; deductible does not apply | \$70 copay /visit; deductible does not apply | Deductible and/or coinsurance may apply for additional services performed at your visit. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 30% coinsurance | Not covered | Prior authorization is required. See www.QuartzBenefits.com/WIPAList or call Customer Service for additional information. |
| | Physician/surgeon fees | 30% coinsurance | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|---|--|---|
| | | In Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$35 copay /visit; deductible does not apply | Not covered | Benefits are not available for care that is Maintenance and Supportive Care. Virtual Visits and Telehealth Visits are covered at no charge. Deductible and/or coinsurance may apply for additional services performed at your visit. Prior authorization is required. See www.QuartzBenefits.com/WIPAList or call Customer Service for additional information. |
| | Inpatient services | 30% coinsurance | Not covered | |
| If you are pregnant | Office visits | PCP: \$35 copay /visit Specialist : \$70 copay /visit; deductible does not apply | Not covered | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Prior authorization is required for inpatient services. See www.QuartzBenefits.com/WIPAList or call Customer Service for additional information. Deductible and/or coinsurance may apply for additional services performed at your visit. |
| | Childbirth/delivery professional services | 30% coinsurance | Not covered | |
| | Childbirth/delivery facility services | 30% coinsurance | Not covered | |
| If you need help recovering or have other special health | Home health care | 30% coinsurance | Not covered | Coverage is limited to 60 visits per Benefit Year. Prior authorization is required. See www.QuartzBenefits.com/WIPAList or call Customer Service for additional information. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|----------------------|---|-------------------------------------|--|---|
| | | In Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| needs | Rehabilitation services | 30% coinsurance | Not covered | Coverage is limited to 20 visits each for Physical, Speech and Occupational therapy and Pulmonary Rehab per Benefit Year. Cardiac Rehab is limited to 36 visits per Benefit Year. Inpatient Rehab is limited to 60 days per Benefit Year. Post Cochlear Implant Aural Therapy is limited to 30 visits per Benefit Year. A covered Telehealth visit applies the same cost-sharing as an in-person visit. |
| | Habilitation services | 30% coinsurance | Not covered | Coverage is limited to 20 visits each for Physical, Speech and Occupational therapy per Benefit Year. Prior authorization may be required. See www.QuartzBenefits.com/WIPAList or call Customer Service for additional information. A covered Telehealth visit applies the same cost-sharing as an in-person visit. |
| | Skilled nursing care | 30% coinsurance | Not covered | Coverage limited to 30 days per confinement. This benefit is combined with the Swing Bed Care benefit. Prior authorization is required. See www.QuartzBenefits.com/WIPAList or call Customer Service for additional information. |
| | Durable medical equipment | 30% coinsurance | Not covered | Purchase of DME with a per unit cost of \$500 or more (except for hearing aids) and all DME rentals must be Prior Authorized. Coverage for -- Hearing Aids: Limited to one per ear every 36 months. To obtain the list of covered hearing aid models log onto www.QuartzBenefits.com/hearingaids or contact Customer Service. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------------|--|--|--|
| | | In Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| | Hospice services | 30% coinsurance | Not covered | Prior authorization is required. See www.QuartzBenefits.com/WIPAList or call Customer Service for additional information. Hospice coverage excludes room and board charges in a Skilled Nursing Facility. |
| If your child needs dental or eye care | Children's eye exam | No charge; deductible does not apply | Not covered | Limited to one exam per Benefit Year. |
| | Children's glasses | 30% coinsurance | Not covered | Limited to one pair of glasses per Benefit Year. |
| | Children's dental check-up | Not covered | Not covered | -----none----- |

Excluded Services & Other Covered Services:

| Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.) | | |
|--|--|---|
| <ul style="list-style-type: none"> • Abortions (except in cases of rape, incest or when the life of the mother is endangered) • Acupuncture • Bariatric surgery • Cosmetic surgery | <ul style="list-style-type: none"> • Dental care (Adult) • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Private-duty nursing • Routine eye care (Adult) • Routine foot care • Weight loss programs |

| Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.) | |
|---|--|
| <ul style="list-style-type: none"> • Chiropractic care | <ul style="list-style-type: none"> • Hearing aids |

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: Office of the Commissioner of Insurance, Complaints Department, PO Box 7873, Madison, WI 53707-7873, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa, or visit www.HealthCare.gov or call 1-800-318-2596. 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 on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or for assistance, contact: Office of the Commissioner of Insurance, Complaints Department, PO Box 7873, Madison, WI 53707-7873, or if coverage is under a group health [plan](#) the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Does this Plan Provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium](#) tax credit.

Does this Coverage Meet the Minimum Value Standard? Not Applicable

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-362-3310 or 1-800-877-8973 (TTY).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-362-3310 or 1-800-877-8973 (TTY)

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-362-3310 or 1-800-877-8973 (TTY)

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-362-3310 or 1-800-877-8973 (TTY)

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

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 | \$2,000 |
| ■ Specialist copayment | \$70 |
| ■ Hospital (facility) coinsurance | 30% |
| ■ Other coinsurance | 30% |
| This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>) | |
| Total Example Cost | \$12,700 |
| In this example, Peg would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$2,000 |
| Copayments | \$100 |
| Coinsurance | \$2,400 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$4,500 |

| Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition) | |
|--|----------------|
| ■ The plan's overall deductible | \$2,000 |
| ■ Specialist copayment | \$70 |
| ■ Hospital (facility) coinsurance | 30% |
| ■ Other coinsurance | 30% |
| This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>) | |
| Total Example Cost | \$5,600 |
| In this example, Joe would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$100 |
| Copayments | \$1,300 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$1,400 |

| Mia's Simple Fracture (in-network emergency room visit and follow up care) | |
|--|----------------|
| ■ The plan's overall deductible | \$2,000 |
| ■ Specialist copayment | \$70 |
| ■ Hospital (facility) coinsurance | 30% |
| ■ Other coinsurance | 30% |
| This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>) | |
| Total Example Cost | \$2,800 |
| In this example, Mia would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$1,700 |
| Copayments | \$400 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,100 |

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



Non-Discrimination & Language Access

Quartz is the brand name for a group of companies committed to your health: Quartz Health Benefit Plans Corporation, Quartz Health Insurance Corporation, Quartz Health Plan Corporation, and Quartz Health Plan MN Corporation. These companies are separate legal entities. In this notice, “we” refers to all Quartz companies.

For assistance understanding these materials in a language other than English, call (800) 362-3310, and a Customer Success representative will assist you. TTY users should call 711 or (800) 877-8973.

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex, including sexual orientation and gender identity.

We provide free aids and services to people with disabilities to communicate effectively with us, such as –

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

For help to translate or understand this, please call (800) 362-3310, TTY: 711 / (800) 877-8973.

Spanish – Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Quartz. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Hmong – Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm Quartz. Saib cov caij nyooog los yog tej hnuv tseem ceeb uas sau rau hauv daim ntawv no kom zoo. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyooog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

We provide free language services to people whose primary language is not English, such as –

- Qualified interpreter
- Information written in other languages

If you need these services, contact Customer Success at (800) 362-3310.

If you believe we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sexual orientation and gender identity, you can file a grievance with –

Kristie Breunig, Compliance Officer
2650 Novation Parkway
Madison, WI 53713
Phone: (800) 362-3310
TTY: 711 or toll-free (800) 877-8973
Fax: (608) 644-3500
Email: AppealsSpecialists@QuartzBenefits.com

Vietnamese – Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình Quartz. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Chinese – 本通知含有重要的訊息 本通知對於您透過 Quartz 所提出的申請或保險有重要的訊息 請在本通知中查看重要的日期 您可能要在特定的截止日期之前採取行動，以保留您的健康保險或有助於省錢 您有權利免費以您的母語得到幫助和訊息 請致電 (800) 362-3310 : 711 / (800) 877-8973.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Kristie Breunig, Compliance Officer, is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019; (800) 537-7697 (TDD)

Complaint forms are available at hhs.gov/ocr/office/file/index.html

Quartz is a Qualified Health Plan issuer in the Health Insurance Marketplace in certain states. To learn more, visit the Health Insurance Marketplace at HealthCare.gov.

Russian – Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Quartz. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Laotian – ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນທີ່ສໍາຄັນ. ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນທີ່ສໍາຄັນກ່ຽວກັບໃບສະຫມັກ ຫຼື ການຄຸ້ມຄອງຂອງທ່ານຜ່ານ Quartz. ຄຸກຫວັງທີ່ສໍາຄັນໃນຫນັງສືແຈ້ງການສະບັບນີ້. ທ່ານອາດຈຳເປັນຕ້ອງປະຕິບັດຕາມເວລາທີ່ກຳນົດໄວ້ທີ່ແນ່ນອນເພື່ອຮັກສາໄວ້ການຄຸ້ມຄອງສະຖາບັນຂອງທ່ານ ຫຼື ຄ່ອຍເຫຼືອດ້ານຄ່າໃຊ້ຈ່າຍ. ທ່ານມີສິດທີ່ຈະໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຄ່ອຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີ (800) 362 3310. TTY / TDD: 711 / (800) 877 8973.

