

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



9032512 - QUARTZ ONE ACHIEVE W/UW HEALTH SILVER
STANDARD EASY PRICING CSR 87

Coverage Period: 1/1/2026 - 12/31/2026
Coverage for: Individual/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 Customer Success: 1-800-362-3310 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	Individual: \$700 per Benefit Year Family: \$700 /individual or \$1,400 /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 . 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 services covered before you meet your deductible ?	Yes. Preventive care services are covered before you meet your deductible .	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	Individual: \$3,300 per Benefit Year Family: \$3,300 /individual or \$6,600 /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 , cost-sharing assistance for certain brand drugs, and health care this plan doesn't	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

	cover.	
Will you pay less if you use a network provider ?	Yes. See www.QuartzBenefits.com/FindADoc or call 1-800-362-3310 for a list of network providers .	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.
Do you need a referral to see a specialist ?	In- Network providers : No. Out-of- Network providers : Yes, written referral is required.	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 .



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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay /visit; deductible does not apply	Not covered	Virtual Visits are covered with a \$20 copay ; deductible does not apply. 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.
	Specialist visit	\$40 copay /visit; deductible does not apply	Not covered	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.
	Other practitioner office visit	Chiro/Non-Routine Adult Vision: \$20 copay /visit; deductible does not apply	Not covered	Benefits are not available for care that is Maintenance and Supportive Care. Routine Adult Vision exams are not covered. Deductible and/or coinsurance may apply for additional services performed at your visit.

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)	
	Preventive care/screening/immunization	No charge; deductible does not apply	Not covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not covered	Prior authorization may be required. See www.QuartzBenefits.com/WIPAList or call (800) 362-3310 for additional information.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	-----none-----
	Low Cost Generic	\$10 copay /prescription; deductible does not apply	Not covered	Preventive medications are covered without member cost sharing as specified on the formulary .
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.QuartzBenefits.com/formulary	Generic Tier 1	\$10 copay /prescription; deductible does not apply	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.
	Preferred Brand Tier 2	\$20 copay /prescription; deductible does not apply	Not covered	Coverage restrictions may apply to some medications. See the Quartz Formulary for details; the formulary is subject to change following quarterly Pharmacy & Therapeutics Committee meetings, or following updates to drug availability (e.g., new generic drugs).
	Non-Preferred Brand & Generic Tier 3	\$60 copay /prescription	Not covered	Manufacturer-funded cost-sharing assistance for your prescriptions will be credited to your Annual Deductible or Annual Maximum Out-of-Pocket Limit.
	Specialty Tier 4	\$250 copay /prescription	Not covered	
	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	Prior authorization may be required. See www.QuartzBenefits.com/WIPAList or call (800) 362-3310 for additional information.
If you have outpatient surgery	Physician/surgeon fees	30% coinsurance	Not covered	Oral Surgery: Not covered
	Emergency room care	30% coinsurance	30% coinsurance	Foreign claims for emergency care are subject to

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)	
immediate medical attention				a \$20,000 limit per Benefit Year.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Foreign claims for emergency care are subject to a \$20,000 limit per Benefit Year.
	Urgent care	\$30 copay /visit; deductible does not apply	\$30 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 (800) 362-3310 for additional information.
	Physician/surgeon fees	30% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 copay /visit; deductible does not apply	Not covered	Benefits are not available for care that is Maintenance and Supportive Care. A covered Telehealth visit applies the same cost-sharing as an in-person visit. However, reduced cost-sharing may apply for visits through the mental well-being program. Deductible and/or coinsurance may apply for additional services performed at your visit.
	Inpatient services	30% coinsurance	Not covered	Prior authorization is required. See www.QuartzBenefits.com/WIPAList or call (800) 362-3310 for additional information.
	Office visits	PCP: \$20 copay /visit; deductible does not apply Specialist: \$40 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 (800) 362-3310 for additional information. Deductible and/or coinsurance may apply for additional services performed at your visit.
If you are pregnant	Childbirth/delivery professional services	30% coinsurance	Not covered	
	Childbirth/delivery	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 help recovering or have other special health needs	facility services			Coverage is limited to 60 visits per Benefit Year. Prior authorization is required. See www.QuartzBenefits.com/WIPAList or call (800) 362-3310 for additional information.
	Home health care	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.
	Rehabilitation services	\$20 copay /visit; deductible does not apply	Not covered	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. Deductible and/or coinsurance may apply for additional services performed at your visit.
	Habilitation services	\$20 copay /visit; deductible does not apply	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 (800) 362-3310 for additional information. 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.
	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 (800) 362-3310 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)	
If your child needs dental or eye care	Durable medical equipment	30% coinsurance ; deductible does not apply	Not covered	Purchase or rental of DME items may require Prior Authorization. See www.QuartzBenefits.com/WIPAList or call (800) 362-3310 for additional information. Glasses/contacts for Adult Routine Vision are not covered. 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 Success.
	Hospice services	30% coinsurance	Not covered	Prior authorization is required. See www.QuartzBenefits.com/WIPAList or call (800) 362-3310 for additional information. Hospice coverage excludes room and board charges in a Skilled Nursing Facility.
	Children's eye exam	\$20 copay /visit; deductible does not apply	Not covered	-----none-----
	Children's glasses	30% coinsurance ; deductible does not apply	Not covered	Limited to one pair of glasses or set of contacts 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 .)	
• Abortions (except in cases of rape, incest or when the life of the mother is endangered) • Acupuncture • Allergy testing	• Non-formulary drugs without an approved exception • Private-duty nursing • Routine eye care (Adult) • Weight loss programs

- Bariatric surgery
- Cosmetic surgery

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.)

- Chiropractic care
- Hearing aids
- Routine foot 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: 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](http://HealthInsuranceMarketplace). 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

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:

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): Dinekehgo 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	\$700
■ Specialist copayment	\$40
■ 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:	
Cost Sharing	
Deductibles	\$700
Copayments	\$60
Coinsurance	\$2,500
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$3,260

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
■ The plan's overall deductible	\$700
■ Specialist copayment	\$40
■ 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:	
Cost Sharing	
Deductibles	\$100
Copayments	\$900
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,000

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$700
■ Specialist copayment	\$40
■ 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:	
Cost Sharing	
Deductibles	\$700
Copayments	\$100
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,200

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



Notice of Non-Discrimination and Availability of Language Assistance Services and Auxiliary Aids and Services

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 (includes sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes). Quartz does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide reasonable modifications and free appropriate auxiliary aids and services to people with disabilities to communicate effectively with us and to participate in health programs or activities, such as -

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

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

- Qualified interpreters
- 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, you can file a grievance with-

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

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Chief 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.

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call (800) 362-3310, TTY: 711 / (800) 877-8973.

Spanish – ATENCION: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al (800) 362-3310. TTY: 711 / (800) 877-8973 o hable con su proveedor.
Chinese - 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务。以无障碍格式提供信息。致电 (800) 362-3310. TTY: 711 / (800) 877-8973 或咨询您的服务提供商。
Hmong - LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau (800) 362-3310. TTY: 711 / (800) 877-8973 los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.
Russian – ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону (800) 362-3310. TTY: 711 / (800) 877-8973 или обратитесь к своему поставщику услуг.
Vietnamese - LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số (800) 362-3310. TTY: 711 / (800) 877-8973 hoặc trao trảo đối với người cung cấp dịch vụ của bạn.
Laotian - ຝົນຊາວ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ໜ້າກະສັມແລະອີໃຫ້ຊ່ວຍໃນຮູບແບບທີ່ກະນາດຂ້າງໄດ້. ໂທຫາລູ (800) 362-3310. TTY: 711 / (800) 877-8973 ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.
German - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie (800) 362-3310. TTY: 711 / (800) 877-8973 an oder sprechen Sie mit Ihrem Provider.

