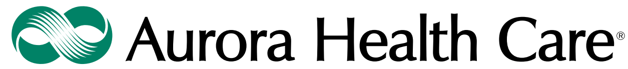

QuartzBenefits.com/MedicareAdvantage

Quartz Medicare Advantage (HMO), in collaboration with Aurora Health Care

Summary of Benefits

Value · Elite · Core D · Value D · Elite D

Effective January 1, 2021

H5262_20 286a_M CMS ACCEPTED
GH00417 (0720)

Summary of Benefits

January 1, 2021 – December 31, 2021

This Summary of Benefits booklet gives you a summary of what **Quartz Medicare Advantage (HMO), in collaboration with Aurora Health Care,** covers and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call Customer Service and ask for the "Evidence of Coverage." Phone numbers are listed on the next page.

Quartz Medicare Advantage is an HMO plan with a Medicare contract. Enrollment in this plan depends on contract renewal. Benefits, premiums, copayments, and coinsurance **may change on January 1 of each year**. Limitations, copayments, and restrictions may apply. Other pharmacies/physicians/providers are available in our network. Other plans may be available in the service area. The formulary, pharmacy network, and provider network may change at any time. You will receive notice about this change when necessary.

Who Can Join?

To join Quartz Medicare Advantage, you must be entitled **to Medicare Part A, enrolled in Medicare Part B and live in our service area.** Our service area includes the following Wisconsin counties: **Brown, Kenosha, Ozaukee, Manitowoc, Milwaukee, Racine, Sheboygan, Walworth, Washington, Waukesha, and Winnebago.**

Which Doctors, Hospitals, and Pharmacies Can I Use?

Quartz Medicare Advantage has a network of doctors, hospitals, pharmacies, and other providers. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. If you use the providers that are not in our network, the plan may not pay for these services. For some services, you can use providers that are not in our network. You can see our plan's provider/pharmacy directory at our website **QuartzBenefits.com/MAfindadoctor** or call us and we will send you a copy.

This information is not a complete description of benefits. Call **(800) 394-5566 or TTY 711** for more information.

What Do We Cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more.* Our plan members get all the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less. Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. We also cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary (list of covered drugs) and any restrictions on our website, **QuartzBenefits.com/MedicareAdvantage**, or call us and we will send you a copy of the formulary.

How Do I Determine My Drug Costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. **The amount you pay depends on the drug's tier and what stage of the benefit you have reached.** Later in this document, we explain the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

Need More Information?

Please call us at the numbers below or go to our website at **QuartzBenefits.com/MedicareAdvantage.**

- If you are a member of this plan, call us toll-free at **(800) 394-5566, TTY 711** or **(800) 877-8973.**
- If you are not a member of this plan, call us toll-free at **(800) 394-5566, TTY 711** or **(800) 877-8973.**

Customer Service hours: From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. Central time. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. Central time.

More Information about Original Medicare

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare and You" handbook. View it online at medicare.gov or get a copy by calling **1-800-MEDICARE (1-800-633-4227),** 24 hours a day, 7 days a week. **TTY users** should call **1-877-486-2048.**

PRE-ENROLLMENT CHECKLIST

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service representative at **(800) 394-5566, TTY 711** or **(800) 877-8973.**

Understanding the Benefits

☐ **The Evidence of Coverage (also called an "EOC").** Review the full list of benefits in the EOC, especially for those services that you routinely see a doctor. To view a copy of the EOC, visit **QuartzBenefits.com/MedicareAdvantage** or call **(800) 394-5566, TTY 711** or **(800) 877-8973**.

☐ **The Quartz Medicare Advantage Provider/Pharmacy Directory.** Review our directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to find a new doctor.

Understanding Important Rules

☐ In addition to your monthly plan premium, you will need to continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

☐ Benefits, premiums, and/or copayments/coinsurance may change on **January 1, 2022.**

☐ Except in an emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in our provider/pharmacy directory).

2021 Summary of Benefits — Quartz Medicare Advantage (HMO), in collaboration with Aurora Health Care

If you have any questions about this plan's benefits or costs, please contact Quartz for details.

BENEFIT	Value (NO Rx) (HMO)	Elite (NO Rx) (HMO)	Core D (With Rx) (HMO)	Value D (With Rx) (HMO)	Elite D (With Rx) (HMO
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES.					
MONTHLY PLAN PREMIUM	**$0 per month.** In addition, you must keep paying your Medicare Part B premium.	**$40 per month.** In addition, you must keep paying your Medicare Part B premium.	**$0 per month** In addition, you must keep paying your Medicare Part B premium.	**$31 per month.** In addition, you must keep paying your Medicare Part B premium.	**$70.90 per month.** In addition, you must keep paying your Medicare Part B premium.
DEDUCTIBLE	None.	None.	Part D drugs listed on Tiers 1 and 2: **$0** Part D drugs listed on Tiers 3-5: **$150/year**.	Part D drugs listed on Tiers 1 and 2: **$0** Part D drugs listed on Tiers 3-5: **$150/year**.	Part D drugs listed on Tiers 1 and 2: **$0** Part D drugs listed on Tiers 3-5: **$150/year**.
MAXIMUM OUT-OF-POCKET RESPONSIBILITY *(Does not include what you pay for prescription drugs.)*	**Your yearly limit(s) in this plan:** **$4,900 for services you receive from in-network providers.**	**Your yearly limit(s) in this plan:** **$3,900 for services you receive from in-network providers.**	**Your yearly limit(s) in this plan:** **$5,900 for services you receive from in-network providers.** **(Does not include what you pay for prescription drugs.)**	**Your yearly limit(s) in this plan:** **$4,900 for services you receive from in-network providers.** **(Does not include what you pay for prescription drugs.)**	**Your yearly limit(s) in this plan:** **$3,900 for services you receive from in-network providers.** **(Does not include what you pay for prescription drugs.)**
If you reach the limit on out-of-pocket costs, you will keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premium.					

BENEFIT	Value (NO Rx) (HMO)	Elite (NO Rx) (HMO)	Core D (With Rx) (HMO)	Value D (With Rx) (HMO)	Elite D (With Rx) (HMO
INPATIENT HOSPITAL COVERAGE	Our plan covers an unlimited number of days for an inpatient hospital stay. You pay: **$265 copay per day for days 1-7.** **You pay nothing per day for days 8 and beyond.**	Our plan covers an unlimited number of days for an inpatient hospital stay. You pay: **$325 per stay**	Our plan covers an unlimited number of days for an inpatient hospital stay. You pay: **$295 copay per day for days 1-7.** **You pay nothing per day for days 8 and beyond.**	Our plan covers an unlimited number of days for an inpatient hospital stay. You pay: **$265 copay per day for days 1-7.** **You pay nothing per day for days 8 and beyond.**	Our plan covers an unlimited number of days for an inpatient hospital stay. You pay: **$325 per stay**
OUTPATIENT HOSPITAL COVERAGE	Outpatient Hospital: (Ambulatory Surgical Center) **$250 copay per surgery.** **$0 copay for minor surgical procedures.** Outpatient Observation: **$0 copay.**	Outpatient Hospital: (Ambulatory Surgical Center) **$200 copay per surgery.** **$0 copay for minor surgical procedures.** Outpatient Observation: **$0 copay.**	Outpatient Hospital: (Ambulatory Surgical Center) **$275 copay per surgery.** **$0 copay for minor surgical procedures** Outpatient Observation: **$0 copay.**	Outpatient Hospital: (Ambulatory Surgical Center) **$250 copay per surgery.** **$0 copay for minor surgical procedures.** Outpatient Observation: **$0 copay.**	Outpatient Hospital: (Ambulatory Surgical Center) **$200 copay per surgery.** **$0 copay for minor surgical procedures** Outpatient Observation: **$0 copay.**
DOCTOR'S OFFICE VISITS	Primary care provider visit: **$0 copay per visit.** Specialist visit: **$35 copay per visit**	Primary care provider visit: **$0 copay per visit.** Specialist visit: **$25 copay per visit.**	Primary care provider visit: **$0 copay per visit.** Specialist visit: **$50 copay per visit**	Primary care provider visit: **$0 copay per visit.** Specialist visit: **$35 copay per visit.**	Primary care provider visit: **$0 copay per visit.** Specialist visit: **$25 copay per visit**

BENEFIT	Value (NO Rx) (HMO)	Elite (NO Rx) (HMO)	Core D (With Rx) (HMO)	Value D (With Rx) (HMO)	Elite D (With Rx) (HMO
PREVENTIVE CARE	**You pay nothing.** Our plan covers many preventive services, including: ▪ Abdominal aortic aneurysm screening ▪ Alcohol misuse counseling ▪ Bone mass measurement ▪ Breast cancer screening (mammogram) ▪ Cardiovascular disease (behavioral therapy) ▪ Cardiovascular screening ▪ Cervical and vaginal cancer screening ▪ Colorectal cancer screenings (Colonoscopy, fecal occult blood test, flexible sigmoidoscopy) ▪ Depression screening ▪ Diabetes screening ▪ HIV screening ▪ Lung cancer screening ▪ Medical nutrition therapy services ▪ Obesity screening and counseling ▪ Prostate cancer screenings (PSA) ▪ Sexually transmitted infections screening and counseling ▪ Tobacco use cessation counseling (for people with no sign of tobacco-related diseases) ▪ Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots ▪ “Welcome to Medicare” preventive visit (one-time) ▪ Yearly “Wellness” visit ▪ Yearly Routine Physical Any additional preventive services approved by Medicare during the contract year will be covered.				
EMERGENCY CARE (WORLDWIDE)	**$90 copay per visit.** If you are admitted to a hospital within three days, you do not have to pay your share of the cost for emergency care.				
URGENTLY NEEDED SERVICES (WORLDWIDE)	You pay: **$50 copay.**	You pay: **$40 copay.**	You pay: **$60 copay.**	You pay: **$50 copay.**	You pay: **$40 copay.**

BENEFIT	Value (NO Rx) (HMO)	Elite (NO Rx) (HMO)	Core D (With Rx) (HMO)	Value D (With Rx) (HMO)	Elite D (With Rx) (HMO
DIAGNOSTIC SERVICES, LABS AND IMAGING	Diagnostic radiology services: (Such as MRIs, CT scans.) **You Pay $125 copay.** Diagnostic tests and procedures: **You pay: $10 copay** Lab Services: **You pay: $10 copay** Outpatient X-rays: **You pay: $15 copay** Therapeutic radiology services: (Such as radiation treatment for cancer.) **You pay: $60 copay.**	Diagnostic radiology services: (Such as MRIs, CT scans.) **You Pay $100 copay.** Diagnostic tests and procedures: **You pay: $5 copay** Lab Services: **You pay: $5 copay** Outpatient X-rays: **You pay: $5 copay** Therapeutic radiology services: (Such as radiation treatment for cancer.) **You pay: $60 copay.**	Diagnostic radiology services: (Such as MRIs, CT scans.) **You Pay $200 copay.** Diagnostic tests and procedures: **You pay: $15 copay** Lab Services: **You pay: $15 copay** Outpatient X-rays: **You pay: $25 copay** Therapeutic radiology services: (Such as radiation treatment for cancer.) **You pay: $60 copay.**	Diagnostic radiology services: (Such as MRIs, CT scans.) **You Pay $125 copay.** Diagnostic tests and procedures: **You pay: $10 copay** Lab Services: **You pay: $10 copay** Outpatient X-rays: **You pay: $15 copay** Therapeutic radiology services: (Such as radiation treatment for cancer.) **You pay: $60 copay.**	Diagnostic radiology services: (Such as MRIs, CT scans.) **You Pay $100 copay.** Diagnostic tests and procedures: **You pay: $5 copay** Lab Services: **You pay: $5 copay** Outpatient X-rays: **You pay: $5 copay** Therapeutic radiology services: (Such as radiation treatment for cancer.) **You pay: $60 copay.**
HEARING SERVICES	Annual routine hearing exam: **$0 copay.** Hearing Aids: **$700-$1,200 copay per aid.** Limit: **1 aid per ear annually.**				

BENEFIT	Value (NO Rx) (HMO)	Elite (NO Rx) (HMO)	Core D (With Rx) (HMO)	Value D (With Rx) (HMO)	Elite D (With Rx) (HMO
DENTAL SERVICES (No network – you can choose the dentist you want to see.)	Medicare-covered dental: **$35 copay.** Reimbursement for combined preventive and comprehensive dental services: **$500 limit.** OPTIONAL: Purchase an additional $1,000 of dental coverage: **$48.10/month.**	Medicare-covered dental: **$25 copay.** Reimbursement for combined preventive and comprehensive dental services: **$700 limit.** OPTIONAL: Purchase an additional $1,000 of dental coverage: **$48.10/month.**	Medicare-covered dental: **$50 copay.** Reimbursement for combined preventive and comprehensive dental services: **$300 limit.** OPTIONAL: Purchase an additional $1,000 of dental coverage: **$48.10/month.**	Medicare-covered dental: **$35 copay.** Reimbursement for combined preventive and comprehensive dental services: **$500 limit.** OPTIONAL: Purchase an additional $1,000 of dental coverage: **$48.10/month.**	Medicare-covered dental: **$25 copay.** Reimbursement for combined preventive and comprehensive dental services: **$700 limit.** OPTIONAL: Purchase an additional $1,000 of dental: **$48.10/month.**
VISION SERVICES	Exam to diagnose and treat diseases and conditions of the eye: **$35 copay.** Routine eye exam each year: **$0 copay.** Yearly glaucoma screening: **$0 copay.** **Our plan pays up to $200 every year for eyeglasses (frames, lenses, and upgrades) or contact lenses.** *Eyeglasses or contact lenses after cataract surgery: $0 copay.*	Exam to diagnose and treat diseases and conditions of the eye: **$25 copay.** Routine eye exam each year: **$0 copay.** Yearly glaucoma screening: **$0 copay.** **Our plan pays up to $300 every year for eyeglasses (frames, lenses, and upgrades) or contact lenses.** *Eyeglasses or contact lenses after cataract surgery: $0 copay.*	Exam to diagnose and treat diseases and conditions of the eye: **$50 copay.** Routine eye exam each year: **$0 copay.** Yearly glaucoma screening: **$0 copay.** **Our plan pays up to $100 every year for eyeglasses (frames, lenses, and upgrades) or contact lenses.** *Eyeglasses or contact lenses after cataract surgery: $0 copay.*	Exam to diagnose and treat diseases and conditions of the eye: **$35 copay.** Routine eye exam each year: **$0 copay.** Yearly glaucoma screening: **$0 copay.** **Our plan pays up to $200 every year for eyeglasses (frames, lenses, and upgrades) or contact lenses.** *Eyeglasses or contact lenses after cataract surgery: $0 copay.*	Exam to diagnose and treat diseases and conditions of the eye: **$25 copay.** Routine eye exam each year: **$0 copay.** Yearly glaucoma screening: **$0 copay.** **Our plan pays up to $300 every year for eyeglasses (frames, lenses, and upgrades) or contact lenses.** *Eyeglasses or contact lenses after cataract surgery: $0 copay.*

BENEFIT	Value (NO Rx) (HMO)	Elite (NO Rx) (HMO)	Core D (With Rx) (HMO)	Value D (With Rx) (HMO)	Elite D (With Rx) (HMO
MENTAL HEALTH SERVICES	Inpatient visit: **Our plan covers an unlimited number of days for an inpatient hospital stay.** You pay per day: **Days 1-6: $265 copay** **Days 7 and beyond: $0.** Outpatient group therapy visit: **$25 copay per visit.** Outpatient individual therapy visit: **$25 copay per visit.** Partial hospitalization: **$35 copay.**	Inpatient visit: **Our plan covers an unlimited number of days for an inpatient hospital stay.** You pay: **$325 per stay.** Outpatient group therapy visit: **$25 copay per visit.** Outpatient individual therapy visit: **$25 copay per visit.** Partial hospitalization: **$0 copay.**	Inpatient visit: **Our plan covers an unlimited number of days for an inpatient hospital stay.** You pay per day: **Days 1-6: $295 copay** **Days 7 and beyond: $0.** Outpatient group therapy visit: **$25 copay per visit.** Outpatient individual therapy visit: **$25 copay per visit.** Partial hospitalization: **$55 copay.**	Inpatient visit: **Our plan covers an unlimited number of days for an inpatient hospital stay.** You pay per day: **Days 1-6: $265 copay** **Days 7 and beyond: $0.** Outpatient group therapy visit: **$25 copay per visit.** Outpatient individual therapy visit: **$25 copay per visit.** Partial hospitalization: **$35 copay.**	Inpatient visit: **Our plan covers an unlimited number of days for an inpatient hospital stay.** You pay: **$325 per stay.** Outpatient group therapy visit: **$25 copay per visit.** Outpatient individual therapy visit: **$25 copay per visit.** Partial hospitalization: **$0 copay.**
SKILLED NURSING FACILITY *(A hospital stay is not required.)*	Our plan covers up to 100 days in a skilled nursing facility. Days 1-20: **$0** Days 21-100: **$184 copay** per day.	Our plan covers up to 100 days in a skilled nursing facility. Days 1-20: **$0** Days 21-100: **$150 copay** per day.	Our plan covers up to 100 days in a skilled nursing facility. Days 1-20: **$0** Days 21-100: **$184 copay** per day.	Our plan covers up to 100 days in a skilled nursing facility. Days 1-20: **$0** Days 21-100: **$184 copay** per day.	Our plan covers up to 100 days in a skilled nursing facility. Days 1-20: **$0** Days 21-100: **$150 copay** per day.

BENEFIT	**Value** **(NO Rx) (HMO)**	**Elite** **(NO Rx) (HMO)**	**Core D** **(With Rx) (HMO)**	**Value D** **(With Rx) (HMO)**	**Elite D** **(With Rx) (HMO**
REHABILITATION SERVICES (Per visit) *(Prior Authorization may be required.)*	Cardiac (heart) rehab services: **$15 copay.** Pulmonary rehab services: **$15 copay.** Occupational & Physical Therapy: **$35 copay.**	Cardiac (heart) rehab services: **$10 copay.** Pulmonary rehab services: **$10 copay.** Occupational & Physical Therapy: **$25 copay.**	Cardiac (heart) rehab services: **$20 copay.** Pulmonary rehab services: **$20 copay.** Occupational & Physical Therapy: **$40 copay.**	Cardiac (heart) rehab services: **$15 copay.** Pulmonary rehab services: **$15 copay.** Occupational & Physical Therapy: **$35 copay.**	Cardiac (heart) rehab services: **$10 copay.** Pulmonary rehab services: **$10 copay.** Occupational & Physical Therapy: **$25 copay.**
AMBULANCE (Per trip)	**$275 copay.**	**$250 copay.**	**$295 copay.**	**$275 copay.**	**$250 copay.**
TRANSPORTATION	**Not covered.**	**Not covered.**	**Not covered.**	**Not covered.**	**Not covered.**
MEDICARE PART B DRUGS *(Prior Authorization may be required.)*	For Part B drugs, such as chemotherapy drugs: **You pay 20% of the cost.** Other Part B drugs: **You pay 20% of the cost.** **This plan does not cover Part D prescription drugs.**	For Part B drugs, such as chemotherapy drugs: **You pay 20% of the cost.** Other Part B drugs: **You pay 20% of the cost.** **This plan does not cover Part D prescription drugs.**	For Part B drugs, such as chemotherapy drugs: **You pay 20% of the cost.** Other Part B drugs: **You pay 20% of the cost.**	For Part B drugs, such as chemotherapy drugs: **You pay 20% of the cost.** Other Part B drugs: **You pay 20% of the cost.**	For Part B drugs, such as chemotherapy drugs: **You pay 20% of the cost.** Other Part B drugs: **You pay 20% of the cost.**
CHIROPRACTIC	**$20 copay per visit.**	**$20 copay per visit.**	**$20 copay per visit.**	**$20 copay per visit.**	**$20 copay per visit.**

BENEFIT	Value (NO Rx) (HMO)	Elite (NO Rx) (HMO)	Core D (With Rx) (HMO)	Value D (With Rx) (HMO)	Elite D (With Rx) (HMO
MEDICAL EQUIPMENT & SUPPLIES *(Prior Authorization may be required.)*	Durable Medical Equipment: (e.g., wheelchairs, oxygen). **You pay 20% of the cost.** Prosthetics: (e.g., braces, artificial limbs). **You pay 20% of the cost.** Diabetic Supplies: (e.g., test strips, lancets). **You pay Nothing.** Self-Management Training: **You pay nothing.**				
FITNESS BENEFIT (No Network – you can choose the fitness facility)	$25 per month reimbursement for a membership at a licensed fitness facility of your choice.				
OVER-THE-COUNTER BENEFIT PROGRAM	Use the benefit card at participating retailers to purchase eligible over-the-counter medications, health and wellness items, first-aid supplies, and other qualifying items. Purchase in-store or online. **$50 is automatically reloaded to card every three months for a total of $200 a year.**				
MASSAGE THERAPY FOR CHRONIC CONDITIONS	12 (60-minute) visits per year: **$20 copay.**	12 (60-minute) visits per year: **$0 copay.**	6 (60-minute) visits per year: **$20 copay.**	12 (60-minute) visits per year: **$20 copay.**	12 (60-minute) visits per year: **$0 copay.**
MEAL DELIVERY POST HOSPITAL DISCHARGE	20 meals delivered to your home after discharge from either a hospital or skilled nursing facility at no extra charge. **Limited to four times per calendar year.**	20 meals delivered to your home after discharge from either a hospital or skilled nursing facility at no extra charge. **Limited to four times per calendar year.**	**Not covered.**	20 meals delivered to your home after discharge from either a hospital or skilled nursing facility at no extra charge. **Limited to four times per calendar year.**	20 meals delivered to your home after discharge from either a hospital or skilled nursing facility at no extra charge. **Limited to four times per calendar year.**
TRAVEL BENEFIT	You may receive all plan covered services at in-network cost for up to six months when you travel domestically outside of Wisconsin, Illinois, Minnesota, or Iowa.				
ACUPUNCTURE BENEFIT	Receive up to 20 treatments with a licensed practitioner annually. **$20 copay per treatment.**				

Prescription Drug Coverage Available with Core D, Value D, and Elite D plans

If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy but may pay more than you pay at an in-network pharmacy. Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Stage 1: **Yearly Prescription Deductible**	**Retail: $0** per year for Tier 1 and Tier 2; $150 for Tier 3, Tier 4, and Tier 5 Part D prescription drugs. **Mail-Order: $0** per year for Tier 1 and Tier 2; **$150** for Tier 3, Tier 4, and Tier 5 Part D prescription drugs.			
Stage 2: **Initial Coverage** **(After you pay your deductible)**	After you pay your yearly deductible of **$150**, you pay the following until your total yearly drug costs reach **$4,130**. Total yearly drug costs are the total drug costs paid by both you and your Part D plan. You may get your drugs from network retail or mail-order pharmacies. ▪ **For retail:** Your share of the retail cost shown is based on a 30-day, 60-day, or 90-day covered Part D prescription drug. ▪ **For mail-order:** Your share of the cost shown is based on a 90-day supply of a covered Part D prescription drug.			
	Retail			**Mail-Order**
	30-Day	**60-Day**	**90-Day**	**90-Day**
Tier 1 (Preferred Generic)	**$0**	**$0**	**$0**	**$0**
Tier 2 (Generic)	**$8**	**$16**	**$24**	**$20**
Tier 3 (Preferred Brand)	**$47**	**$94**	**$141**	**$118**
Tier 4 (Non-Preferred Drug)	**30% of cost**	**30% of cost**	**30% of cost**	**30% of cost**
Tier 5 (Specialty Tier)	**30% of cost**	**N/A**	**N/A**	**N/A**
Stage 3: **Coverage Gap**	After your total yearly drug costs reach **$4,130**, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap.			
Stage 4: **Catastrophic Coverage**	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and mail order) reach **$6,550,** you pay the greater of: ▪ **5% of the cost; or** ▪ **$3.70 copay for generic (including brand name drugs treated as generic); and** ▪ **$9.20 copay for all other drugs.**			
Note: Tetanus (Tdap) and shingles vaccines are covered under the Part D benefit only when you receive them from a network pharmacist certified to administer vaccines. See our provider directory for a list of network pharmacies.				

Notes:

Protecting Your Privacy

Quartz Health Plan Corporation and Quartz Health Plan MN Corporation are committed to protecting the privacy and confidentiality of your protected personal and health information. We comply with all state and federal privacy laws, including the Gramm-Leach-Bliley Act (GLBA), the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH). These laws require that we provide our members with a Privacy Notice that explains our privacy practices. We must also provide you with access to your records, allow you to request corrections to your information and allow you to request that access to your information be limited. In order to provide you with insurance products and services, we must collect healthcare and personal information about you. Access to your information is restricted to those persons who need to know in order to provide service or administer Quartz Health Plan Corporation and Quartz Health Plan MN Corporation insurance products and services. We maintain physical, electronic, and procedural safeguards that comply with state and federal laws to protect your information. Quartz Health Plan Corporation and Quartz Health Plan MN Corporation do not use, disclose, sell, or make available any protected personal or health information about you to affiliates or non-affiliated third parties, unless required or permitted by law. Furthermore, if any of this information is disclosed without your authorization, we will notify you as required by law.

Our Notice of Privacy Practices is available online at QuartzBenefits.com/privacy-practices or by calling Customer Service at (800) 394-5566 or TTY 711 to request a copy.

NOTICE OF NONDISCRIMINATION

Quartz Medicare Advantage (HMO) is the marketing name operating under the entities of Quartz Health Plan Corporation and Quartz Health Plan MN Corporation. These companies are separate legal entities. In this notice, “we” refers to these companies. We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex.

- 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)
- 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 Service at **(800) 362-3310**.

If you believe that we have 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 –

Kristie Meier, Compliance Officer; 840 Carolina Street, Sauk City, WI 53583
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, Kristie Meier, 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**.

Multi-Language Insert

Multi-Language Interpreter Services

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-394-5566 (TTY: 711).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-394-5566 (TTY: 711).

Chinese: 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 1-800-394-5566（TTY：711）。

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-394-5566 (TTY: 711).

Arabic: ملاحظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية المجانية متاحة من أجلك، يُرجى الاتصال على الرقم 1-800-394-5566 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-394-5566 (телетайп: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-394-5566 (711)번으로 전화해 주십시오.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-394-5566 (TTY: 711).

Pennsylvania Dutch: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-394-5566 (TTY: 711).

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-394-5566 (TTY: 711).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-394-5566 (ATS : 711).

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-394-5566 (መስማት ለተሳናቸው: 711).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-394-5566 (TTY: 711) पर कॉल करें।

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-394-5566 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

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