



Your Prescription Drug Benefit

Quartz

Underwritten by Unity Health Plans Insurance Corporation.



**We want you to receive the
most value from your
prescription drug benefits.**

Here are some tips to help you.

**The information in this document is specific to members of Quartz –
underwritten by Unity Health Plans Insurance Corporation (Unity).**

The Unity Prescription Drug Formulary

The purpose of the Prescription Drug Formulary is to promote use of safe, effective and cost-effective medications. A formulary is an important tool to help us meet our goal of providing coverage for safe and effective medications in an affordable manner.

The formulary is made up of a list of preferred medications, a list of non-preferred medications and a list of restricted medications.

- **Preferred medications** are cost-effective drugs
- **Non-Preferred medications** are those that have suitable alternatives on the formulary or those that are considered less effective or less safe for most patients.
- **Restricted medications** are those for which you must obtain Prior Authorization before you can receive coverage. Restricted medications may be preferred or non-preferred.

Excluded medications are not listed on the formulary. These are medications that your prescription benefit plan specifically excludes from coverage. Examples of commonly excluded medications include hair loss medications, sexual dysfunction medications, most over-the-counter (OTC) medications and cosmetic medications. Your specific benefit exclusions are listed in the Exclusions section of your Prescription Drug Benefit Rider.

Drugs that are not specifically listed on the formulary and not excluded in the exclusions section of your Prescription Drug Benefit Rider are non-formulary and not covered.

How is the Formulary Developed?

Unity's Pharmacy & Therapeutics (P&T) Committee is responsible for creating and maintaining the Prescription Drug Formulary. This committee is made up of physicians and pharmacists who provide care for members in our community. The P&T Committee meets monthly to review medications and determines the formulary status and restriction status of each medication. They consider a variety of factors such as safety, side effects, drug interactions, how well the drug works, dosing schedule and dose form, appropriate uses and cost-effectiveness.

In making formulary decisions, the committee obtains the most up-to-date information on the medication from a variety of sources including published clinical trials, data submitted to the Food and Drug Administration (FDA) for drug approval and recommendations from local or national treatment guidelines. Additionally, the committee asks for information from local practitioners who are experts in the use of the drug class under review.

THERE ARE THREE WAYS YOU CAN VIEW YOUR PRESCRIPTION DRUG FORMULARY -

- 1 View the complete list in our up-to-date formulary PDF at QuartzBenefits.com. This is the easiest and fastest way to answer formulary questions such as whether or not your drug is on formulary for your plan, if it requires Prior Authorization or has other restrictions and what tier copay it is.
- 2 Log in to your secure member portal, MyChart, and search Unity's formulary. You can price-check individual drugs to see what your copay may be, based on your specific drug benefit. This tool provides more detail and member-specific information than the PDF formulary listing and is a more interactive process.
- 3 Request an updated version from Quartz Customer Service.

Pharmacy Benefit Basics

In order to meet the wide-ranging needs of the marketplace, we have developed a variety of pharmacy benefits for employers to choose. The employer purchasing the policy makes the final decision as to what pharmacy benefit you will have. Understanding a few basics about each type of pharmacy benefit will help you with some of the questions that you may have. Some of the common features of the drug benefits are described below. To determine your coverage, refer to your Summary of Benefits and Coverage or Schedule of Benefits to determine your pharmacy benefit.

DEDUCTIBLES

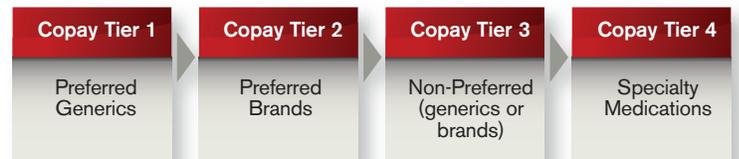
A deductible is the amount paid out-of-pocket before the plan pays for covered services. The drug benefit may have a deductible that combines costs for both pharmacy and medical services, or it may only count pharmacy costs. In either case, 100 percent of the covered drug costs are paid by the member until the deductible is met. Once the deductible is met, the member pays nothing for covered prescriptions until the end of the benefit year. Deductible amounts can vary significantly. Refer to your Summary of Benefits and Coverage for information about your deductible.

With deductible requirements, it is important that you have your pharmacy submit claims online to Unity even though you will be paying 100 percent until the deductible is met. This is important because you will get a lower negotiated price and the amount you pay will be applied toward the deductible amount as tracked in our system.

MEMBER COST SHARE

Once the deductible has been met (if you have one), the drug benefit provides benefits for covered drugs for the rest of the coverage period. The patient's share of the cost for each claim may be a copayment or it may be a coinsurance. This amount is paid by you to the pharmacy. Unity pays the rest of the cost of the drug.

Fixed dollar copayments are usually based on the type of drug. Typical copay tiers for Unity's benefits are as follows.



Each tier may have a different copay amount. For example, a common pharmacy benefit sold by Quartz may look like –

- Tier 1 copay of \$10
- Tier 2 copay of \$35
- Tier 3 copay of \$60
- Tier 4 copay of \$200

Copayment amounts for each tier will vary, depending on what benefit plan your employer purchased; however, the majority of Unity's members have a three-tier benefit with a copay structure of \$10 / \$35 / \$60, with or without a \$100 specialty tier. Other three-tier benefits offered by Unity have copay ranges for Tier 1 of \$0 to \$10, Tier 2 of \$15 to \$35 and Tier 3 of \$30 to \$60.

The tier of a medication can be determined by reviewing the formulary. Please note that patients with the three-tier benefit cannot have a 3rd tier copayment reduced to a 2nd tier copayment. Copayment tiers are fixed based on preferred status and brand / generic status and are not adjusted based on individual circumstances.

Coinsurance is the percentage of the total cost of the drug that you are required to pay. Coinsurance may range from 0 to 50 percent depending on the benefit. Since the prices of drugs can change, the cost share for that drug may also change from time to time. When you receive your prescription medication, the pharmacy staff will inform you of the amount of your cost share.

OUT-OF-POCKET LIMITS

The prescription benefit may include an out-of-pocket limit. This is a limit on the share of the cost of covered services during a coverage period. The limit on the benefit may combine out-of-pocket costs for both pharmacy and medical services. Alternatively, it may only count the pharmacy costs.

There are typically individual and family out-of-pocket limits. If you meet the individual limit, it will result in zero out-of-pocket for you for the rest of the coverage period. Meeting the family out-of-pocket limit will result in zero out-of-pocket for the entire covered family for the rest of the coverage period.

So, if the benefit includes a deductible, cost share and out-of-pocket limit, there could be three phases during a coverage period –



COVERAGE OF DRUGS



Not all drugs are covered by your prescription benefit. Some are covered only under specific circumstances. Categories of non-covered drugs are described below.

Exclusions –

Some drugs or groups of drugs are excluded from coverage under the drug benefit. An example is a drug for cosmetic uses.

Restrictions –

Restricted drugs are those that require Prior Authorization or Step Therapy before you can receive coverage. Restricted drugs may be preferred or non-preferred. Restrictions are noted on the Formulary.

Non-Preferred drugs –

Some of your drug benefits provide coverage for non-preferred drugs at higher copays or at the coinsurance amount.

Non-formulary drugs –

Drugs that are not specifically listed on the formulary and not excluded in the exclusions section of your Prescription Drug Benefit Rider are non-formulary and not covered.

Specialty Pharmaceutical Benefit

Your employer may have purchased a Specialty Pharmaceutical benefit. This benefit requires the use of the Specialty Pharmaceuticals Program for certain medications, and a higher copayment (Tier 4) per prescription is charged, regardless of the formulary status. Medications included in the Specialty Pharmaceutical Benefit are required to be filled by a pharmacy in the Specialty Pharmaceutical Program and to adhere to the specific requirements for each program. Medications included in the Specialty Pharmaceutical Program are denoted with an “SP” on the formulary listing.

RX Outcomes Benefit

Some employers have purchased the RX Outcomes benefit; this benefit provides a lower copay for selected medications in a Value Tier that has a greater impact on medical outcomes. Medications included in the Value Tier are in a special category that provides an incentive for staying on therapy by reducing the copayment to \$5. Medications in the Value Tier are noted by “RXO” on the formulary listing.

Non-Formulary Medications Exceptions Process

Exceptions for non-formulary medications can be considered for medical necessity as noted below. Exceptions requests can be submitted using the standard Medication Prior Authorization Form.

Medication Prior Authorization

Some medications on the Prescription Drug Formulary, as denoted with “PA”, require an approved Prior Authorization prior to coverage. To see which medications need Prior Authorization, refer to the formulary.

To request Prior Authorization or Non-formulary exceptions, members, providers or designated representatives can request coverage via the web, fax, mail or telephone. It is strongly recommended that you ask your health care practitioner to initiate the process on your behalf. This is because your health care practitioner will be able to include the medical history necessary for us to make a timely decision based on all of the relevant information.

There are two types of requests –

1. Standard – for a standard request, the Medication Prior Authorization Request Form should be completed by the prescriber and submitted online or via fax. We



will accept standard request forms from members or their authorized representatives but recommend having your health care practitioner complete the forms as discussed above. Decisions are made on standard requests within 15 calendar days depending on how quickly the information is received. Notification of the decision will be provided to the requesting provider via fax and member via mail. If the pharmacy fax information is included, the pharmacy will be notified of approvals via fax.

2. Urgent – An Urgent Request is defined as a request for a situation when making routine or non-life-threatening determination could jeopardize your life, health, or safety or others, due to your psychological state, or in the opinion of your practitioner (as provided in documentation) could put you at risk to adverse health consequences without the medication being requested being available in an expedited manner.

For an Urgent Request, the Medication Prior Authorization Request Form should be completed by the prescriber and submitted online or via fax. We will accept standard request forms from members or their authorized representatives; however, your health care practitioner must document the urgent need.

- Coverage determination for an Urgent Request for a new medication therapy will be decided within 72 hours unless more information is needed and in which case, your provider will be given an additional 48 hours to respond. Additional information will not be requested if not provided for Exceptions Requests.
- Coverage determination for an Urgent Request for a medication you are currently taking will be decided within 24 hours. Another option is to ask your practitioner to file a standard request and use the Emergency Drug Supply or New Member Drug Supply to obtain your medications while the review is in process (a description of both can be found on page 8).

Prior Authorization Requests are reviewed by pharmacists based on criteria set by the P&T Committee. You and your practitioner will receive written notification of the decision.

Non-formulary exceptions requests will be decided upon based upon medical necessity for you to receive the requested medication. This includes the need to receive the requested medication instead of potential appropriate covered alternatives on the formulary.

If your request is approved, your copay will match the preferred and brand / generic status of the drug.

If your request is denied, you will have no coverage for the medication under your Prescription Drug Benefit.

- Notifications for denials will include the reasons for the denial
- If you would like additional details about the reasons for denial, you can call the UW Health Pharmacy Benefit Management Program at (888) 450-4884
- You can still purchase the drug with a prescription, but you will have no insurance coverage for the prescription
- You can also discuss with your practitioner the possibility of changing to another appropriate drug that may be covered under your Prescription Drug Benefit

Generic Drugs and Unity's Generic Substitution Policy

GENERIC DRUGS

A generic drug contains the same active ingredient (the specific chemical ingredient that makes a drug work) as the brand drug. It must have the same dosing and labeling as the brand drug, and must meet the same standards for purity and quality. The FDA must approve generic drugs as equivalent to the brand before allowing them to be marketed as interchangeable. Because the FDA has determined the generic to be equivalent, your pharmacist can dispense the generic version of your medication without a new prescription from your physician. Visit the FDA website at www.fda.gov and click *Drugs, Resources for You*, and then *Information for Consumers (Drugs)* for more information.

WHY CHOOSE A GENERIC?

Why would you want to choose the generic drug over the brand drug? By choosing a generic, you can save money without losing quality. Generic drugs are not advertised or marketed as much as brand drugs, so generic drugs usually cost less. This allows you to get the generic at a lower copay.

UNITY'S GENERIC SUBSTITUTION POLICY

The Generic Substitution Policy states that when FDA approved equivalent generics are available, coverage of the brand product is only provided with an approved Prior Authorization.

- If the active ingredient is a preferred product on the formulary, coverage for the generic is provided at the Tier 1 copay.
- If a Prior Authorization has been approved, coverage for the brand is provided at the Tier 3 copay.
- A trial of one or more preferred therapeutic alternatives may be required before approval of brand-name product with a generic equivalent.
- If your prescription is written for the brand drug, with your permission, your pharmacist can dispense the equivalent generic product without a new prescription. The purpose of this policy is to ensure you receive an effective drug at the lowest cost.

Certain drugs on the Prescription Drug Formulary are exempt from the Generic Substitution Policy since even slight differences between brands or brands and generics could cause differences in the effect of the drug. These medications are sometimes called Medication Substitution Exception medications. To see which medications are exempt from the generic substitution policy, refer to the Prescription Drug Formulary. Drugs denoted with "MSE" are exempt.

Choice90 Program

Choice90 is a convenient option for your prescription maintenance medications.

Choice90 makes it easy to make sure you have a supply of the medicine you take most often. You can get a 90-day supply of certain medicines

from your local pharmacy. Unity offers a Choice90 program to allow for coverage of a 90-day supply of selected medications, which differs from typical mail-order pharmacy programs. Most pharmacies in Unity's Wisconsin pharmacy network participate in the Choice90 program. This program offers greater flexibility and expands pharmacy choices in Wisconsin to include more than 1,000 pharmacies.



Your medicine may be covered in the Choice90 program if –

- The medication is considered to be a maintenance medication in national databases
- The medication does not cost more than a certain dollar amount for a 90-day supply
- All other benefit requirements have been met* (restrictions and exclusions apply)



Why aren't all prescriptions eligible to be included in the program?

Choice90 eligibility is patient-specific. For example, if you start a new blood pressure medication, you may need to have your blood pressure levels checked in four weeks to make sure you have the right dose. The doctor may change your dose at that time. It would not make sense to order a 90-day supply of a medicine that could change after a month. Other medications you take often may not be on the list of maintenance medications because they are not considered “chronic”. For example, you may take your migraine medication regularly but it is not considered a chronic maintenance medication.

Where can I fill my Choice90 prescription? What pharmacies are included in Choice90?

Participating pharmacies are listed in *Find a Pharmacy* on the Quartz website and include more than 1,000 participating pharmacy locations in Wisconsin.

Will the pharmacy mail my prescriptions or do I need to pick them up?

If you want your medication mailed to you, ask your pharmacy if they offer free mailing. Each pharmacy will have their own policies on mailing free of charge or not. Many pharmacies offer this service.

What will my copay be for Choice90?

For most members, there will be three copays for Choice90-eligible prescriptions.

Are my Specialty Medications eligible for Choice90?

No, medications included in the Specialty Programs are not part of the Choice90 program. These medications are listed with the letters “SP” in the Formulary and are not eligible for a 90-day supply.

How will I know if my medication is considered a “maintenance medication”?

Included medications are designated as “C90” on the formulary listing.

* The program is not available for members with drug coverage through Navitus or BadgerCare Plus, or those who do not have a prescription drug benefit. Medications that are excluded from coverage are not eligible for Choice90. Medications that require Prior Authorization must have a valid Prior Authorization in place before Choice90 will process.

Vacation Supply of Drugs

Members who are planning to travel should ensure they have adequate supplies of their medications while they are traveling.

There are three ways to make sure you have what you need –

1. Call MedImpact at (800) 788-2949 to receive approval for coverage for an extra 30-day supply to take with you (applicable copays apply).
2. Make arrangements with your local pharmacy to send your medications to wherever you'll be staying when they are needed.
3. Go to a participating pharmacy located where you're staying. Quartz has a national network of participating pharmacies from which you can receive medications. Use the *Find a Pharmacy* tool at QuartzBenefits.com/findapharmacy, or contact MedImpact for help identifying participating pharmacies in the area where you're traveling. To receive your prescription at one of these national pharmacies, you need to call ahead and provide the chosen pharmacy with the name and phone number of the pharmacy where you last filled the prescription so they can call and transfer the remaining refills.

Step Therapy Program

Certain medical conditions can be treated using a variety of medications. In some cases, there is a very large difference in cost among the medications, but a very small difference in the way the medications work.

The Step Therapy Program is approved by the P&T Committee and requires a member to try the more cost-effective medications before receiving coverage for (or “stepping up to”) the more expensive medications. Many members find the first medication very effective and never need to step up.

Step Therapy medications require Prior Authorization for coverage. Each medication has specific criteria for approval, which are established by the P&T Committee. Preferred or non-preferred drugs may be included in a step therapy program. To see which medications have step therapy requirements, refer to your Prescription Drug Formulary. Drugs denoted with “ST” require step therapy.

Emergency Drug Supply

If you have an urgent need for medication that requires a Prior Authorization and you need the medication before the Prior Authorization can be reviewed, your pharmacy can contact MedImpact at (800) 788-2949 to receive coverage for a five-day emergency supply of that medication.

During the five days, it is your responsibility to ask your practitioner to either switch you to a medication that does not require Prior Authorization, or to submit a Prior Authorization Request for consideration of continued coverage after the five-day emergency supply is used.

The emergency supply policy does not apply to some medications, including those that are excluded from coverage on your Prescription Drug Benefit, those which are not used in urgent situations and those for which you have received previous emergency coverage. No copay is charged for the emergency supply. A full copay is charged for any subsequent supplies of the medication. If the Prior Authorization is denied, the ongoing supply of medication will not be covered.



New Member Drug Supply

New members may be taking medications that require Prior Authorization for coverage. New members may also be in the process of identifying and making appointments with new primary care physicians.

To assist in making this transition, Unity provides new members with coverage for up to 90 days (in 30-day increments at the usual copayment) of their current medications that usually require Prior Authorization.

When the 90 days is complete, an approved Prior Authorization is required before the member can receive additional coverage. To request a “New Member Override,” you or your pharmacy can contact MedImpact at (800) 788-2949 within the first 90 days of being a member.

Specialty Pharmaceuticals Program

Medications denoted by “SP” are required to be obtained from a pharmacy participating in the Specialty Pharmaceuticals Program for coverage through Unity. The UW Health Specialty Pharmacy and Gundersen Health System Specialty Pharmacy are currently participating in the Unity Specialty Pharmaceuticals Program. Once you have an approved Prior Authorization for the medication, you can contact the UW Health Pharmacy at (866) 894-3784 or Gundersen Health System Pharmacies at (877) 208-1096 to make arrangements for receiving the medication (by mail or pick up at one of the pharmacy locations). Because of the types of medications dispensed in the Specialty Program, additional contact with Specialty Pharmacists are included as part of the program.



Frequently Asked Questions

How often does the Prescription Drug Formulary change?

The P&T Committee meets monthly to review the Prescription Drug Formulary. Most changes to the formulary involve the addition of new drugs or drugs which are newly available as generics. On occasion, drugs are removed from the formulary or moved to restricted status. The Prescription Drug Formulary is updated monthly, so be sure to check the website or request an updated version from Quartz Customer Service. Be sure to check on the website for more information about additions and changes to the Prescription Drug Formulary.

What happens when a drug I'm taking changes its formulary status?

If the drug you are taking changes from preferred to non-preferred, you can continue to receive coverage for the drug at the Tier 3 copay. For some benefits, an approved Prior Authorization will be required. If you have had a recent claim for the medication as a current member, you and your practitioner will receive a detailed notification of the formulary change and your options BEFORE the change occurs. You will be given sufficient time to discuss your options with your practitioner and make a decision. You generally have two options –

- Continue taking the drug at the Tier 3 copay level

or

- Switch to an appropriate preferred medication to receive coverage at the preferred copay level

What happens when a drug I am taking is changed to restricted status?

If you are taking a drug that becomes a restricted drug, your coverage may change in one of two ways depending on the properties of the medication and the diseases it treats –

1. If the P&T Committee decides it is not safe for you to stop taking the medication, or is difficult to transition patients off the newly restricted drug, they will allow you continued coverage for the drug without having to obtain Prior Authorization. Only patients newly beginning the drug after it becomes restricted need Prior Authorization to receive coverage.
2. If the P&T Committee decides it is safe and appropriate to transition patients to a new medication, you will need an approved Prior Authorization for continued coverage of the medication that became restricted. At any copay level, if you have had claims with Unity for a medication that is newly restricted, you and your practitioner will receive a detailed notification

of the change and your options BEFORE the change occurs. You will be given sufficient time to discuss your options with your practitioner before you need to make a decision. You generally have three options in this situation –

- Switch to an appropriate preferred medication that does not require Prior Authorization to receive coverage at the formulary copay level

or

- Ask your practitioner to request Prior Authorization for continued coverage of the medication

or

- Continue taking the drug without coverage through your Prescription Drug Benefit (you pay the full cost)

If my Prior Authorization Request is denied, is there a way to appeal that decision?

If you disagree with the decision to deny coverage for a drug, you have a right to appeal the decision. You can appeal a denial of coverage by contacting Quartz Customer Service at (800) 362-3310. Your appeal will be reviewed by a panel of experts who will consider whether the decision should be changed based on your medical condition and your specific benefits. Additional details about your appeal rights are included with the denial letter.

What can I do to ensure that the prescriptions my practitioner gives me are for preferred medications at the lowest possible copay?

The best way to ensure that the prescriptions you receive are for covered preferred medications is to tell your practitioner that you are a Quartz (underwritten by Unity) member before the prescriptions are written. Let your practitioner know that you would like preferred and / or generic medications if appropriate for treating your medical condition. If your practitioner provides you with drug samples to start treatment, find out if the medication is on your Prescription Drug Formulary. Starting with samples does not guarantee that the medication will be covered or covered at the lowest possible copay. The use of copay cards to lower copays also does not guarantee coverage for the medication.

Why does my coverage only pay for a one-month supply of medication at a time?

Your Prescription Drug Benefit provides coverage for a one-month supply of most medications for a couple of reasons. First, providing coverage for one month of medications reduces waste that occurs when a medication is switched or the dosage is increased.

Even chronic medications that you have been taking for some time may unexpectedly change and the remaining quantity of that medication is then thrown away. Second, allowing coverage of a greater supply of medications would allow members whose coverage will be terminating to stockpile a supply of medications just before their membership ends. This stockpiling increases the cost of medications and impacts your premiums as a continuing member. Coverage for a 90-day supply of medication is allowed for certain medications and in certain situations. Refer to Choice90 program for details.

How can I obtain reimbursement for medications I had to purchase out-of-pocket?

You'll need to complete and submit a Pharmacy Claim Form also known as the Direct Member Reimbursement Form (DMR). The DMR is used to reimburse members for covered prescription drugs that were filled at a non-participating pharmacy due to an emergency or other unforeseen circumstances. For example, let's assume you're on vacation and develop a sinus infection. You receive a prescription and have it filled at the local pharmacy where you are vacationing. Because the local pharmacy is not a participating pharmacy, you have to pay the full cost of the medication at the pharmacy. When you return from vacation, you should complete the DMR to receive reimbursement. To be reimbursed, follow these steps –

1. Print a copy of the form (available on Quartz's website at QuartzBenefits.com or by calling (800) 362-3310)
2. Complete the form – be sure to follow the directions carefully

3. Attach all receipts for the prescription medications noted on the form
4. Mail form and attached receipts to the address indicated on the form

You will receive reimbursement roughly four weeks after the request is received. The amount paid will be less your copay. DMR forms received more than 18 months from the date the prescription was filled are not eligible for reimbursement. Reimbursement is based on your benefits and is not guaranteed. If you have any questions regarding this form or the status of your reimbursement, please call MedImpact at (800) 788-2949.

How is the determination made whether a drug is classified as generic or brand?

There are many ways to classify drugs as either brand or generic. The most common process is to call the first version of that medication to be available on the market “the brand” (for example, Prozac). When the patent expires for the brand, other manufacturers may market versions of the medication; these versions are considered “generics” (for example, fluoxetine is the generic of Prozac and fluoxetine is marketed by several companies). Because determining brand / generic status is not always this straightforward, brand / generic status for your drug benefit is determined using a national database of medication-related information called the First Data Bank National Drug Data File. The brand or generic status of a medication as listed in First Data Bank determines whether that medication is considered a generic or a brand on the Prescription Drug Formulary.

Where to find information when you have questions

TOPIC	WHERE AVAILABLE
To check the formulary status or restriction status of a drug	Unity's Prescription Drug Formulary
To obtain a copy of the Prescription Drug Formulary	Visit QuartzBenefits.com/drugformulary to print your plan's drug formulary or call Customer Service at (800) 362-3310
To appeal a Prior Authorization denial	Customer Service – (800) 362-3310
To speak to a clinical pharmacist about why a Prior Authorization Request was denied	Call the UW Health Pharmacy Benefit Management Program at (888) 450-4884
To check the status of a Prior Authorization	MedImpact Customer Service – (800) 788-2949
For criteria for coverage of a medication	Call the UW Health Pharmacy Benefit Management Program at (888) 450-4884 or read the info online at QuartzBenefits.com
Early refills, vacation supplies, emergency supplies, new member supply, reimbursement of medications purchased out-of-pocket	Visit QuartzBenefits.com/pharmacy and click on Pharmacy Programs and Policies
To enroll in the Specialty Pharmaceuticals Program	Call the UW Health Pharmacy at (866) 894-3784; or, call the Gundersen Health System Pharmacy at (877) 208-1096
To inquire about the Specialty Pharmaceuticals Program	Visit QuartzBenefits.com/pharmacy and click on Specialty Pharmaceuticals Program

Quartz

QuartzBenefits.com

840 Carolina Street | Sauk City, WI 53583 | Quartz Customer Service (800) 362-3310



**Commercial
HMO and POS**