Quartz
Find your spark.

Qualified health plan transparency of coverage

Coordination of Benefits

Coordination of Benefits (COB) exists when an enrollee is covered by more than one health plan. In this situation, one plan becomes the primary plan and pays a claim first. If needed, the second plan then steps in to pay toward the remaining cost of the claim. Both plans work together to "coordinate" the payment based on your coverage.

Explanation of Benefits

An Explanation of Benefits (EOB) document details how much Quartz has paid, how much Quartz has saved you, and what you might owe after receiving care. It is created after Quartz processes a claim for the services you received. Learn more about your EOB here.

Medical necessity and prior authorization

Medical necessity describes reasonable, necessary, and appropriate care based on evidence-based clinical standards of care. Through the direction of the Medical Director, Quartz reviews care needs based on criteria developed by our Medical Management department and other recognized sources. These defined standards determine whether the service, treatment, procedure, prescription drug, device, or supply is deemed medically necessary.

Some services and supplies covered by your plan may need Quartz's approval ahead of time. This means that you, your doctor, or your nurse must fill out a Prior Authorization Request Form before treatment. Quartz will then review and determine if the service or supply will be covered. If you don't receive prior authorization when required, your claims may not be approved.

Prior authorization requests review timeline			
By type and state	**Illinois**	**Minnesota**	**Wisconsin**
Urgent requests	48 hours from receipt of a complete request	48 hours, to include 1 business day	72 hours
Non-urgent Pre-service decisions	5 calendar days from receipt of a complete request	5 calendar days	15 calendar days

Learn more about prior authorization.

Drug exception timeframe and member responsibilities

To access drugs not included in Quartz's formulary (a list of approved drugs), your prescribing doctor should complete a Medication Coverage Request Form and submit the form online, via mail, or via fax.

We will accept exception requests from members or their authorized representatives but recommend having a health care provider complete the form.

QA01607_0823 ©2023 Quartz Health Solutions, Inc.

Medical information is needed to make a decision on exception requests. Decisions are made based on the medical necessity for the member to receive the requested medication, including the need to receive the requested medication instead of covered alternatives on the formulary.

For urgent requests: A determination will be made within 24 hours of receiving the request. A request is urgent if (1) the standard time frame for a non-urgent request may seriously jeopardize the patient's life, health, or ability to regain maximum function or (2) the patient is undergoing a current course of treatment using a non-formulary drug. For urgent or expedited requests, please complete the **Medication Coverage Request Form** and call 1-800-496-7509.

For non-urgent requests: A determination will be made within 72 hours of receiving the request and all necessary medical information.

Requests will be processed, and notification to you and your provider(s) will occur in an appropriate and timely manner. When a request is denied, you and your provider(s) will be made aware of the reason for the denial and the right to appeal the denial of coverage.

If you feel we have denied the non-formulary request incorrectly, you may ask us to submit the case for an external review by an impartial, third-party known as an independent review organization (IRO). We must follow the IRO's decision.

An IRO review may be requested by a member, member's representative, or prescribing provider by completing an Appeal Filing Form and sending it to Quartz, Attn: Appeals Specialists, 2650 Novation Parkway, Fitchburg, WI 53713.

Pharmacy and medication resources	
If you want to:	**Here's how to find information:**
Check the formulary status or restriction status of a drug	Visit the prescription drug formulary
Find a pharmacy	Visit find a pharmacy
Appeal a prior authorization denial	Call Customer Success at (800) 362-3310
Speak to a clinical pharmacist about why a prior authorization request was denied	Call Quartz Pharmacy Program at (888) 450-4884
Find criteria for coverage of a medication	Call Quartz at **(800) 362-3310** or view the medication prior authorization information to learn more about the process and timeline
Get early refills, vacation supplies, emergency supplies, supplies for a new member, or reimbursement for medications purchased out-of-pocket	Visit understanding your pharmacy benefits
Request coverage of medication not on your formulary	Complete the form that corresponds to your state of residence **Illinois, Iowa, Minnesota, Wisconsin**

Out-of-network services and balance billing

Out-of-network care typically isn't covered unless it is provided in the case of an emergency or when a member uses an out-of-network provider with an approved referral.

If you get services from an out-of-network provider, the provider may charge you more than Quartz would pay for the service. This practice is called “balance billing.” Balance billing happens when the amounts charged for your care exceed the “allowable expense,” which is the amount defined as necessary, reasonable, and customary for your care. So, for example, if a provider’s charge is $100 and the allowable expense is $70, the provider may “balance bill” you for the remaining $30 because the $30 exceeds the allowable expense of $70.

Your policy generally covers services from out-of-network providers only in case of an emergency, or with an approved referral from Quartz. Keep in mind, an in-network provider may not balance bill you for any covered services, and an out-of-network provider may not balance bill you for covered emergency services. Also, some out-of-network providers providing supplemental care (e.g., radiologists) at an in-network facility are prevented by law from balance billing you—unless you agree to their charges.

Member submission of a medical claim from an out-of-network provider

A claim is a request made to Quartz to pay for health care services. In-network providers file claims with us on your behalf. At times, you may receive services from a health care provider not in your plan's network. In that case, you must send claims to Quartz to ensure payment.* **Out-of-network (OON) claims will not be accepted or reviewed without the submission of a completed member claim form.**

To submit a member claim form and claim:

1. Fill out the Member Claim Form
2. Include a copy of the billing statement or claim form received from the doctor, clinic, or other provider
3. Include itemized receipts and any proof of payment
4. Fax the completed form with documentation to (608) 644-2006 or mail to Quartz, Attn: Claims Department, 2650 Novation Parkway, Fitchburg, WI 53713
5. Claims must be sent to Quartz within 90 days from the date of the service

Questions? Call Quartz Customer Success at (800) 362-3310.

* Note: Quartz processes claims according to your plan's benefits. Some plans may not cover services outside of the plan's provider network.

Grace periods and pending claims

After enrolling in an individual and family plan, you must pay the first month’s premium for your coverage to be active. If you don’t pay any premiums after you enroll in the plan, your policy will be canceled.

Once your plan is active, you are eligible for a grace period for your monthly recurring premiums. A grace period is the amount of time you have to pay after the original due date of your premium invoice. The duration depends on whether you get advanced premium tax credits (APTC) or not.

If you get APTC: By law, you have a 90-day (or three-month) grace period. Your coverage remains active during the grace period, but claims are treated differently depending on which month of the grace period they are incurred.

- All medical and pharmacy claims will pay as usual during the first month of your 90-day grace period.
- During months two and three of grace, pharmacy claims will be denied at the point of sale. Medical claims will be pended. This means they are held open until the grace period has passed. Once Quartz receives your premium payment in full, we will process pended claims and pay the provider the amount due.
- If the grace period ends and payment is not made in full, Quartz will only pay claims from the first month of the grace period. All claims incurred after the first month of grace, including pended claims, will be denied and become your responsibility. Your coverage will be terminated back to the end of the first month of your 90-day grace period. You are still responsible for paying the premium for your first month of grace.

If you do not get APTC: You have 31 days to pay your premium invoice after the due date. Otherwise, Quartz will not pay claims, and your policy will be terminated retroactively to the end of the last month in which your premium was paid in full.

Retroactive denials

Claims may be denied retroactively if your policy is canceled or terminated due to nonpayment. You will be responsible for paying all claims incurred after the termination date of your policy. To avoid your claims being retroactively denied, make sure to pay your premium on time each month.

Recoupment of overpayments

Your account will show a credit balance if you have overpaid your premium balance. This credit will be applied to future months' coverage unless you request a refund. Please call Quartz Customer Success at (800) 362-3310 to request a refund of the premium overpayment.