Offered by Quartz Health Benefit Plans Corporation

HMO MEDICARE SUPPLEMENT INSURANCE
MEDICARE SELECT POLICY

This health insurance policy is offered by ***Quartz Health Benefit Plans Corporation***, referred to in this policy as "***Quartz***," "we," "us" or "our." These shorthand terms may also be used to refer to the ***plan*** administrator or subcontractors performing administrative tasks on behalf of ***Quartz***.

The Wisconsin Insurance Commissioner has set standards for Medicare supplement insurance. This policy meets these standards. It, along with Medicare, may not cover all of your medical costs. You should carefully review all policy limitations. For an explanation of these standards and other important information, see "Wisconsin Guide to Health Insurance for People with Medicare," given to you when you applied for this policy. **Do not buy this policy if you did not receive the Wisconsin Guide to Health Insurance for People with Medicare**.

YOUR RIGHT TO RETURN THIS POLICY

Please read this policy right away. If you are not satisfied with it for any reason, you can return it within 30 days. Upon return, this policy becomes invalid. We will refund any payments you have made on it.

IMPORTANT NOTICE – APPLICATION FOR INSURANCE

Please read the copy of the application attached to your policy. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to ***Quartz*** within 10 days if any information shown on the application is not correct and complete or if

any medical history has not been included. The application is part of the insurance contract. The insurance contract was issued on the basis that the answers to all questions and any other material information shown on the application are correct and complete.

PRE-EXISTING CONDITION LIMITATIONS

This policy requires a six-month waiting period before certain conditions are covered. ***If you are enrolling during an open enrollment period, then this waiting period shall be reduced by that period of time that you were covered by Continuous Creditable Coverage. Please note that the preexisting condition waiting period will not apply to a person who is eligible for guaranteed issuance of this policy.*** However, benefits are payable under this policy for any condition covered by any other ***Quartz*** policy in effect prior to the ***effective date*** of this policy if coverage is continuous and without lapse. Please read Section III for complete information.

THIS POLICY IS GUARANTEED RENEWABLE FOR LIFE (PREMIUM SUBJECT TO CHANGE)

This policy is issued for a defined period.

- For ***members*** joining the ***plan*** due to special enrollment and who have an ***effective date*** of:
  - November 1st, the initial period of coverage is 14 months. For all subsequent renewals, the coverage period is the calendar year;
  - December 1st, the initial period of coverage is 13 months. For all subsequent renewals, the coverage period is the calendar year.
- For all other ***members***, the coverage period is the calendar year.
- This policy may be canceled only for nonpayment of ***premium***, material misrepresentation, or if you move outside ***Quartz's service area***. Please read the Renewability and Reinstatement section of this policy for complete renewal information.

NEITHER QUARTZ NOR ITS REPRESENTATIVES ARE CONNECTED WITH MEDICARE.

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I. INTRODUCTION

Welcome to ***Quartz***! We are pleased that you have chosen us as your health care insurer. This introduction will provide you with information on how to best use your policy to satisfy your health care needs. Remember that you must show your ***Quartz member*** ID card to all providers, including ***hospitals***, before receiving benefits or services.

SELECTING YOUR PRIMARY CARE PROVIDER

When you enroll in this policy, you must select a ***primary care provider*** or clinic from our list of ***in-network providers***. A ***primary care provide***r is a licensed physician or clinic that provides the full range of primary care services ordinarily rendered by Internists, Family Practitioners and General Practitioners. Please choose your ***primary care provider*** carefully; your choice is very important. He or she will provide or authorize all treatments and services covered by your policy.

Your ***primary care provider*** will coordinate and manage your entire health care program. You need the expert advice that he or she can give you. Together you can develop the health care program that is best suited to your lifestyle. Your ***primary care provider*** will keep your medical record complete and up-to-date so that it will be a valuable long-term health care document.

You may change your ***primary care provider*** at any time. To do this, notify ***Quartz*** by the 20th day of the month. The change will be effective the first day of the following month.

REFERRAL TO A SPECIALIST

Your ***primary care provider*** can take care of most of your healthcare needs directly. If other services are necessary, he or she will refer you to the right source for x-rays, laboratory tests, physical therapy and the like. If specialty

care services are necessary, your ***primary care provider*** will refer you to an appropriate ***in-network specialist***. A ***standing referral*** may be available to you if you need ongoing treatment or care from the specialist. No ***referral*** is needed to seek care from an ***in-network*** OB/GYN ***provider***.

IMPORTANT: A *referral* does not guarantee payment. All services must be in accordance with the terms of this policy.

OUT-OF-NETWORK PHYSICIANS AND PROVIDERS

If you wish to consult a physician or other provider who is not participating with ***Quartz***, your ***PCP*** must submit a request for a ***referral*** to ***Quartz*** for review and consideration. If ***medically necessary*** services are not available from an ***in-network provider***, ***Quartz*** will prior authorize consultation or treatment with an ***out-of-network provider***. If you obtain services from an ***out-of-network provider*** without ***Quartz's prior authorization***, you will be responsible for the charges incurred.

HOSPITALIZATION

When your ***primary care provider*** decides that admission to a ***hospital*** is necessary, arrangements will be made for you at an ***in-network hospital***. If your ***primary care provider*** feels that you need facilities that are not available at your local ***hospital***, care will be arranged for you at one of our ***in-network specialty hospitals***.

URGENT AND EMERGENCY CARE

In the event you need urgent or emergency services, you are not restricted to the use of ***in-network providers***. However, please contact your ***primary care provider*** as soon as possible after you receive emergency and ***urgent care*** so that they can coordinate your continued care. Follow-up care received from ***out-of-network providers*** will not be covered unless it has been ***prior***

authorized by ***Quartz***. Notify ***Quartz*** within 72 hours or three business days to report your emergency or ***urgent care*** services to ensure proper handling of your claim.

CARE MANAGEMENT SERVICES

Care management is a collaborative process that assesses ***member*** needs, establishes goals and care plans, helps to coordinate care, and connects ***members*** to resources with the aim of improving ***member*** health and well-living. ***Quartz*** offers care management to ***members*** of ***this plan*** at no additional cost. These services are provided by a staff of health care professionals, including Registered Nurses, Certified Social Workers, and Health Coaches. Examples of these services are clinical programs that address hypertension/blood pressure (Quartz InControl), diabetes, and prenatal care coordination. If you feel that ***you*** would benefit from care management, you can fill out a request form at ***QuartzBenefits.com*** or call Customer Success. Someone from the Care Management Team will reach out to you. As part of care management, ***Quartz*** reserves the right to direct treatment to the most appropriate and cost-effective option available.

In addition to the benefits described in this policy, if your condition would otherwise require continued care in a ***hospital*** or other health care facility, provision of alternative benefits for services rendered by an ***in-network provider*** in accordance with an alternative treatment plan may be available to you.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations or ***exclusions*** of this policy.

MEDICALLY NECESSARY SERVICES, TREATMENTS AND SUPPLIES

Your policy covers only ***medically necessary*** or appropriate services,

treatments and supplies. This means services, treatments and supplies provided by a ***hospital***, physician or other licensed health care provider that are required to identify or treat ***illness*** or ***injury*** and which, as determined by ***Quartz***, are:

- Consistent with the symptoms or diagnosis and treatment of a ***member's illness*** or injury;
- Appropriate with regard to standards of acceptable medical practice;
- Not solely for the convenience of the ***member***, a physician, ***hospital*** or other health care provider; and,
- The most appropriate supply or level of services that can be safely provided to the ***member***.

For Medicare-covered services, ***Quartz*** will use the Medicare standard to determine ***medical necessity***. For all other covered services, ***Quartz*** determines ***medical necessity*** using criteria developed by Medical Management and other recognized sources.

SUSPENSION OF BENEFITS AND PREMIUMS

If you become eligible for ***Medicaid*** after purchasing this policy, the benefits and ***premiums*** under this policy can be suspended during the period you are entitled to benefits under ***Medicaid***. You must request the suspension within 90 days of becoming eligible for ***Medicaid***. Suspension can last for up to 24 months (or such other period of time as determined by federal law).

If you are no longer entitled to ***Medicaid***, we will reinstate your suspended policy if you make a request within 90 days of losing ***Medicaid*** eligibility. However, the reinstated policy will not have coverage for outpatient prescription drugs. Other than the absence of pharmacy coverage, the new policy will be substantially equivalent to your coverage before the date of suspension. You must pay the ***premium*** attributable to the period effective as of the date of termination of ***Medicaid*** entitlement. See the Miscellaneous Provisions section for more information.

II. DEFINITIONS

When used in this policy, the terms below have the following meanings:

BASIC MEDICARE SUPPLEMENT COVERAGE
Means the comprehensive prepaid health care benefits and services, outlined in Section III of this policy, which are provided to ***Quartz members*** by ***Quartz's in-network physicians*** and ***providers***.

BENEFIT PERIOD
See definition of "Medicare Benefit Period" below.

COMPLAINT
Means any expression of dissatisfaction expressed to ***Quartz*** by you**,** or your authorized representative, about ***Quartz*** or its ***in-network providers***.

CONTINUOUS CREDITABLE COVERAGE
Means the period during which an individual was covered by creditable coverage, if during the period of the coverage, the individual had no break in coverage that was greater than 63 days.

CREDITABLE COVERAGE
Means health ***plan*** coverage maintained by an enrollee and may include any of the following:

- A group health ***plan***;
- Health insurance coverage;
- Part A or Part B of Title XVII of the Social Security Act (Medicare);
- Title XIX of the Social Security Act (***Medicaid***), other than coverage consisting solely of benefits provided under section 1928;
- Chapter 55 of Title 10, United States Code, commonly referred to as TRICARE (formerly known as CHAMPUS);
- A medical care program of the Indian Health Service or of a tribal organization;
- A state health benefits risk pool;

- A health ***plan*** offered under Chapter 89 of Title 5, United States Code, commonly referred to as the Federal Employee Health Benefits Program;
- A public health program as defined by federal regulation; and,
- A health benefit ***plan*** under Section 5(e) of the Peace Corps Act (22 United States Code 2504 (e)).

Creditable coverage does not include any of the following:

- Coverage only for accident or disability income insurance, or any combination thereof;
- Coverage issued as a supplement to liability insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Workers' Compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance;
- Coverage for on-site medical clinics; and,
- Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

Creditable coverage shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the ***plan***:

- Limited scope dental or vision benefits;
- Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and,
- Such other similar, limited benefits as are specified in federal regulations.

Creditable coverage shall not include the following benefits if offered as independent, non-coordinated benefits:

- Coverage only for a specified disease or ***illness***; and,
- ***Hospital*** indemnity or other fixed indemnity insurance.

Creditable coverage shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

- Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;
- Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and,
- Similar supplemental coverage provided to coverage under a group health ***plan***.

CUSTODIAL CARE

Means room and board, nursing care, personal care or other care that is designed to assist an individual in the activities of daily living, such as help in walking, getting in and out of bed, bathing, dressing, eating, using the toilet, preparing special diets and taking medicines properly. ***Custodial care*** does not require continued attention by trained medical personnel, such as registered and licensed practical nurses. ***Custodial care*** also includes rest care, respite care and home care provided by family ***members***. ***Custodial care*** is not a covered benefit under this policy.

EFFECTIVE DATE

Means the date a person becomes enrolled as a ***Quartz member*** and is entitled to the benefits of this policy.

EMERGENCY MEDICAL CONDITION

Means a condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson who has an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

- Serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child;
- Serious impairment to the person's bodily functions; or,
- Serious dysfunction of one or more of the person's body organs or parts.

EXPEDITED REVIEW
Means a review process used when the standard review process would jeopardize the ***member's*** life, health or ability to regain maximum function.

EXPENSE INCURRED
Means an expense paid for at the time or after the service or supply is actually provided, but not before.

EXPERIMENTAL TREATMENT
Means those drugs, procedures, surgeries, equipment and devices that do not meet the following criteria as determined by ***Quartz***:

- Must have FDA approval;
- Scientific evidence must permit conclusions concerning the effect on health outcome; and,
- Research and experimental stage of development must be completed.

Quartz considers all services, procedures, and treatments with Category III codes to be ***experimental***, ***investigational***, and/or ***emerging technology***.

EXTERNAL REVIEW
Means a review of ***Quartz's*** decision conducted by an ***independent review organization (IRO)***.

GRIEVANCE
Means any dissatisfaction with ***Quartz's*** provision of services or ***Quartz's*** claims practices or ***Quartz's*** administration of a health benefit ***plan*** that is expressed to ***Quartz*** by or on behalf of a ***member***.

HOSPITAL
Means an institution that:

- Is licensed and operated according to Wisconsin laws that apply to ***hospitals*** and maintains at its location all the facilities needed to provide diagnosis of, and medical and surgical care for, injury and ***illness***. To meet the definition, the institution must also provide:
  - Care for a fee;

  - Care by or supervised by physicians;
  - Care on an inpatient basis; and,
  - Continuous 24-hour nursing services by registered graduate nurses; or,
- Qualifies as a psychiatric or tuberculosis ***hospital***, is a Medicare provider, and is accredited as a ***hospital*** by the Joint Commission on Accreditation of Healthcare Organizations.

The term "***hospital***" does not mean an institution that is chiefly:

- A place for treatment of substance use disorders;
- A nursing home or convalescent home;
- A federal ***hospital***; or,
- A facility primarily affording custodial, educational or rehabilitative care.

HOSPITAL CONFINEMENT or CONFINED IN A HOSPITAL

Means (1) being registered as a bed patient in a ***hospital*** on the advice of an ***in-network physician***, or (2) receiving emergency care for ***illness*** or injury in a ***hospital*** outside the ***Quartz service area***.

ILLNESS

Means sickness or disease of a ***member*** that first manifests itself after the ***effective date*** of this policy and while the policy is in force. Sickness does not include any sickness or disease for which benefits are provided under any Workers' Compensation, occupational disease, employer's liability, or similar law.

IMMEDIATE FAMILY

Means the spouse, dependents, parents, brothers and sisters of the ***Quartz member*** and their spouses.

INDEPENDENT REVIEW ORGANIZATION or IRO

Means an entity certified by the Office of the Commissioner of Insurance to review ***Quartz's*** decisions. Please refer to Section IX, "Complaint and Grievance Procedure," for a description of the independent review process.

IN-NETWORK PHYSICIANS
Means duly licensed physicians who contract with ***Quartz*** to provide covered services to ***Quartz members***.

IN-NETWORK PROVIDERS
Means a person or other entity (such as a ***hospital***) that contracts to provide one or more benefits to ***Quartz members***.

MAINTENANCE AND SUPPORTIVE CARE AND/OR THERAPY
The terms are often used interchangeably to refer to therapies that seek to prevent disease in the absence of significant symptoms or to prevent deterioration of a condition once maximum therapeutic benefit has been achieved, even if symptoms are still present. The determination of what constitutes ***maintenance and supportive care and/or therapy*** is made by ***Quartz's medical director*** after reviewing a ***member's*** case history and/or treatment plan.

MEDICAL DIRECTOR
A physician duly appointed by ***Quartz*** to serve as the policy's final decision-maker for determining whether a service or treatment is eligible for coverage under the policy.

MEDICALLY NECESSARY (applies to services, treatments and supplies)
Means services, treatments and supplies deemed proper for a ***member's*** condition. The ***member's in-network physician*** decides this in the first instance. Such decisions are subject to review by ***Quartz's medical director***. For Medicare-covered services, ***Quartz*** will use the Medicare standard to determine ***medical necessity***. For all other covered services, ***Quartz*** determines ***medical necessity*** using criteria developed by Medical Management and other recognized sources.

MEDICAID
Means a program provided under the federal "Grants to States for Medical Assistance Program" under Title XIX of the Social Security Act, as it is now or later amended.

MEDICARE
Means the Health Insurance for the Aged Act, Title XVIII of the Federal Social Security Amendments of 1965, as it is now or later amended.

MEDICARE APPROVED CHARGE
Means the charge that is determined by Medicare to be reasonable and customary. This is also called the Medicare Allowable Charge.

MEDICARE BENEFIT PERIOD
Means the method by which your use of services under Medicare ***hospital*** insurance is measured. Your first ***benefit period*** starts the first time you enter a ***hospital*** after your ***hospital*** insurance begins. A ***benefit period*** ends when you have been out of a ***hospital*** or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row (including the day of discharge). There is no limit to the number of ***benefit periods*** you can have for ***hospital*** or ***skilled nursing care***.

MEDICARE ELIGIBLE EXPENSES
Means health care expenses that are covered by Medicare Parts A and B and recognized as ***medically necessary*** and reasonable by Medicare. These expenses may or may not be fully reimbursed by Medicare.

MEDICARE SUPPLEMENT COVERAGE
Means coverage that meets the definition of s. 600.03 (28r), Wis. Stat., as interpreted by sub. (2)(a), and that conforms to subs. (4), (4s), (5), (5m), (6), (30) and (30m). Medicare Supplement coverage includes Medicare Supplement and Medicare Select ***plans*** but does not include coverage under Medicare Advantage ***plans*** established under Medicare Part C or Outpatient Prescription Drug ***plans*** established under Medicare Part D.

MEMBER
Means any person who is eligible for and covered by Medicare Parts A, B and D, and for whom ***Quartz*** has accepted proper application and the correct prepaid ***premium***.

MISCELLANEOUS HOSPITAL EXPENSES

Means regular ***hospital*** charges, other than room and board, which cover care needed because of illness or other condition requiring inpatient or outpatient ***hospital confinement***.

OUT-OF-NETWORK PHYSICIANS AND PROVIDERS

Means ***hospitals***, physicians and other health care providers who are not contracted with ***Quartz*** to provide services to ***Quartz members***.

PREMIUMS

Means the periodic fees established by ***Quartz*** to cover the provision of benefits to ***Quartz members***.

PRIMARY CARE PROVIDER or PCP

A licensed physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), physician assistant (PA), or nurse practitioner that has been designated by ***Quartz*** to provide primary health care services to its ***members***. Each ***member*** is required to select a ***primary care provider*** from a list contained in the ***Quartz Provider Directory***. The ***primary care provider*** will provide a full range of primary health care services of the type ordinarily provided by:

- General Practitioners;
- Internists;
- Family Practitioners;
- Pediatricians;
- OB/GYN's (in some cases); and,
- Geriatricians.

Your ***primary care provider*** will also determine when specialty care is needed and will refer you to an appropriate specialist.

PRIOR AUTHORIZATION

The process by which ***Quartz*** gives prior written approval for coverage of (1) specific covered services, treatment, Durable Medical Equipment (DME), and (2) elective services rendered by an ***out-of-network provider***. The purpose of ***prior authorization*** is to determine and/or authorize the following:

- The specific type and extent of care, DME or supply that is necessary;
- The number of visits, or the period of time, during which care will be provided;
- The name of the ***in-network provider*** to whom the ***member*** is being referred; and,
- Whether the ***member*** should receive coverage for the services of an ***out-of-network provider*** because needed services are not available from ***in-network providers***.

PROVIDER NETWORK (OR NETWORK)

The facilities, health care providers and suppliers who have entered into a contract with ***Quartz*** and who agree to follow the ***referral*** and ***prior authorization*** rules and limitations that apply to a ***service area*** or benefit ***plan***.

PROVIDER NETWORK DIRECTORY

In-network physicians, ***hospitals*** and other health care providers who are available to provide care to ***Quartz members*** are identified in ***Quartz's Provider Network Directory***.

QUARTZ

Quartz is the shorthand name for ***Quartz Health Benefit Plans Corporation***, located at 2650 Novation Parkway, Fitchburg, WI 53713. ***Quartz Health Benefit Plans Corporation*** is a health maintenance organization that operates pursuant to Chapters 609 and 611, Wis. Stat. This term may also be used to refer to the ***plan*** administrator or subcontractors performing administrative tasks on behalf of ***Quartz***.

REFERRALS AND STANDING REFERRALS

Your ***primary care provider*** may give you a ***referral*** or a ***standing referral*** so that you may seek care from another ***in-network physician*** or ***in-network provider***. A ***referral*** authorizes you to receive coverage for certain health care services. The purpose of a ***referral*** is to authorize the following:

- The specific type and extent of care that is necessary;
- The number of visits or the period of time during which care will be required; and,

- The name of the provider to whom the ***member*** is being referred.

A request for a ***referral*** to an ***out-of-network provider*** must be submitted to ***Quartz*** for consideration and review. Elective services received from ***out-of-network providers*** must be ***prior authorized*** by ***Quartz*** before services are obtained to be eligible for coverage.

RESCISSION or RESCIND

A cancellation or discontinuance of coverage that has retroactive effect. However, a cancellation or discontinuance of coverage is not a rescission if:

- The cancellation or discontinuance of coverage has only a prospective effect; or,
- The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required ***premiums*** or contributions towards the cost of coverage.

SERVICE AREA

The counties within which ***Quartz*** is authorized by the Wisconsin Office of the Commissioner of Insurance to do business, and where ***Quartz*** has determined that there are enough ***in-network providers*** to serve its ***members***. The ***service area*** is that geographical area within which ***Quartz*** benefits are provided to ***members*** on a regular basis through ***Quartz's in-network providers***.

SKILLED NURSING CARE

Means care that can be performed only by, or under the supervision of, licensed nursing personnel.

SKILLED NURSING FACILITY

Means an institution which:

- Is licensed by the State of Wisconsin as a ***skilled nursing facility*** or is Medicare certified;
- Is primarily engaged in providing, in addition to room and board, ***skilled nursing care*** under the supervision of a duly licensed physician;
- Provides continuous 24 hours a day nursing service by or under the

supervision of a registered graduate professional nurse (R.N.); and,
- Maintains a daily medical record of each patient.

This definition does not include a facility or part thereof primarily used for rest, or for the treatment of substance use disorders, or a facility primarily used for the care and treatment of mental diseases or disorders or custodial or educational care.

URGENT CARE

Means (1) care for ***illness*** or injury that occurs during the ***Quartz member's*** temporary absence from the ***Quartz service area***, or (2) care which the ***member*** needs to prevent his or her health or condition from getting seriously worse before they can reach the ***primary care provider***.

III. BENEFITS AND SERVICES

Benefits and services described in this policy are available only (1) if the ***member's primary care provider*** provides or authorizes them, (2) if they are ***medically necessary***, and (3) after the ***member's effective date*** of coverage. Coverage is subject to payment of ***premium***. Benefits are in accordance with the terms and conditions of this policy. This policy does not pay or reimburse you for services you administer to *yourself*, even if you are a provider.

Payment for Medicare benefits and services will not be duplicated. ***Quartz*** benefits may change when Medicare benefits change. When benefits change, your ***premium*** may change.

Pre-existing Condition Limitation: Until you have been covered by this policy for six consecutive months, no benefits will be paid for medical care, advice, service or treatment for any injury or ***illness*** or any related condition for which medical care, advice, service or treatment was received within six months before your coverage first became effective. **If you enroll during an open enrollment period, then this limitation period shall be reduced by that period of time during which you had *continuous creditable coverage* under another health *plan* that constitutes creditable coverage. Please see the definition of *continuous creditable coverage* that appears above in Section II - Definitions.**

HOSPITAL SERVICES AND SUPPLIES

This policy covers inpatient and outpatient ***hospital*** services. This includes inpatient psychiatric care that is ***medically necessary*** for diagnosis and treatment. ***Quartz*** will pay inpatient ***hospital*** benefits for each ***Medicare benefit period*** and:

- The Medicare Part A deductible during the first 60 days;
- The Medicare Part A daily coinsurance for the 61st through the 90th day;

- The Medicare Part A daily coinsurance for the 91st through the 150th day;
- Beyond 150 days, 100% of the Medicare allowable charges; and,
- All Medicare Part A-eligible expenses for blood to the extent not covered by Medicare.

Inpatient Psychiatric Care
Upon exhaustion of Medicare ***hospital*** inpatient psychiatric coverage, ***Quartz*** pays 175 days per lifetime for inpatient psychiatric ***hospital*** care.

Licensed Skilled Nursing Home Care
Coverage applies only when skilled nursing or skilled rehabilitation services are required on a daily basis. Coverage shall be applied as follows:

- **For a Medicare Eligible Confinement**
  If the ***member*** meets the following requirements:
  - Was ***confined*** in a general ***hospital*** for at least three days;
  - Was transferred to a ***skilled nursing facility*** within 30 days after leaving the general ***hospital***; and,
  - Medicare pays 100% of the allowable charges for the first 20 days.

  Quartz will pay the Medicare Part A coinsurance for care during the 21st through the 100th day. There is no coverage for ***custodial care*** or ***maintenance and supportive care and/or therapy***.

- **For a Non-Medicare Eligible Confinement**
  Quartz pays covered charges in full for a maximum of 30 days in a state-licensed ***skilled nursing facility*** if:
  - The ***member*** requires ***skilled nursing care***; and,
  - Confinement is for continued treatment of a medical or surgical condition for which the ***member*** had been treated before entering the ***skilled nursing facility***.

Hospice Services
If your physician certifies that you are terminally ill, ***Quartz*** will cover ***Medicare eligible expenses*** if you use a hospice provider that is approved by ***Quartz***

and if ***Quartz*** has ***prior authorized*** the care. Prescription drugs are not covered under this benefit.

PROFESSIONAL AND RELATED SERVICES

[***Quartz*** pays the Medicare Part B calendar year deductible. ***Quartz*** also pays 20% of all Part B ***Medicare eligible expenses***.][***Quartz*** pays 20% of all Part B ***Medicare eligible expenses*** after you have satisfied the Part B calendar year deductible.] **Exception:** This policy will make payment in full for all ***medically necessary*** charges for the following services when received from a ***Quartz in-network provider***:

- Breast reconstruction of affected tissue incident to a mastectomy, and reconstruction of the other breast to produce a symmetrical appearance; and,
- Dental anesthesia services as specified under Anesthesia Services, below.

Surgical Services
Quartz covers recognized surgical procedures needed to treat disease and injury. Services include:

- Preoperative and postoperative care;
- Needed services of assistants and consultants;
- Elective sterilization;
- Medically recognized procedures in lieu of surgery; and,
- Breast reconstruction of affected tissue incident to a mastectomy.

Medical Services
Attending physicians provide these services to hospitalized ***members*** and those receiving home care services.

Anesthesia Services
Covered when performed in connection with medical and surgical benefits. Anesthesia services for dental care are covered under certain circumstances and must be ***prior authorized*** by ***Quartz***. Care must be provided by an ***in-network provider***. These services are available if any of the following applies:

- The ***member*** is a child under the age of five;
- The ***member*** has a chronic disability that meets all of the conditions under s. 230.04(9r)(a)2., Wis. Stat.; or,
- The ***member*** has a medical condition that requires hospitalization or general anesthesia for dental care.

Radiation Therapy
Includes generally accepted therapeutic methods such as x-ray, radium and radioactive isotopes when performed and billed by a physician.

Mental Health Services
Includes care for psychiatric illness and substance use disorders. The ***member*** must use an ***in-network provider*** on an outpatient basis, or the outpatient department of a ***hospital*** must bill for the services.

Ambulance Services
Covers ***medically necessary*** ambulance transportation, but only if (1) the ambulance, equipment and personnel meet Medicare requirements, and (2) transportation in any other vehicle could endanger the ***member's*** health.

Emergency Services
Medical care for an injury or sudden ***illness*** severe enough to require a physician's immediate attention. See the Definitions section for examples.

Out-of-Area Services
Quartz provides emergency and ***urgent care*** services to ***members*** outside the ***Quartz service area***. Coverage is provided for services not available from ***Quartz in-network providers*** as determined by ***Quartz***. **However, benefits for services outside the *Quartz service area* will be limited to the Medicare deductible and coinsurance, up to the Medicare limiting charge**. This benefit does not apply to services received outside the United States.

Diagnostic Services
X-rays and lab tests given with general physical exams, vision and hearing tests, and other covered services.

Short-Term Rehabilitative Therapy
Quartz pays the deductible and coinsurance for ***Medicare eligible expenses***. ***Maintenance and supportive care and/or therapy*** is not covered.

Private Duty Nursing
The ***in-network physician*** must order the care. ***Quartz's medical director*** must approve the order in writing. A registered nurse or licensed practical nurse must provide the care. This nurse must not live in the patient's home or be a family member.

Medical Supplies and Durable Medical Equipment
Initial acquisition of artificial limbs or eyes; initial lenses following cataract surgery; casts, splints, trusses, crutches, orthopedic braces and appliances; rental of durable medical equipment or purchase of such equipment at the option of ***Quartz***; oxygen and rental of equipment for the administration of oxygen; radium and radioactive isotopes; other medical equipment and supplies as approved by ***Quartz's medical director***.

Transplants
Covered transplants are those approved by Medicare.

Preventive Care
Preventive care as required under the Affordable Care Act is covered upon renewal 12 months after publication of the recommendation or guideline. This includes:

- Evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

- With respect to women, such additional preventive care and screenings not described above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph; and,
- The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current.

Per s. 632.87(5), Wis. Stat., we will pay for services and associated laboratory fees for preventive pelvic examinations or Pap tests under this benefit, whether they are received from a physician or from a licensed nurse practitioner acting within the scope of their license.

Chiropractic Services
This policy covers services within the scope of a chiropractor's professional license. The chiropractor must be an ***in-network provider***. You do not need a ***referral*** from your ***primary care provider*** for this benefit. Benefits are not available for ***maintenance and supportive care and/or therapy***.

Foreign Travel Emergency Services
Coverage is for 80% of billed charges for Medicare-eligible expenses for ***medically necessary*** emergency ***hospital***, physician and medical care received outside the United States. Benefits are for care needed immediately because of ***illness*** or injury of sudden and unexpected onset. Care must begin during the first 60 days of each trip. This benefit is subject to a $250 deductible. There is a lifetime maximum payment of $50,000. Bring your ***Quartz*** ID Card with you when traveling inside or outside the United States.

Second Opinion
A second opinion is covered when the opinion is provided by an ***in-network provider***.

OUTPATIENT CARE

Emergency Care
Immediate medical attention required to treat an ***emergency medical condition***.

Surgical Procedures
Includes care given as a substitute for surgery. This benefit also covers facility charges for dental anesthesia.

Mental Health Services
See the Professional and Related Services section above.

Diagnostic Testing
Laboratory; x-ray; other diagnostic tests.

KIDNEY DISEASE

Covers charges for inpatient, outpatient and home treatment of kidney disease. Services must be necessary for the ***member's*** diagnosis and treatment. This benefit covers the expenses of (1) dialysis treatment, and (2) kidney transplantation, including immunosuppressive drugs.

TREATMENT OF DIABETES

Medicare Part B covers some blood glucose test strips, blood glucose monitors, lancet devices and lancets, glucose control solutions for checking test strip accuracy and monitors. This policy covers a percentage of approved charges and education required for treatment and self-management of diabetes. This policy does not cover prescription drugs, insulin and diabetic supplies that are covered under Medicare Part D. If these items are not already covered in full by Medicare Part B or Part D, this policy covers installation and use of an insulin infusion pump, and all other

equipment and supplies, including insulin or any other prescription medication used in the treatment of diabetes.

HOME CARE BENEFITS

The following definitions apply only to this section:

HOME CARE
Covers care and treatment under a specific plan of care. The plan must be made and approved in writing by the attending physician. It must be reviewed by the physician after the first two months. Thereafter, review may be less frequent. This benefit is limited to an aggregate of 365 home care visits per year, including those covered by Medicare.

POLICY YEAR
First, the period from your policy's ***effective date*** to December 31 of the same year; then from January 1 to December 31 of each subsequent year.

Benefits

Quartz will pay for home care benefits if ***medically necessary***. Deductible and coinsurance provisions apply. Prescription drugs are not included under this benefit. Services must be provided or coordinated by (1) a state-licensed or Medicare-certified home health agency, or (2) a certified rehabilitation agency. Payment for Medicare benefits will not be duplicated. Home care benefits include:

- Part-time or intermittent home nursing care. This must be given by or under the supervision of a registered nurse;
- Part-time or intermittent home health aide services when ***medically necessary*** under the home care plan. Services must consist solely of caring for the ***Quartz member***. A registered nurse or medical social worker must supervise;
- Physical, respiratory, occupational and speech therapy provided by a registered therapist;
- Medical supplies prescribed by a physician and laboratory services provided by or for a ***hospital***. These must be ***medically necessary***

under the home care plan. Supplies and services (except for prescription drugs) are covered to the same extent as if the ***member*** had been hospitalized;
- Nutrition counseling given by the ***primary care provider***, a registered dietitian or a certified dietitian. This must be ***medically necessary*** under the home care plan; and,
- Evaluation of the need for and the development of a home care plan. A registered nurse, physician extender or medical social worker must do this. The attending physician must request or approve this evaluation.

The maximum weekly cost for home care services must not exceed the amount ***Quartz*** would reimburse a ***skilled nursing facility*** for the same period of time.

Limitations

Home care will not be covered unless the attending physician certifies that:
- Confinement in a ***hospital*** or ***skilled nursing facility*** would be needed if home care were not provided;
- The ***Quartz member's immediate family***, or others living with the ***Quartz member***, cannot provide the needed care and treatment without undue hardship; and,
- A state-licensed or Medicare-certified home health agency or certified rehabilitation agency provides or coordinates the home care.

The ***Quartz member*** may have been hospitalized immediately before starting home care. If so, the physician who was the ***primary provider*** of services during the ***hospital confinement*** must approve the home care plan. This must be done before services are provided.

A home care visit is defined as each visit by a person who:
- Provides services under the home care plan;
- Evaluates the need for a home care plan; or,
- Helps develop the home care plan.

In each 24-hour period, up to four continuous hours of home health aide services count as one home care visit.

PRESCRIPTION EYE DROP REFILLS

For prescription eye drops covered under Medicare Part A or B, ***Quartz*** will not deny coverage of a ***member's*** request for reasons of an early refill of prescription eye drops if all of the following are satisfied:

- The refill is requested by the ***member*** when 75% or more of the days have elapsed from the later of (1) the original date the prescription was filled, or (2) the date on which the most recent refill was distributed to the ***member***; and,
- The prescription allows for a refill of the prescription eye drops; and,
- The requested refill does not exceed the number of refills allowed by the prescription order.

IV. EXCLUSIONS AND LIMITATIONS

EXCLUSIONS

Quartz does not cover:

1. Expenses for which the ***member*** is compensated by Medicare;
2. Services that Medicare does not cover, unless this policy specifically covers them;
3. Services that ***Quartz*** is not legally obliged to cover (e.g., services provided by free clinics or free government programs). ***Quartz*** does not have to pay any part of such free service, even if such service would otherwise be covered as a ***Quartz*** benefit;
4. Services covered under any present or future governmental agency or law. This includes:
   - Workers' Compensation;
   - Employer Liability Law;
   - "No Fault" auto insurance; and,
   - Veteran's Administration service-connected disabilities or conditions;
5. Services that you need as a result of war or an act of war;
6. Services relating to pre-existing conditions, until this policy has been in effect for six consecutive months;
7. Personal comfort or convenience items. These include:
   - In-hospital TV and telephone;
   - Private hospital room, unless ***medically necessary***; and,
   - Housekeeping services and meal services as part of home health care;
8. Charges for eyeglasses or contact lenses, unless eligible under Medicare;
9. Charges for hearing aids, unless eligible under Medicare;
10. Charges for orthopedic shoes or other supporting devices for the feet unless:
    - The shoes or devices are for a person with diabetes or peripheral vascular disease; and,

- The shoes or devices meet the Medicare standard of ***medical necessity***;

11. Routine foot care, unless related to disease affecting the lower limbs, such as peripheral vascular disease or diabetes, as covered under Medicare guidelines;
12. Charges for ***custodial care*** (see the Definitions section);
13. Charges for, or connected with, cosmetic surgery;
14. Charges for, or connected with, reconstructive surgery unless (1) it is performed mainly to achieve a significant improvement in body function, and (2) ***Quartz's medical director*** has determined the surgery is ***medically necessary***;
15. Charges for services provided by family or household ***members***, unless authorized by ***Quartz***;
16. Charges for dentures and dental care or treatment. This includes filling, removal or replacement of teeth, dental x-rays, root canal therapy, surgery for impacted teeth, other surgical procedures involving the teeth or the structures directly supporting them, and charges for dental anesthesia unless ***prior authorized*** by ***Quartz***;
17. ***Hospital*** charges for non-covered dental procedures;
18. Charges for, or connected with, travel or transportation. However, ambulance transportation is covered. See the Benefits and Services section;
19. ***Expenses incurred*** before the ***effective date*** of your insurance policy or after the policy terminates;
20. Charges for any service provided by a physician, chiropractor, podiatrist or dentist acting outside the scope of authority as defined by the appropriate regulating or licensing authority;
21. Charges for services that are not required in accordance with accepted standards of medical, surgical or psychiatric practice;
22. Charges for equipment and appliances that are not prescribed for the treatment of ***illness*** or injury;
23. Charges for examinations for employment, licensing, insurance, adoption or participation in athletics. This exclusion does not apply to court-ordered mental health services pursuant to s. 609.65, Wis. Stat.;
24. Charges for preparing and presenting medical reports;

25. Transplants and transplant-related charges not approved by Medicare; prescription drugs related to non-covered transplants;
26. Reversals of voluntary sterilization and related procedures;
27. Hypnotherapy;
28. Vocational rehabilitation;
29. Procedures ***Quartz*** considers to be ***experimental*** or ***investigational***, unless the procedure is covered by Medicare. The following criteria are used by the ***medical director*** to determine if the treatment is ***experimental*** or ***investigational***:
    - The medical technology affects health outcome;
    - The net health outcome is beneficial, demonstrable and repeatable;
    - The beneficial outcome is better than that achieved under established alternatives; and,
    - The effect is attainable under the usual conditions of medical practice (i.e., outside of investigational settings);
30. Physical, speech and occupational therapy and psychotherapy are not covered for the following conditions: learning disabilities, developmental delay, communication delay, mental retardation and related conditions. ***Maintenance and supportive care and/or therapy*** for chronic conditions is <u>not</u> covered;
31. Testing, treatment and therapies that are related to treating the conditions listed in paragraph 30, above, are <u>not</u> covered;
32. Psychological and neuropsychological testing for the evaluation of learning disorders;
33. When not authorized in writing by ***Quartz's medical director***, non-emergency services of an ***out-of-network physician*** or ***provider***, non-emergency services received outside ***Quartz's service area***, or any ***hospital*** or medical care or service not provided for in this policy;
34. Services, including non-physician services, provided by health care providers who are not ***in-network providers***. The following are exceptions to this exclusion:
    - With written authorization from ***Quartz*** before services are rendered;
    - Emergencies in the ***service area*** when the ***primary care provider*** cannot readily be reached; and,

- Emergency care or ***urgent care*** services received outside the ***service area***;

35. Unless covered by Medicare, stomach-limiting and bypass procedures to (1) correct obesity, (2) treat the complications or co-morbidities of obesity, or (3) treat gastroesophageal reflux disease. Also excluded are (4) treatment of complications arising from such procedures, and (5) removal of excess skin resulting from weight loss, other than panniculectomy;
36. Penile implants and other erection devices;
37. Breast augmentation or reduction, except for breast reconstruction of affected tissue incident to a mastectomy; any treatment for complications resulting from such uncovered procedures;
38. Repairs or replacement for durable medical equipment unless ***prior authorized*** by ***Quartz***;
39. Prescription drugs;
40. Wart removal, unless covered by Medicare as ***medically necessary***;
41. Pharmacy supply fees and dispensing fees on medical benefit drugs dispensed for self-administration at the patient's home;
42. Coverage for skilled nursing home care beyond what is covered by Medicare and the 30-day ***skilled nursing care*** mandate provided by Wisconsin law;
43. Coverage for home health care beyond what is covered by Medicare and the 365 visits required by Wisconsin law;
44. Coverage for ***maintenance and supportive care and/or therapy***;
45. Charges for services that were not rendered;
46. Any federal, state or local taxes imposed on services or goods; shipping and handling charges; and,
47. If the ***member*** chooses not to maintain Medicare Part B coverage, expenses for what Medicare Part B would have covered if the ***member*** had been insured under Medicare Part B.

LIMITATIONS

Major Disaster or Epidemic

If a major disaster or epidemic occurs, physicians and ***hospitals*** will render medical services and arrange for extended care services and home health care services as is practical according to their best medical judgment and within the limitations of available facilities and personnel. Neither ***Quartz*** nor any ***in-network provider*** shall incur any liability or obligation for delay or failure to provide or arrange for medical services that the disaster or epidemic renders unavailable.

Members Not Enrolled in Medicare Part B

If you are not enrolled in Medicare Part B or discontinue or lapse your Medicare Part B medical insurance, and you incur charges allowable by Medicare, we will pay Medicare-eligible expenses as if you had been insured under Medicare Part B. You will be responsible for the charges that Medicare Part B should have covered, had you been enrolled.

Circumstances Beyond Quartz's Control

Covered services may be delayed or made impractical by circumstances not reasonably within ***Quartz's*** control, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, disability of a significant part of ***hospital*** or medical group personnel or similar causes. If services are delayed or made impractical, ***Quartz*** and its ***in-network providers*** will use their best efforts to provide services and benefits covered under this policy, but neither ***Quartz*** nor any ***in-network provider*** shall incur any liability or obligation for failure to provide services or other benefits.

V. SUBROGATION AND REIMBURSEMENT

The term "Benefit Amount," as used in the Subrogation and Reimbursement Section below, means the Fee-for-Service Equivalent Value of health care services received by a ***member*** minus all out-of-pocket expenses for which a ***member*** is responsible for paying, including all deductibles, coinsurance, copayments, and other similar charges. "Benefit Amount" is the amount for which ***Quartz*** seeks subrogation and reimbursement.

Quartz retains both the right of subrogation against a third party and the right of reimbursement from ***members*** to the extent of benefits paid by ***Quartz***, as defined hereinabove as "Benefit Amount" and as identified as ***Quartz*** Paid Provider in the ***member's*** Explanation of Benefits (EOB). ***Quartz*** may enforce its subrogation rights, to the extent permitted by law, by asserting a claim to any injury-related coverage to which a ***member*** may be entitled, including but not limited to liability coverage, uninsured and underinsured motorist coverage and homeowner's coverage. In addition to its subrogation rights, ***Quartz*** may enforce its reimbursements rights, to the extent permitted by law, by asserting a claim of reimbursement from any and all recoveries obtained by a ***member*** arising out of an injury for which ***Quartz*** has provided benefits. This means that whenever ***Quartz*** provides services or other benefits to any ***member***, ***Quartz*** shall, to the extent a ***member*** has been "made whole" under applicable state law, be entitled to be reimbursed from all of the ***member's*** rights of recovery and all actual recoveries obtained by or on behalf of a ***member*** from any other party, person or corporation ("Third Party"), including but not limited to any proceeds received by a ***member*** under policies of liability coverage, uninsured or underinsured motorist coverage and homeowner's coverage. A ***member's*** obligation to reimburse ***Quartz*** exists, regardless of whether the settlement, compromise or judgment designates payment proceeds received from a Third Party as including or excluding medical expenses. ***Quartz*** is not required to help a ***member*** pursue a claim for damages or personal injuries, and no amount of associated costs, including attorneys' fees, shall be deducted from ***Quartz's*** recovery without ***Quartz's*** express written consent.

Any ***member*** who receives services or benefits from ***Quartz***, and has any right of recovery against any Third Party, including a claim made pursuant to uninsured or underinsured motorist coverage, must, by or on behalf of ***Quartz***, execute and sign all documents as may be required, deliver the same to ***Quartz*** or ***Quartz's*** designee and perform whatever other acts, including an assignment of rights, that are necessary to secure ***Quartz's*** rights. By participating in and accepting benefits from ***Quartz***, ***members*** agree to assign to ***Quartz*** any benefits, claims or rights of recovery a ***member*** has under any automobile policy, including no-fault benefits, PIP benefits and/or medical payments coverage benefits, and all other coverages or against any Third Party, to the full extent of the benefits paid by ***Quartz***, as defined hereinabove as "Benefit Amount" and as identified as ***Quartz*** Paid Provider in the ***member's*** Explanation of Benefits (EOB).

Members must do nothing to prejudice ***Quartz's*** right of recovery. ***Members*** must promptly advise ***Quartz*** in writing whenever a claim against another party is made on behalf of the ***member*** and will further provide such additional information as is reasonably requested by ***Quartz*** or ***Quartz's*** designee. ***Quartz*** reserves the right to be provided notice of any claim against a Third Party. The ***member*** agrees to cooperate in protecting ***Quartz's*** interest and to provide necessary information to ***Quartz*** or ***Quartz's*** designee upon request.

VI. DUPLICATE COVERAGE AND COORDINATION OF BENEFITS

DUPLICATE COVERAGE

Benefits or services to which a ***member*** is entitled under this policy may also be covered under another policy issued by ***Quartz***. If so, the maximum benefit or service available under both ***plans*** shall not exceed the maximum benefit or service allowed under either of the ***Quartz*** policies.

COORDINATION OF SERVICES AND BENEFITS

Applicability

This Coordination of Benefits ("COB") provision applies to ***this plan*** when an employee or the employee's covered dependent has health care coverage under more than one ***plan***. "***plan***" and "***this plan***" are defined below.

If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of ***this plan*** are determined before or after those of another ***plan***. The benefits of ***this plan***:

- Shall not be reduced when, under the order of benefit determination rules, ***this plan*** determines its benefits before another ***plan***; but,
- May be reduced when, under the order of benefit determination rules, another ***plan*** determines its benefits first. This reduction is described in the Effect on the Benefits of ***this plan*** section, below.

Definitions

ALLOWABLE EXPENSE

Means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more ***plans*** covering the person for whom the claim is made.

The difference between the cost of a private ***hospital*** room and the cost of a semi-private ***hospital*** room is not considered an ***allowable expense*** unless the patient's stay in a private ***hospital*** room is ***medically necessary*** either in terms of generally accepted medical practice or as specifically defined in the ***plan***.

When a ***plan*** provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an ***allowable expense*** and a benefit paid.

CLAIM DETERMINATION PERIOD

Means a calendar year. However, it does not include any part of a year during which a person has no coverage under ***this plan*** or any part of a year before the date this COB provision or a similar provision takes effect.

PLAN

Means any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

- Group insurance or group-type coverage, whether insured or uninsured (self-insured), that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage;
- Coverage under a governmental ***plan*** or coverage that is required or provided by law. This does not include Medicare Advantage as this provision is preempted by federal law. This does not include a state ***plan*** under ***Medicaid*** (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any ***plan*** whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.

Each contract or other arrangement for coverage under the bullets above is a separate ***plan***. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate ***plan***.

PRIMARY PLAN/SECONDARY PLAN

The order of benefit determination rules state whether ***this plan*** is a ***plans*** or ***secondary plan*** as to another ***plan*** covering the person.

When ***this plan*** is a ***plans***, its benefits are determined before those of the other ***plan*** and without considering the other ***plan's*** benefits.

When ***this plan*** is a ***secondary plan***, its benefits are determined after those of the other ***plan*** and may be reduced because of the other ***plan's*** benefits.

When there are more than two ***plans*** covering the person, ***this plan*** may be a ***plans*** as to one or more other ***plans*** and may be a ***secondary plan*** as to a different ***plan*** or ***plans***.

THIS PLAN

Means the part of the group contract that provides benefits for health care expenses.

Order of Benefit Determination Rules

When there is a basis for a claim under ***this plan*** and another ***plan***, ***this plan*** is a ***secondary plan*** which has its benefits determined after those of the other ***plan***, unless:

- The other ***plan*** has rules coordinating its benefits with those of ***this plan***; and,
- Both those rules and ***this plan's*** rules described below, require that ***this plan's*** benefits be determined before those of the other ***plan***.

This plan determines its order of benefits using the first of the following rules which applies:

1. **Non-Dependent/Dependent**
   The benefits of the ***plan*** which covers the person as an employee, ***member*** or subscriber are determined before those of the ***plan*** which covers the person as a dependent of an employee, ***member*** or subscriber.

2. **Dependent Child** – **Parents Not Separated or Divorced**
   Except as stated in paragraph 3 below, when ***this plan*** and another ***plan*** cover the same child as a dependent of different persons called "parents":
   - The benefits of the ***plan*** of the parent whose birthday falls earlier in the calendar year are determined before those of the ***plan*** of the parent whose birthday falls later in that calendar year; but,
   - If both parents have the same birthday, the benefits of the ***plan*** which covered the parent longer are determined before those of the ***plan*** which covered the other parent for a shorter period of time.

   However, if the other ***plan*** does not have the rule described above but instead has a rule based upon the gender of the parent, and if, as a result, the ***plans*** do not agree on the order of benefits, the rule in the other ***plan*** shall determine the order of benefits.

3. **Dependent Child** – **Separated or Divorced Parents**
   If two or more ***plans*** cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
   - First, the ***plan*** of the parent with custody of the child;
   - Then, the ***plan*** of the spouse of the parent with the custody of the child; and,
   - Finally, the ***plan*** of the parent not having custody of the child.

   Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' ***plans*** have actual knowledge of those terms, benefits for the dependent child shall be determined according to paragraph 2, above.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the ***plan*** of that parent has actual knowledge of those terms, the benefits of that ***plan*** are determined first. This paragraph does not apply with respect to any ***claim determination period*** or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. **Active/Inactive Employee**
   The benefits of a ***plan*** which covers a person as an employee who is neither laid off nor retired or as that employee's dependent are determined before those of a ***plan*** which covers that person as a laid-off or retired employee or as that employee's dependent. If the other ***plan*** does not have this rule and if, as a result, the ***plans*** do not agree on the order of benefits, this rule is ignored.

5. **Continuation Coverage**
   If a person has continuation coverage under federal or state law and is also covered under another ***plan***, the following shall determine the order of benefits:
   - First, the benefits of a ***plan*** covering the person as an employee, ***member*** or subscriber or as a dependent of an employee, ***member*** or subscriber; and,
   - Second, the benefits under the continuation coverage.

   If the other ***plan*** does not have this rule and if, as a result, the ***plans*** do not agree on the order of benefits, this paragraph 5 is ignored.

6. **Longer/Shorter Length of Coverage**
   If none of the above rules determines the order of benefits, the benefits of the ***plan*** which covered an employee, ***member*** or subscriber longer are determined before those of the ***plan*** which covered that person for the shorter time.

Effect on the Benefits of This Plan
This section applies when, in accordance with the Order of Benefit Determination Rules section, ***this plan*** is a ***secondary plan*** as to one or more other ***plans***. In that event, the benefits of ***this plan*** may be reduced under this section. Such other ***plan*** or ***plans*** are referred to as "the other ***plans***" below.

The benefits of ***this plan*** will be reduced when the sum of the following exceeds the ***allowable expenses*** in a ***claim determination period***:

- The benefits that would be payable for the ***allowable expenses*** under ***this plan*** in the absence of this COB provision; and,
- The benefits that would be payable for the ***allowable expenses*** under the other ***plans***, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made. Under this provision, the benefits of ***this plan*** will be reduced so that they and the benefits payable under the other ***plans*** do not total more than those ***allowable expenses***.

When the benefits of ***this plan*** are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of ***this plan***.

Right to Receive and Release Needed Information
Quartz has the right to decide which facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state law. Each person claiming benefits under ***this plan*** must give ***Quartz*** any facts it needs to pay the claim.

Facility of Payment
A payment made under another ***plan*** may include an amount which should have been paid under ***this plan***. If it does, ***Quartz*** may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under ***this plan***.

Quartz will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by ***Quartz*** is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- The persons it has paid or for whom it has paid;
- Insurance companies; or,
- Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Right to Request Final Benefit Determination

If ***this plan*** is the S ***secondary plan***, ***Quartz*** must be able to determine whether the ***plans*** will make payment prior to making our payment for an ***allowable expense*** under ***this plan***.

Quartz may require evidence of a final benefit determination prior to approving coverage.

VII. RENEWABILITY AND REINSTATEMENT

RENEWAL TERMS

This policy is guaranteed renewable. ***Quartz*** cannot cancel or non-renew your policy because you have used or overused benefits or because your health has deteriorated. ***Quartz*** may cancel this policy only for:

- Nonpayment of ***premium***;
- Material misrepresentation in application for coverage, during the first two years of coverage, or for fraudulent misstatements made at application; or,
- If you move outside the ***Quartz service area***.

REINSTATEMENT

You may terminate your policy by not paying your ***premium***. A terminated policy may be reinstated, at ***Quartz's*** discretion. The following rules apply:

- You must apply for reinstatement within one year of your policy's lapse date;
- You must apply for the same coverage you had;
- ***Quartz*** has the right to approve or decline your application based on evidence of insurability;
- If ***Quartz*** reinstates your policy, losses resulting from accidents occurring or illness beginning between the lapse date and the reinstatement date are not covered; and,
- If ***Quartz*** reinstates your policy, coverage will be effective on the first day of the month following approval, if the required ***premium*** has been paid.

See the Miscellaneous Provisions section for information relating to reinstatement after loss of entitlement to medical assistance under Title XIX of the Social Security Act.

VIII.PREMIUM AND COVERAGE

Upon your payment of ***premium*** and the issue of this policy and a ***Quartz*** ID card, we agree to provide the benefits described in this policy. Unless otherwise explicitly indicated, ***Quartz*** has full discretion and authority to make all determinations required to administer the policy, including eligibility for benefits and interpretation of terms under the policy.

PREMIUM RATES

We determined the ***premium*** rate before accepting your application. We will not change your ***premium*** rate unless we change it for every ***Quartz member*** in the same age and sex category. We reserve the right to increase your ***premium*** at the beginning of each calendar year, when your policy renews. To increase ***premium***, we will notify you 30 days in advance. If the increase is 25% or more, we will notify you 60 days in advance.

PERIODS OF COVERAGE

This policy is issued for a calendar year period. We will send you a ***premium*** notice each month. You may pay your ***premium*** on an annual, quarterly or monthly basis, as you prefer.

PREMIUM DUE DATE

Renewal ***premiums*** are due by the last day of the month before each renewal period. This policy is in force for the initial period of coverage if we have accepted your prepaid ***premium***. ***Quartz*** will renew for further periods of coverage if ***premium*** is received on time.

GRACE PERIOD

You have a grace period for paying ***premiums***. After the last of day of the month in which you paid full ***premium***, you have a grace period of 31 days to pay full ***premium*** for the current month. If you do not pay full ***premium*** during the grace period, this policy will terminate at the end of the grace period. Your policy will remain in force during the grace period, but you remain responsible for the ***premium*** due during that time.

MID-TERM CANCELLATION

We will return a pro rata portion of ***premium*** to you or your estate if:

- You request to cancel the policy mid-term; or,
- The policy terminates mid-term because of your death.

COVERAGE CHANGES

The benefits under this policy change automatically to coincide with any changes in the Medicare deductible amount and copayment or coinsurance percentage factors. There may be a modification of ***premiums*** corresponding to the policy provisions and Wisconsin law.

IX. MISCELLANEOUS PROVISIONS

CONTRACT DOCUMENTS

Our contract consists of this policy and your application, your ID card, and any riders, endorsements or attachments. Changes are valid only if endorsed by ***Quartz's*** President. No agent can change this policy or subtract or waive any provisions.

TIME LIMIT ON CERTAIN DEFENSES

Quartz may investigate statements made by a ***member*** in applying for this policy. It may do so for two years after the original ***effective date***. After this two-year period expires, no misstatements may be used to:

- Void this policy; or,
- Deny a claim that arises after the two-year period expires.

This time limit does not apply to fraudulent misstatements made in the application. This policy was issued on the basis that the statements, representations and warranties made at application are correct and complete. ***Quartz*** may ***rescind*** coverage if information is received that indicates a fraudulent or intentional misrepresentation was made by you or anyone acting on your behalf, if you or the person acting on your behalf knew that the representation was false and the misrepresentation (1) was material or was made with intent to deceive, or (2) contributed to a loss under the ***plan***.

PROOF OF CLAIM

If you pay for services from an ***out-of-network provider***, please submit the itemized bill to ***Quartz*** within 90 days from the date the services were provided. Circumstances beyond your control might make this time limit

unreasonable. If so, you must file the claim as soon as possible, and pursuant to s. 631.81, Wis. Stat., we will still process your claim if you submit it within one year after the time required under this provision. A Member Claim Form is available in the Forms section of ***QuartzBenefits.com***.

If you are submitting claims for which you have already paid, and you are seeking ***Quartz's*** reimbursement, you must provide proof of payment. The bill or receipt from your provider must match the service that you are seeking ***Quartz's*** reimbursement for. In order to be reimbursed, the service(s) or product(s) you received must not be used for employment reasons, will not be used for resale, and are intended for your own personal use. If you submit false receipts or fraudulently altered documents, you may be disenrolled by the ***plan*** and/or subject to civil or criminal penalties.

In-network providers will submit claims on your behalf.

LIMITATIONS ON SUITS

No action may be brought against us to pay benefits until:

- 60 days after we have received or waived proof of loss; or,
- The date we have denied full payment, whichever occurs earlier.

Compliance with this section will not be considered a waiver or be used to prejudice your claim. No action can be brought more than three years after the time we required written proof of loss.

PHYSICIAN AND HOSPITAL REPORTS

Physicians and ***hospitals*** must give ***Quartz*** reports to help ***Quartz*** determine benefits due to you. You agree to cooperate with ***Quartz*** to execute releases that authorize physicians, ***hospitals***, and other providers of service to release all records to ***Quartz*** regarding services you receive. This is also a condition of ***Quartz*** paying benefits. All information must be furnished to the extent ***Quartz*** deems it necessary in a particular situation and as allowed by Wisconsin law.

DIRECT PAYMENT OF BENEFITS

If we choose, we can pay any benefit we owe directly to the physician, ***hospital*** or other provider that furnished the service, care, item or facility. Such payment discharges our liability for the amounts paid.

RECOVERY OF EXCESS PAYMENTS

We might pay more than we owe under this policy. If so, we can recover the excess from you, the ***hospital*** or other provider of care. We can also recover from another insurance company or service plan, or from any other person or entity that has received any excess payment from us.

LIMIT ON ASSIGNABILITY OF BENEFITS

This is your personal policy. You may not assign any benefit except to a physician, ***hospital*** or other provider of health care entitled to receive a specific benefit for you.

SUSPENSION OF COVERAGE DUE TO MEDICAL ASSISTANCE ELIGIBILITY

Benefits and ***premiums*** under this policy may be suspended if:

- You are entitled to Medical Assistance benefits under Title XIX of the Social Security Act (***Medicaid***); and,
- You notify ***Quartz*** within 90 days of entitlement. Suspension of this policy may not exceed 24 months (or such other time period set by federal law).

This policy may be reinstated, without lapse in coverage or an additional waiting period, if:

- You lose ***Medicaid*** entitlement;
- You notify ***Quartz*** within 90 days of the loss; and,

- You pay ***premium*** beginning with the date of loss of ***Medicaid*** entitlement.

SEVERABILITY

If any part of this policy violates state or federal law, that part is without force. However, the remainder of the policy will continue in full force.

CONTINUITY OF CARE

If your chosen ***primary care provider*** leaves the ***provider network***, you will be able to continue seeing that provider through the end of the policy year.

If you are seeing a specialist who leaves the ***provider network***, you will be able to continue seeing the specialist:

- If you are pregnant and in your second or third trimester, through the postpartum period; or,
- For 90 days past the provider's termination date with ***Quartz***, or through the end of the course of treatment, whichever is shorter.

This provision will not apply if the provider is terminated for misconduct.

If you have any questions, please contact ***Quartz*** Customer Success at (800) 362-3310.

X. COMPLAINT AND GRIEVANCE PROCEDURE

RESOLVING COMPLAINTS

If you have a ***complaint*** relating to any aspect of ***Quartz***, you may contact a Customer Success representative. The Customer Success representative will assist in resolving the matter informally. ***Complaints*** may be resolved in this fashion or by filing a ***grievance***.

FILING A GRIEVANCE

You may also file a ***grievance*** according to the procedures described below. A ***grievance*** is a written expression of dissatisfaction with the provision of services under the policy or ***Quartz's*** claims practices or administration of the policy, including a decision to disenroll you. You or a person acting on your behalf may file a ***grievance***.

You must submit the signed ***grievance*** and any supporting materials to the Reconsideration Committee at the following address: 2650 Novation Pkwy., Fitchburg, WI 53713. ***Quartz*** will acknowledge receipt of the ***grievance*** within five business days of receiving it.

You will be notified of the time and place of the Reconsideration Committee meeting at least seven calendar days in advance. You, or a person acting on your behalf, have the right to appear before the Reconsideration Committee in person to present written or oral information concerning the ***grievance***. You may also submit written questions to the person(s) responsible for making the determination that resulted in the denial or determination of benefits or a decision to disenroll you.

You will be notified of the disposition of the ***grievance*** within 30 calendar days of receipt. If ***Quartz*** is unable to resolve the ***grievance*** within 30 calendar days, the time period may be extended an additional 30 calendar days. If an

extension is required, ***Quartz*** will notify you in writing of the reason for extension and when resolution may be expected.

The time periods set forth above do not apply in ***urgent care*** situations. If a ***grievance*** involves an ***urgent care*** situation, ***Quartz*** will treat the ***grievance*** as an expedited ***grievance*** and resolve it within 72 hours after receipt. An ***urgent care*** situation is one which could result in serious or irreparable harm to the health of the ***member*** if the time periods provided by the regular ***grievance*** procedure applied.

OFFICE OF THE COMMISSIONER OF INSURANCE

You may resolve your problem by taking the steps outlined above. You may also contact OCI, a state agency that enforces Wisconsin's insurance laws, and file a ***complaint***. You can file a ***complaint*** electronically with OCI at its website at https://oci.wi/gov, or by writing to:

Office of the Commissioner of Insurance
Complaints Department
125 South Webster Street, P.O. Box 7873
Madison, WI 53707-7873

You may also call (800) 236-8517 outside of Madison or (608) 266-0103 in Madison, and request a ***complaint*** form.

XI. DISENROLLMENT

You may be disenrolled for any of the following reasons:

- You failed to pay required ***premiums*** by the end of the grace period;
- You have made material misrepresentation in an application for coverage. Disenrollment may occur during the first two years of coverage, unless it was a fraudulent misstatement; and,
- You moved outside the ***service area***. If you reside less than 275 days per year within the ***service area***, you are considered to have moved outside the ***service area***.

Non-Discrimination & Language Access

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

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

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

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

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

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

- Qualified interpreter
- Information written in other languages

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

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

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

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

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

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

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

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

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

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

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

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

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

Laotian – ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນທີ່ສຳຄັນ.
ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບໃບສະໝັກ ຫຼື ການຄຸ້ມຄອງຂອງທ່ານຜ່ານ Quartz. ຊອກຫາວັນທີສຳຄັນ ໃນຫນັງສືແຈ້ງການສະບັບນີ້.ທ່ານອາດຈຳເປັນຕ້ອງປະຕິບັດຕາມເວລາ ທີ່ກຳນົດໄວ້ທີ່ແນ່ນອນເພື່ອຮັກສາໄວ້ການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານ ຫຼື ຊ່ວຍເຫຼືອດ້ານຄ່າໃຊ້ຈ່າຍ.ທ່ານມີສິດທີ່ຈະໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີ (800) 362 3310. TTY / TDD: 711 / (800) 877 8973.

German – Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Quartz. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Arabic – يحتوي هذا الإشعار على معلومات مهمة. يتضمن هذا الإشعار معلومات هامة حول طلبك أو تغطيتك عبر Quartz. ابحث عن التواريخ الرئيسية في هذا الإشعار. قد تحتاج إلى إجراء تدابير معيّنة وفقاً لمواعيد معيّنة من أجل الحفاظ على تغطيتك الصحية أو المساعدة في التكاليف. ليدك الحق في الحصول على هذه المعلومات وعلى المساعدة في لغتك دون أي تكلفة. اتصل على TTY / TDD: 711 / (800) 877-8973 / (800) 362-3310.

French – Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Quartz. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Korean – 본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Quartz을 통한 커버리지 에 관한 정보를 포함하고 있습니다.본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가있습니다. (800) 362-3310 로 전화하십시오. TTY / TDD: 711 / (800) 877-8973.

Tagalog – Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Quartz. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Pennsylvanian Dutch – Die Bekanntmaching gebt wichdichi Auskunft. Die Bekanntmaching gebt wichdichi Auskunft baut dei Application oder Coverage mit Quartz. Geb Acht fer wichdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimmde Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix. Kannscht du (800) 362-3310 uffrufe. TTY / TDD: 711 / (800) 877-8973.

Polish – To ogłoszenie zawiera ważne informacje. To ogłoszenie zawiera ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez Quartz.Prosimy zwrócic uwagę na kluczowe daty zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Hindi – **इस सूचना में महत्वपूर्ण जानकारी शामिल है।** इस सूचना में Quartz से जुड़े आपके आवेदन या कवरेज के बारे में महत्वपूर्ण जानकारी शामिल है। इस सूचना में महत्वपूर्ण तारीखों को देखना न भूलें। स्वास्थ्य कवरेज जारी रखने या खर्चे में मदद के लिए आपको कुछ तय तारीखों तक कार्रवाई करनी ज़रूरी है। आपके पास अपनी भाषा में, बिना किसी शुल्क के इस जानकारी और सहायता को पाने का अधिकार है। (800) 362-3310. TTY / TDD: 711 / (800) 877-8973 पर कॉल करें।

Albanian – Ky njoftim përmban informacion të rëndësishëm. Ky njoftim përmban informacion të rëndësishëm për aplikimin ose mbulimin tuaj nëpërmjet Quartz. Kontrolloni për data të rëndësishme në këtë njoftim. Mund t'ju duhet të ndërmerrni veprim brenda afatave të caktuara për të mbajtur mbulimin tuaj shëndetësor ose për ndihmën me koston. Keni të drejtë ta merrni këtë informacion dhe ndihmë falas në gjuhën tuaj. Telefononi numrin (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Somali – FIIRO GAAR AH: Haddii aad ku hadashid af Soomaali, adeegyada caawimada luuqada, ayaa waxaa laguugu siinayaa bilaash, waa laguu heli karaa. 1-800-362-3310 (TTY: 1-800-877-8973) bilbilaa.

Cushite – Oroomiffa XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Amharic – ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ (800) 362-3310. (መስማት ለተሳናቸው: 711 / (800) 877-8973).

Karen – ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤနှ်ံ ကျိာ်အတ်မၤစၢၤလ၊ တလၫ်ဘူဉ်လၫ်စ့ၤ နီတမံၤဘဉ်သုန္ဉ်လီၤ. ကိး (800) 362-3310.TTY / TDD: 711 / (800) 877-8973.

Mon-Khmer, Cambodian – ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Serbocroatian – OBAVJEŠTENJE: Ako govorite srpskohrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite (800) 362-3310 TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711 / (800) 877-8973.

Thai – เรียน: ถา้ คุณพดู ภาษาไทยคุณสามารถใชบ้ ริการช่วยเหลือทางภาษาไดฟ้ รี โทร (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Gujarati – સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Urdu – خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Italian – ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Greek – ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.