Offered by Quartz Health Plan Corporation

Health Maintenance Organization (HMO)

Group Certificate of Coverage

State of Iowa

2650 Novation Parkway
Fitchburg, WI 53713

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Health Maintenance Organization (HMO)
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Quartz Health Plan Corporation, referred to throughout this document as "Quartz," "us," "we," or "health plan"), a health maintenance organization that has entered into an agreement with your employer to provide you with a health care benefit plan. These shorthand terms may also be used to refer to the plan administrator or subcontractors performing administrative tasks on behalf of Quartz. We have issued and delivered to your employer a "Group Master Policy Agreement."

This is your Certificate of Coverage (referred to as "COC") as long as you are eligible for insurance and you become and remain insured with us. This COC is not the contract of insurance. It is the evidence of insurance provided under the Group Master Policy Agreement. This COC describes the essential features of the insurance. This COC replaces and supersedes all Certificates of Coverage and handbooks we may have previously issued to you. This COC is incorporated into and forms a part of the Group Master Policy Agreement issued to your employer. However, if the terms of this COC differ from the terms of the Group Master Policy Agreement, the Group Master Policy Agreement will govern. 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.

Providers are not employed by us. We provide benefits for covered services under the Group Master Policy Agreement. We do not provide health care services. We, in performing our obligations under the Group Master Policy Agreement, are acting only as a health maintenance organization with respect to the Group Master Policy Agreement. We are in no way acting as a plan administrator, a plan sponsor or a plan trustee for the purposes of your Employee Retirement Income Security Act (ERISA), as amended, or any other federal or state law.

The laws of the State of Iowa and federal laws govern all terms, conditions and provisions of the Group Master Policy Agreement.

10-Day Right to Return the Policy

Iowa Code 514A.3(1)(m)

Please read this document carefully. If you are not satisfied with this Policy for any reason you may, within 10 days after you receive it or have access to it electronically, whichever is earlier; return it for a full refund of the premium paid. You can return this policy to our office at 2650 Novation Parkway, Fitchburg, WI 53713. Please state you are returning this policy under “Your Right to Return.” Upon Quartz’s receipt of the returned policy, it becomes invalid. We will refund any premium payments you have made.

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Important Notices

Important Telephone Numbers

Customer Success	(608) 644-3430 or (800) 362-3310
For people who are deaf, hard of hearing, or speech impaired	Call 711 or (800) 877-8973 or you may also call through a video relay service company of your choice.
Free of Charge Language Assistance	(608) 644-3430 or (800) 362-3310
Appeals Specialists	(608) 644-3430 or (800) 362-3310

If you are calling outside of our normal office hours, you can leave a confidential voice mail message. Your call will be returned on the next business day.

Important Fax Numbers

Medical Management	(608) 821-4207
Appeals Specialists	(608) 644-3500
Pharmacy Department	(888) 450-4711

You can also visit our website at **QuartzBenefits.com.**

Guaranteed Issue & Renewability

We will accept every individual that applies for coverage, as outlined in the Eligibility and Enrollment Section of this Policy. This Policy is guaranteed renewable and remains in effect at the option of the Policyholder, except as provided in the When Coverage Ends section of this Policy.

Usual and Customary Charges

Generally, we settle claims from out-of-network providers by determining the usual and customary charge for covered services, supplies and durable medical equipment. The **usual and customary charge** is defined as *the charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.* This could also be an amount developed by Quartz or its vendors using current publicly-available data reflecting fees typically reimbursed to providers or facilities for the same or similar services, adjusted for geographical differences where applicable. We obtain local billing data from a third-party vendor to determine the usual and customary charge.

Your provider may bill more than the usual and customary charge. In that case, Quartz will determine its liability and your cost sharing based on the usual and customary charge. Your provider may bill you for amounts above the usual and customary charge. This is referred to as **balance billing**. Balance billing may also occur when Quartz denies a claim that was coded improperly, and the provider bills you the unpaid amount. Note: An in-network provider may not balance bill you for covered services.

Sometimes, Quartz will base your cost-sharing for out-of-network services on the **qualifying payment amount**, which is *the median contracted rate for Quartz providers in the geographic region*. We use the qualifying payment amount to calculate cost-sharing for:

- Emergency services received out-of-network, including emergency transportation by airplane or helicopter (air ambulance);

- Some ancillary services received from an out-of-network provider at an in-network facility; and,
- Services received from an out-of-network provider at an in-network facility without your informed consent. **Informed consent** is *when an out-of-network provider operating at an in-network facility notifies you that their services are not considered in-network for your Quartz plan, and you agree that the provider may balance bill you for costs that Quartz does not cover*.

In the situations above, out-of-network providers may not balance bill you after you pay the cost-sharing due based on the qualifying payment amount. This cost-sharing will be based on the in-network benefit level and will accumulate towards the annual deductible and maximum out-of-pocket. This is required under the No Surprises Act, which prohibits "surprise billing" or balance billing in many circumstances. If you have questions regarding what constitutes a "surprise" or "balance" bill, please call Customer Success or visit QuartzBenefits.com.

You may contact us before a procedure is performed to determine if the provider's estimated charge will be within the usual and customary charge. You will need to provide us with the provider's estimated charge, the CPT or HCPCS code and the estimated date of service. You may also be provided an advance Explanation of Benefits (EOB) if your provider notifies us that you are scheduled to receive services, as required under federal law.
If you have questions, please contact our Customer Success Representatives at the telephone number provided in the Important Phone Numbers section of this Certificate of Coverage. If you are calling outside of our normal office hours, you can leave a confidential voice mail message and your call will be returned on the next business day.

A Customer Success Representative is available to meet with you in person during our normal office hours. You can also visit our website at QuartzBenefits.com.

Statements in the Application for Your Insurance

Please read the copy of your Enrollment Form included with your Certificate of Coverage previously delivered to you by us, or your employer. Per ***Iowa Code 514A.3****,* misstatements in the Enrollment Form shall be used to void this policy or to deny a claim. Carefully check the Enrollment Form and write to us within 10 days if any information shown on the form is not correct and complete. Insurance coverage is issued on the basis that the answers to all questions and any other material information shown on the Enrollment Form are correct and complete.

Your Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife or physician assistant), in consultation with the mother, decides to discharge the mother or newborn earlier.

Also, under federal law, we may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, we may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, we may impose continued stay approval for the portion of stay after the 48 or 96 hours.

Changes in Eligibility

If you or your dependents have any change in eligibility, you must contact your employer or us as soon as possible.
Changes in eligibility include the following events:

1. Marriage or divorce;
2. Birth, adoption, or Medical Child Support order;
3. A dependent reaches the maximum limiting age;
4. Total disability;
5. Retirement;
6. Medicare eligibility or entitlement; or,
7. Death of you or your dependent.

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act (the "Women's Health Act") was signed into law in October of 1998. The Women's Health Act amended your Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act (PHS Act). This federal law requires individual health policies to provide certain coverage for breast reconstruction following mastectomies. This coverage took effect on January 1, 1999.

Your Group Master Policy Agreement provides coverage for mastectomies. As part of this coverage, your Group Master Policy Agreement also covers the procedures necessary to effect reconstruction of the breast on which the mastectomy was performed, as well as the cost of prostheses (implants, special bras, etc.) and physical complications of all stages of mastectomy, including lymphedema.

This mandate also requires your Group Master Policy Agreement to provide the following coverage to a member who elects breast reconstruction in connection with such mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;

- Surgery and reconstruction of the other breast to produce symmetrical appearance; and,
- Coverage for prostheses and treatment of physical complications of all stages of mastectomy, including lymphedema, in a manner determined in consultation with the attending physician and the patient.

Under the Women's Health Act, coverage of breast reconstruction benefits is subject to the same deductibles, coinsurance and copayments, consistent with those established for other benefits under your Group Master Policy Agreement.

If you have questions, please contact our Customer Success Representatives at the telephone number provided in the Important Phone Numbers section of this Certificate of Coverage. If you are calling outside of our normal office hours, you can leave a confidential voice mail message and your call will be returned on the next business day.

A Customer Success Representative is available to meet with you in person during our normal office hours. You can also visit our website at QuartzBenefits.com.

Availability of Language Services

See the Non-Discrimination & Language Access notice at the end of this Certificate of Coverage for assistance understanding these materials in a language other than English.

Non-Discrimination Rule

Quartz complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, sexual orientation or health status.

Quartz:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters; and,
  - Written information in other formats (large print, audio, accessible electronic formats, other formats);
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreter; and,
  - Information written in other languages.

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

If you believe that Quartz has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex you can file a grievance with:

Compliance Officer
2650 Novation Pkwy.
Fitchburg, WI 53713
Phone: (608) 644-3430 or (800) 362-3310
TTY number: 711 or (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, the 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 at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building, Washington, D.C. 20201

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

Notice of Privacy Practices

EFFECTIVE DATE: SEPTEMBER 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Interpreter Services
For help to translate or understand this, please call (800) 632-3310 or (608) 644-3430.

For people who are deaf, hard of hearing or speech impaired, please call 711 or (800) 877-8973, or you may call through a video relay service company of your choice.

Interpreter services are provided free of charge to you.

We are required by law to protect the privacy of your personal and medical information. We are also required to provide you with this Notice, which explains how we obtain, use and protect your personal and medical information and when we can give out or "disclose" that information to others. You also have rights regarding your personal and medical information that are described in this Notice.

Quartz maintains physical, electronic and procedural safeguards that comply with federal and state regulations to protect your non-public personal information. We limit the use of oral, written, and electronic information about you and ensure that only authorized staff, with a job-related need to know, have access to it. We maintain these safeguards and review them regularly to protect your privacy.

The terms “personal information” or “medical information” in this Notice include any non-public personal information, in any form, that is created or received by Quartz. “Medical information” relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care.

If you have questions about any part of this Notice, complaints regarding our privacy practices, or would like more information about our privacy practices, please contact us at the following address, or call our Customer Success Department at (800) 362-3310. For people who are deaf, hard of hearing or speech impaired, please call TTY 711, (800) 877-8973, or you may call through a video relay service company of your choice.

Privacy Officer
2650 Novation Pkwy.
Fitchburg, WI 53713
Phone: (800) 362-3310

Email: PrivacyOfficial@QuartzBenefits.com

How We May Use or Disclose your Health Information

The following categories describe the ways that Quartz may use and disclose your health information. For each category of uses and disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

Payment Functions

We may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits. Health information may be shared with other government programs such as Medicare, Medicaid, or private

insurance to manage your benefits and payments. For example, payment functions may include reviewing the medical necessity of health care services, determining whether a particular treatment is experimental or investigational, or determining whether a treatment is covered under your plan.

Health Care Operations

We may use and disclose health information about you to carry out necessary insurance-related activities. For example, such activities may include underwriting, premium rating and other activities relating to plan coverage, conducting quality assessment and improvement activities; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration.

Treatment

We may use or disclose your health information to a physician or other health care provider for treatment, provide information on health-related programs such as alternative medical treatments, or health related products and services.

To Business Associates

We may share your information with third party "business associates" that perform various activities for Quartz, for example services related to claims processing, collections, or mailing of information to our members. Whenever an arrangement between Quartz and a business associate involves the use or disclosure of your personal or medical information, we will have a written contract that contains terms to protect the privacy of your information.

Disclosures to Plan Sponsors

We may disclose your health information to the sponsor of your group health plan, for purposes of administering benefits under the plan. If you have a group health plan, your employer is the plan sponsor.

Required by Law

As required by law, we may use and disclose your health information. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

Public Health

Information may be reported to a public health authority or other appropriate government authority authorized by law to collect or receive information for purposes related to preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Health Oversight Activities

We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings related to oversight of the health care system.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Public Safety

We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Workers' Compensation

We may disclose your health information as necessary to comply with workers' compensation or similar laws.

Marketing

We may contact you to give you information about health-related benefits and services that may be of interest to you. If we receive compensation from a third party for providing you with information about other products or services (other than drug refill reminders or generic drug availability), we will obtain your authorization to share information with this third party.

Fundraising

We may contact you for fundraising purposes at which time you may opt out from receiving these communications. Use or disclosure for fundraising purposes is limited to information related to demographics (including your contact information), dates of service, and health insurance status.

Research

Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

National Security

We may use or disclose health information relating to military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

When Quartz May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, Quartz will not use or disclose personal or medical information without your written authorization from you. If you do authorize us to use or disclose your personal or medical information for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose health information about you for the reasons covered by your written authorization, though we will be unable to take back any disclosures we have already made with your permission.

- Your authorization is necessary for most uses and disclosures of psychotherapy notes; and,

- Your authorization is necessary for any disclosure of health information for which the health plan receives compensation.

Genetic Information and Underwriting Activities

Quartz is prohibited from using or disclosing genetic information for underwriting purposes, including determination of benefit eligibility. If we obtain any health information for underwriting purposes and the policy or contract of health insurance or health benefits is not written with us or not issued by us, we will not use or disclose that health information for any other purpose, except as required by law.

Applicability of More Stringent State Law

Some of the uses and disclosures described in this notice may be limited in certain cases by applicable State laws that are more stringent than Federal laws, including disclosures related to mental health and substance abuse, developmental disability, alcohol and other drug abuse (AODA), and HIV testing.

Your Rights Regarding Protected Health Information About You

Right to Request Restrictions

You have the right to request restrictions on certain uses and disclosures of your personal and medical information. Quartz is not required to agree to the restrictions that you request. If you would like to make a request for restrictions, you must submit your request in writing to the Quartz Privacy Officer at 2650 Novation Pkwy., Fitchburg, WI 53713.

Right to Request Confidential Communications

You have the right to receive your health information through a reasonable or alternative means or at an alternative location. For example, you may ask that we only communicate with you at a certain phone number or address. If you wish to request confidential communications, you must submit your request in writing to the Quartz Privacy Officer at 2650 Novation Pkwy., Fitchburg, WI 53713.

Right to Inspect and Copy

You have the right to inspect and receive an electronic or paper copy of health information about you that may be used to make decisions about your plan benefits. To inspect and copy such information, you must submit your request in writing to the Quartz Privacy Officer at 2650 Novation Pkwy., Fitchburg, WI 53713. If you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request.

Right to Request Amendment

You have the right to request that Quartz amend your health information that you believe is incorrect or incomplete. We are not required to change your health information and if your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To request an amendment, you must make your request in writing to the Quartz Privacy Officer, 2650 Novation Pkwy., Fitchburg, WI 53713. You must provide a reason for your request.

Right to an Accounting of Disclosures

You have the right to receive a list or "accounting of disclosures" of your health information made by us in the past six years. To request an accounting of disclosures, you must submit your request in writing to the Quartz Privacy Officer, 2650 Novation Pkwy., Fitchburg, WI 53713. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the cost of providing the lists. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. This will not include disclosures made for the purpose of treatment, payment, or health care operations.

Right to a Paper Copy

Upon request, even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy. You may print a copy of this Notice and future amendments to it by accessing the Quartz website, QuartzBenefits.com/certlookup, or by sending your written request to the Quartz Privacy Officer, 2650 Novation Pkwy., Fitchburg, WI 53713.

Right to be Notified of a Breach

You will be notified in the event of a breach of your unsecured protected health information. Quartz is required by law to maintain the privacy practices with respect to the health information and provide you with notice of its legal duties and privacy practices with respect to health information.

Changes to this Notice and Distribution

Quartz reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that it maintains.

As your health plan, we will provide a copy of our notice upon your enrollment to the plan and will remind you at least every three years where to find our notice and how to obtain a copy of the notice if you would like to receive one. If we have more than one Notice of Privacy Practices, we will provide you with the Notice that pertains to you. The notice is provided to the named insured/subscriber/primary insured of the plan and will pertain to the insured and dependents named under this insured.

As a health plan that maintains a website describing our customer service and benefits, we also post to our website the most recent Notice of Privacy Practices which will describe how your health information may be used and disclosed, as well as the rights you have to your health information. Quartz is required to abide by the terms of its then-current Notice. If our Notice has a material change, we will post information regarding this change to QuartzBenefits.com for you to review. In addition, following the date of the material change, we will include a description of the change that occurred and information on how to obtain a copy of the revised Notice in our annual mailing to all individuals then covered by the plan.

Complaints

Complaints about this Notice of Privacy Practices or about how we handle your health information should be directed to the Quartz Privacy Officer, 2650 Novation Pkwy., Fitchburg, WI 53713. Quartz will not retaliate against you in any way for filing a complaint. All complaints to Quartz must be submitted in writing. If you believe your privacy rights have been violated, you may file a

complaint with the Secretary of the Department of Health and Human Services at hhs.gov/ocr/privacy/hipaa/complaints/ or call (800) 368-1019.

Financial Information Privacy Notice

We are committed to maintaining the confidentiality of your personal financial information. For the purposes of this Notice, **personal financial information** *means information, other than medical information, about insured member or prospective member applying for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.*

We collect personal financial information about you from the following sources:

- Information we receive from you on applications, enrollment forms, or other forms such as name, address, age, and social security number; and,
- Information about your transactions with us, our affiliates or others, such as premium payment history.

We do not disclose personal financial information about our members or former members to any third party, except as required or permitted by law. We restrict access to personal financial information about you to employees, affiliates and service providers who are involved in administrating your health care coverage or providing services to you. We maintain physical, electronic, and procedural safeguards that comply with federal standards to guard your personal financial information.

We may disclose personal financial information to financial institutions which perform services for us, such as electronic fund transfer for payment of premiums.

Plan Description Information

This is a fully insured group health benefit plan. Quartz is the shorthand name for the administrator of this Policy and the insurance underwriting company, Quartz Health Plan Corporation (also referred to as "us," "we" or "health plan"). These shorthand terms may also be used to refer to the plan administrator or subcontractors performing administrative tasks on behalf of Quartz. Benefits are provided under a Group Master Policy Agreement entered into between your employer and us. Claims for benefits are sent to us and we are responsible for paying claims covered under the Group Master Policy Agreement. We and your employer share responsibility for administering the plan. Your employer pays insurance premiums for you and your dependents to us.

Each employee covered under the Group Master Policy Agreement will receive a Certificate of Coverage ("COC"). It contains information regarding eligibility requirements, termination provisions, a description of the benefits provided, and other general plan information.
In addition to this Policy, please refer to your Summary of Benefits and Coverage (SBC) and Schedule of Benefits (SOB) for specific coverage and cost sharing information. Individual and family deductibles are shown on the Summary of Benefits and Coverage document.

- If you have family coverage and are enrolled in a qualified high deductible health plan (HDHP) with a Health Savings Account (HSA), you may have an aggregate deductible. **Aggregate deductible** means *the entire family annual deductible must be met before the plan pays benefits.* Cost sharing limits for individuals on family plans are listed on the SBC.
- If you have family coverage and are enrolled in a plan that is <u>not</u> an HSA-qualified HDHP, you have an embedded deductible. **Embedded deductible** means *each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, before the plan pays benefits.*

The purpose of this COC is to set forth the provisions of this plan that provides for the payment or reimbursement of all or a portion of eligible medical services incurred.

PLAN NAME: Quartz HMO

TYPE OF PLAN: A group health plan providing certain medical benefits to covered employees and dependents.

CLAIMS ADMINISTRATOR:
Quartz
Attn: Claims Department
2650 Novation Pkwy.
Fitchburg, WI 53713

(608) 644-3430 or (800) 362-3310
For people who are deaf, hard of hearing or speech impaired, please call 711, (800) 877-8973, or you may call through a video relay service company of your choice.

Section 1 – Introduction

The Group Master Policy Agreement is a legal contract between your employer and us where we agree to provide medically necessary covered health care benefits to members of your employer group. Terms used the Group Master Policy Agreement are defined within this Certificate of Coverage.

It is important to us that you understand this COC in order to effectively use the benefits provided. You will gain a basic understanding the first time you read this COC. However, thorough understanding will only be gained if you review the COC whenever you plan to receive medical services.

If you have questions, require language assistance, or need to have your member materials provided in another format, please call Customer Success at the telephone number located in the Important Phone Numbers section of this COC. For people who are deaf, hard of hearing or speech impaired, please call 711 or (800) 362-3310. You also may call through a video relay service company of your choice. Interpreter services and assistance with plan information are provided free of charge to you. If you are calling outside of our normal office hours, you can leave a confidential voice mail message. Your call will be returned on the next business day. You can also visit our website at QuartzBenefits.com.

You can visit us at our office by calling and scheduling an appointment. A Customer Success Representative is available to meet with you in person during our normal office hours. You can also visit our website at QuartzBenefits.com.

Section 2 – Access To Covered Health Care

We want to ensure that care is sought when and where it is most appropriate. When obtaining treatment, please present your Health Plan ID card. We will then be billed directly and will notify you of any charges for which you are responsible.

Provider Network

The definition of an **in-network provider** is *a physician, practitioner, qualified treatment facility, pharmacy, hospital, clinic or other healthcare provider which has entered into a participating provider contract with us to provide medical treatment, services or supplies in our provider network, who is listed in the Provider Directory; and from which a member may seek services without a written referral.*

In addition to both primary and specialty care, the network of providers includes other health care providers such as pediatric nurse practitioners, nurse midwives, occupational and physical therapists, chiropractors, durable medical equipment providers, hospice, home health care, pharmacy providers and behavioral health service providers such as psychiatrists, clinical psychologists, and social workers.

This plan does not generally cover non-urgent or non-emergency services received from an out-of-network provider. If you receive prior authorization or a referral for services through an out-of-network provider, you may be subject to balance billing.

In-network providers are listed in our Provider Directory. Included in the Provider Directory are the addresses and phone numbers of in-network providers. The network participation status of providers may change from time-to-time, or may not apply at certain locations. Please review the online Provider Directory at https://quartzbenefits.com/ProviderDirectoryPDFs.

You may seek services of a specialist directly without obtaining prior approval through a written referral as long as you seek care from an in-network provider.

It is your responsibility to use in-network providers. Services from an out-of-network provider are not covered unless:

- They are covered services for urgent/emergent care as described in Section 4;
- An in-network provider has provided us with a written referral, and our Medical Management Staff has approved the referral prior to services being provided. Referrals for out-of-network services will not be granted/approved when capability exists for a particular expertise or service within our provider network.

If you receive a referral to an out-of-network provider, you may be subject to balance billing.

Specialty drugs may be required to be dispensed from an exclusive network specialty pharmacy. Immune globulin and anti-hemophilic factor drugs are some examples. It is your responsibility to use in-network exclusive specialty pharmacies when filling certain specialty drugs if it is determined to be required through our prior authorization process. Prescriptions received from an out-of-network Specialty Pharmacy are not covered.

Prior Authorization

We recognize that your physician is responsible for making medical recommendations regarding your care. However, in order to monitor the frequency, intensity and appropriateness of the services rendered to you, we require prior authorization for certain services. The prior authorization process determines both benefit determinations and medical necessity (see definition below). Services that require a prior authorization are listed on our website at QuartzBenefits.com/IAPAList; however, different requirements may apply if you seek services outside of Quartz's service area.

If you receive prior authorization for services through an out-of-network provider, you may be subject to balance billing.

Medical Prior Authorization
Medical prior authorization requests are handled by our Medical Management Department. Failure to obtain necessary prior authorization may result in a denial of coverage, in which case the responsibility of payment may be yours. Please read this COC, your Summary of Benefits and Coverage, and your Schedule of Benefits carefully to see what covered services require a prior authorization. It is suggested that you or your provider contact us for prior authorization requirements before you receive care. Please call the Customer Success Department at (800)362-3310.

Drug Prior Authorization
Drug prior authorization activities are conducted by our Pharmacy Department. Certain prescription drugs require prior authorization. Failure to obtain the necessary approval may result in a denial of coverage. Please refer to Section 4 – Benefits: Covered and Non-Covered Services of this COC to review covered and non-covered pharmacy services. Due to periodic changes of the prescription drug prior authorization list, it is recommended that you refer to the searchable formulary on our website at QuartzBenefits.com/formulary to review the most current information.

Medically necessary care means *health care services appropriate in terms of type, frequency, level, setting, and duration, to the enrollee's diagnosis or condition, and diagnostic testing and preventive services*. Medically necessary care must:

- Be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and,
- Help restore or maintain the enrollee's health; or,
- Prevent deterioration of the enrollee's condition; or,
- Prevent the reasonably likely onset of a health problem or detect an incipient problem.

The member's attending physician or service provider makes decisions regarding service and treatment. The plan, through its Medical Director(s) or pharmacists, using criteria developed by Medical Management and other recognized sources, has the authority to determine whether a service, treatment, procedure, prescription drug, device or supply is medically necessary and eligible for coverage under the plan. Quartz may also delegate criteria development and medical necessity reviews to other entities.

The fact that a physician, in-network provider, or any other provider has prescribed, ordered, recommended or approved a treatment, service or supply, or has informed you of its availability, does not make the treatment, service or supply medically necessary.

Obtaining Prior Authorization

You may obtain a prior authorization by contacting your in-network provider, who will coordinate with Quartz. The provider may submit a prior authorization request to us for review before any recommended treatment, services, prescription medication/drugs, devices and/or supplies are obtained.

Prior authorization requests for medical services may be sent to us at:

Quartz
Attn: Medical Management
2650 Novation Pkwy.
Fitchburg, WI 53713
Fax: (608) 821-4207

Prior authorization requests or exception requests for prescription drug coverage may be sent to us at:

Quartz Pharmacy Program
2650 Novation Pkwy.
Fitchburg, WI 53713
Fax: (888) 450-4711

For prescription standard determinations, the plan will make its decision and notify you, your authorized representative and the prescribing physician of its coverage determination no later than 72 hours following receipt of the request. The period of the initial decision may be extended up to an additional 24 hours if we determine it is necessary due to such matters beyond our control (including a failure to submit necessary information), if we notify you to explain the circumstances regarding an extension.

You or your prescriber can request an expedited review based on exigent circumstances. ***Exigent circumstances*** *exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.* Exigent circumstances also exist when the enrollee's attending provider attests that an expedited review is needed based on exigent circumstances. For prescription expedited determinations, the plan will make its decision and notify you, your authorized representative and the prescribing physician of its coverage determination no later than 24 hours following receipt of the request. The period of the initial decision may be extended up to an additional 24 hours if we determine it is necessary due to such matters beyond our control, including a failure to submit necessary information, if we notify you to explain the circumstances regarding an extension.

Prior authorized services are subject to benefit limitations and eligibility. Prior authorization requirements apply whether we are your primary or secondary payer of benefits. If you receive prior authorization services through an out-of-network provider, you may be subject to balance billing.

Referral Prior Authorizations

If your in-network provider feels that you require specialty care beyond that available from other in-network providers, then they may submit a referral form to request services from an out-of-network provider. The definition of a **referral form** is *the form prepared in writing by an in-network provider for you in order for you to receive coverage for medical treatment, services, or supplies from an out-of-network provider.* Medical care, treatment, services or supplies that are received through a referral are subject to the exclusions

and limitations of this COC. Referrals must be submitted and approved in writing before any recommended treatment, services or supplies are obtained for a covered expense.

The definition of **out-of-network provider** is *a physician or other health care provider who has not signed a participating provider contract with us to provide medical treatment, services or supplies to members.* Except for emergency care or urgent care outside the service area, benefits are excluded when you receive medical treatment, services, or supplies from an out-of-network provider without a written referral from an in-network provider that has been approved in writing. Referrals for out-of-network services will not be granted/approved when capability exists for a particular expertise or service within our provider network. Depending on whether the referred-to provider is located inside or outside Quartz's service area and what type of care is sought, additional medical necessity review may be required by other entities.

If you receive a referral for services through an out-of-network provider, you may be subject to balance billing.

You will be notified in writing of the decision. If it is approved, the referral form will state the provider, type or the extent of treatment being authorized, the number of visits, and the period of time during which the referral is valid. Take a copy of the approved written referral with you when you receive the services.

Standing Referrals to an Out-of-Network Specialty Provider
You may request that your in-network provider generate a written standing referral to an out-of-network specialty provider if that type of specialty provider is not available in our provider network. Approved standing referrals to an out-of-network specialty provider need to be renewed each year. Specific examples of such specialty providers include:

- Transplant physicians and surgeons; and,
- Specialists in major burn care.

Referral authorization services are subject to benefit limitations and eligibility. The referral requirements apply whether we are your primary or secondary payer of benefits. If you receive a referral for services through an out-of-network provider, you may be subject to balance billing.

Emergency Care

An **emergency** is defined as *a medical condition involving acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child), impairment to bodily functions or serious dysfunction to one or more organs or body parts.*

In case of an emergency medical condition, you should seek care from the nearest provider of health care equipped to handle your condition. If you require follow up care before being able to return to the service area, you must obtain prior authorization for the follow-up care.

Please contact our Customer Success Department at the telephone number provided in the Important Phone Numbers section of this COC to initiate the prior authorization process. See Section 4 – Benefits: Covered and Non-Covered Services for the definition and coverage guidelines of the urgent care services.

New Technology

We frequently evaluate new technology for inclusion as a covered service. In order to cover the services that utilize new technology, all the following criteria must be met:

1. The technology must be non-experimental/non-investigational;
2. It must be approved by the appropriate regulatory body;

3. The research and review of evidence-based medicine demonstrates that the new technology has a positive effect on health and is safe; and,
4. It is more beneficial or less expensive than current alternative treatments.

If an evaluation is performed due to a request for coverage from your provider, a decision shall be made within five working days after all the necessary information needed to make the decision has been received. If coverage is denied, the criteria for the denial will be communicated to the party requesting the evaluation. An explanation of the appeal process will also be issued.

Continuity of Care

Iowa Code 514C.17; Section 2799A-3 of the PHSA

If we terminate our contract with an in-network health care provider while (1) you are undergoing a course of treatment for institutional or inpatient care, or a serious and complex condition, (2) you are pregnant, (3) you are scheduled for non-elective surgery, or (4) you are terminally ill, you may continue to receive treatment from that provider for your condition for a period of up to ninety days, or until treatment is complete, whichever is shorter.

During the period of continuity, payment for covered benefits shall be based on the in-network contracted rates and in-network cost-sharing levels. This continuity of care requirement does not apply if the provider is terminated due to misconduct.

Dependents Attending School Outside Quartz's Service Area

Quartz will provide limited coverage for elective (non-emergency) services for dependents who are full-time students at an accredited school located

outside Quartz's service area. **Service area** means *the geographic area within which Quartz and its affiliated entities are authorized to do business and where Quartz has determined that there are enough in-network providers to serve its members*. This coverage is subject to the deductible shown in the Schedule of Benefits. Coverage is limited to 50% of the usual, customary and reasonable charge as determined by Quartz. All services must be prior authorized by Quartz's Medical Management or Behavioral Health Care Management Departments to be eligible for coverage, and must be obtained through a provider located in reasonably close proximity to the school in which the student is enrolled. Call (800) 362-3310 to authorize medical services, or (800) 683-2300 to authorize behavioral health services. Medical Management and Behavioral Health Care Management will not authorize a service after the service has been obtained.

The school must be:

- An accredited, post-secondary vocational, technical or adult education school; or,
- An accredited college or university that provides a schedule of courses or classes and whose principal activity is the provision of an education.

In order to be eligible for coverage under this section, the student must attend the school in person. Online attendance does not qualify.

Section 3 – Eligibility and Effective Dates for Employees and Dependents

Eligibility

Eligibility of Employees

Iowa Code 513B.9A

You are eligible for coverage if you are in active status, meaning you are scheduled to perform the duties of your occupation with your employer and meet the hours requirement your employer sets for eligibility, have a completed W-4 form on file with your employer, and belong to the eligible class of employees specified by your employer. Your effective date is determined from your eligibility date combined with your employer's established probationary period specific to health insurance eligibility.

If you are not in active status, but your employer continues to pay the required premiums and continues to participate under the Group Master Policy Agreement, your coverage in active status will remain in effect for a maximum of six consecutive months if you are on an employer-approved leave of absence.

Per HIPAA Final Rules – Nondiscrimination in Health Coverage in the Group Market at 45 C.F.R. § 146.121, you are considered to be in active status if you are actively working, or not actively working, but meet all of the following conditions:

1. You retain employment rights in the industry;
2. You have not had your employment terminated by the employer, if the employer provides the coverage, or you have not had your membership in an employee organization (such as an association or union) terminated, if the employee organization provides the coverage;
3. You are not receiving any disability payments from an employer for more than six months;
4. You are not receiving any Social Security disability benefits; and,

5. You have employment-based group health plan coverage that is not COBRA continuation coverage.

Note: An individual may not be enrolled as both an eligible employee subscriber and as a child or spouse dependent under the same employer group policy.

Eligibility of Dependents

An eligible dependent is as follows:

1. Your legally recognized spouse (including common law spouse if you reside in the State of Iowa);
2. Your married or unmarried child, under age 26, that is a:
   - Natural child;
   - Legally adopted child;
   - Child placed with you for the sole purpose of adoption;
   - Foster child;
   - Stepchild, including your common law spouse's child; or,
   - Child for whom you have legal guardianship, including a child who is your legal ward.

You may cover your dependent only if you are covered. We will not deny eligibility to your child, or set a premium rate for your child based on financial dependency, residency with a parent, residency outside of the service area, whether or not you claim the child as a tax exemption, student status, marital status, or based on the fact that your child is eligible to enroll in other employer-sponsored health plan coverage.

Quartz does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

Effective Dates

Enrollment and Effective Date

The **effective date** is the *date on which you and your eligible dependents, if any, become enrolled and entitled to benefits* specified in your Summary of Benefits and Coverage. You may enroll for coverage by contacting your employer to determine if you are eligible to enroll and completing the required forms. Your enrollment form must be received within 31 days of your eligibility date. Unless otherwise stated in this Certificate of Coverage, the effective date of coverage is always the 1st of the month.

You are eligible to enroll for coverage when you meet your employer's eligibility requirements as a new employee. Subsequent eligibility for enrollment depends on meeting Special Enrollment criteria or enrolling during an open enrollment period, if offered by your employer.

Open Enrollment Period

An **Open Enrollment Period** is a *period of time when all potential members are allowed to enroll for coverage, whether or not they are currently enrolled in any of the employer's other health benefit plans*. Your employer can provide you with information on the Open Enrolment Period and how to enroll. Your enrollment form must be received within 31 days of the Open Enrollment Period date.

Special Enrollment Periods

1. **Birth**

   You may enroll your child retroactive to the date of birth by submitting an application and paying any additional premiums due from that date. If no other dependent child has coverage, the employee has 60 consecutive days from the date of birth of a child to apply for dependent coverage effective on the newborn's birth date. The employee may apply for dependent coverage for a newborn up to one year after the newborn's birth date if the employee pays all past premium for the coverage period.

2. Adoption or Placement for Adoption

The date of eligibility is the date a minor child is placed in the employee's home for adoption or the date that a court issues a final order granting adoption or legal guardianship of the minor child to the employee, whichever occurs first.

You may enroll your child retroactive to the child's eligibility date by submitting an enrollment form and paying all premiums due from that date. The employee may apply for dependent coverage for an adopted child up to 60 days after the eligibility date. The employee must pay all past premium for the coverage period.

3. Other Court Orders for Dependent Children

Enrollment form must be received within 31 days from the date of the order.

Effective date of coverage will be the date of the court order.

4. Marriage

Enrollment form must be received within 31 days of the date of marriage.

Your effective date can be the date of marriage or if you choose, first of the month following receipt of your enrollment form.

5. Involuntary Loss of Minimum Essential Coverage

Enrollment form must be received within 31 days of the loss of coverage.

Your effective date will be the day following the date of the loss of other coverage.

6. **Termination of Another Employer's Group Health Plan Coverage During the Other Plan's Open Enrollment Period**
   This special enrollment period only applies when the other group health plan's open enrollment period does not overlap with the open enrollment period of this plan.

   To be eligible for this special enrollment, a completed enrollment form must be received within 31 days of the termination date of the other plan's coverage.

   Your effective date will be the day following the termination date of the other coverage.

7. **Permanent Move or Relocation**
   Enrollment form must be received within 31 days.

   Your effective date will be the first of the month following receipt of your enrollment form.

8. **Loss of Medicaid or SCHIP Coverage**
   Enrollment form must be received within 60 days from the date of loss of your coverage.
   Your effective date will be the date of the loss of other coverage.

When Coverage Ends

Grace Period
A grace period of 31 days will be granted for the payment of each premium falling due after the first premium. During the grace period, this policy will continue in force. If you fail to pay full premium and the grace period expires, your coverage will end at 11:59 pm on the last day of the grace period.

Your Coverage will end on the last day of the month in which any of the following occur:

1. The Group Master Policy Agreement terminates;
2. Your employment terminates (unless you elect continuation coverage);
3. You cease to meet eligibility requirements;
4. You request voluntary termination for you or for your Dependents;
5. You retire, unless retirees are listed as a covered class on the Employer Group Application;
6. You die;
7. You have allowed an unauthorized person to use your health plan ID card to obtain services or you have knowingly provided fraudulent information in applying for coverage. If we terminate your coverage for this reason, we will make arrangements to provide you with similar alternate coverage until you find other coverage or until you have the option to change insurers; or,
8. You change coverage during the annual open enrollment period or during a special enrollment period.

Coverage for your dependent will end on the last day of the month in which:

1. Divorce – a divorce decree is granted;
2. Children (including legal guardianship of children) – the child turns age 26; and,
3. Death – the death occurred.

Your employee termination notice must be received in our office within 60 days from the date of the event.

There are federal and state laws that apply to continuing your coverage when you are no longer in active status under the Group Master Policy Agreement. See Section 9 in this COC.

Extension of Coverage for Children

Physical or Mental Impairment
Children who are currently covered under the Group Master Policy Agreement who are, or become, incapable of self-support due to a physical or mental impairment, continue to be eligible after attainment of the limiting age if the child is:

1. Dependent on you for support and maintenance; and,
2. Incapable of self-sustaining employment.

A **physical or mental impairment** is defined as *an impairment that substantially limits one or more of the major life activities of a person.* Physical impairments include a physical disorder or condition, a cosmetic disfigurement or an anatomical loss affecting one or more of the following body systems:

1. Neurological;
2. Musculoskeletal;
3. Special sense organs, including speech organs;
4. Respiratory;
5. Cardiovascular;
6. Reproductive;
7. Digestive;
8. Genitourinary;
9. Hemic and lymphatic;
10. Skin; or,
11. Endocrine.

Coverage may be continued as long as you remain insured under the Group Master Policy Agreement and your child remains unmarried, incapacitated and dependent upon you. You must provide us with written proof of incapacity within 30 days after the child's attainment of the limiting age. Dependency proof will be verified by submitting a copy of your annual tax return that lists this child as a dependent. Annually, or at reasonable intervals during the first two years of the continued coverage, we may request that an

in-network provider examine your child. You must notify us immediately of a cessation of incapacity or dependency.

Termination of Group Master Policy Agreement

Iowa Administrative Code Ch. 35.26(1), Ch. 40.10

We may cancel or non-renew the Group Master Policy Agreement with at least 30 days' advance written notice only for the following reasons:

1. Failure of your employer to pay a premium when due;
2. Fraud or a misrepresentation by you or your employer;
3. Failure to meet enrollment participation;
4. Failure to meet employer group premium contribution or participation requirements, if applicable;
5. There is no longer a member in your employer group who resides or works in the service area; or,
6. The Group Master Policy Agreement is issued to a *bona fide* association and your employer ceases to be a member of the plan.

Product Discontinuation

We may choose to discontinue offering a product under the Group Master Policy Agreement if all of the following apply:

1. We provide notice of the discontinuance to each employer and to the members covered under the plan at least 90 days before the date on which the coverage will be discontinued;
2. We act uniformly without respect to the health status of a group; and,
3. We offer to each employer to whom we provide coverage of this type in the state of Iowa the option to purchase any of our other plans available for sale for which the employer is eligible.

Market Exit

We may choose to discontinue offering all group coverage in the state of Iowa if all of the following apply:

1. We must provide notice to all of the affected employers and to the Commissioner in each state in which an affected member resides no later than 180 days before termination of coverage;
2. We act uniformly without respect to the health status of a group; and,
3. We do not establish a new class of business earlier than five years after the nonrenewal of the discontinuation of the group policies.

Section 4 – Benefits: Covered and Non-Covered Services

If you are unsure if a service will be covered, please call Customer Success at (800) 362-3310 prior to having the service performed.

Medical services, supplies or treatment are all covered expenses when they are (1) incurred while your coverage is in force, (2) received from an in-network provider, (3) received from an out-of-network provider, but only with a prior approved written referral, (4) received from an out-of-network provider in an emergency, (5) listed as a covered expense under this COC, (6) not in excess of any maximum amount payable under this COC, (7) consistent with your Summary of Benefits and Coverage and your Schedule of Benefits, and (8) medically necessary.

Medically necessary care is defined as *medical treatment, services or supplies that are required to identify or treat an illness or injury and which, as determined by us, are*:

1. Consistent with the symptoms, the diagnosis or the treatment of your medical condition;
2. Appropriate with regard to the standards of good medical practice;
3. Not primarily for the convenience of you or your immediate family, or that of your physician or another provider;
4. The most appropriate and cost-effective level of medical service or supplies that can be safely provided. When applied to inpatient care, it further means that the medical symptoms or the conditions require that the medical services or the supplies cannot be safely provided as an outpatient;
5. Of proven value or usefulness; and,
6. Compliant with your provider's treatment plan.

Please refer to Section 2 of this COC, as well as your Summary of Benefits and Coverage and your Schedule of Benefits for a list of services that require prior authorization, noting that different requirements may apply if you seek services outside of Quartz's service area. Because we may periodically add to, remove from, or change the prior authorization list, it is recommended that

you or your provider contact us for prior authorization for the services listed. Please call Customer Success at (800)362-3310.

It is your responsibility to use in-network providers. Non-emergency services from an out-of-network provider are not covered unless they are a covered expense as described in this section, or an in-network provider has provided us with a written referral and our Medical Director has approved the referral prior to the services being provided.

The fact that a physician, an in-network provider, or any other provider has prescribed, ordered, recommended, or approved a treatment, a service or supply, or has informed you of its availability, does not make a covered service medically necessary.

The **coverage period** is defined as *the 12-month policy year for group renewal*. The coverage period begins on your group's anniversary or renewal date, and could begin any time during the calendar year. Some changes in your coverage of services may be introduced on your group's renewal date. Regulatory changes required by federal or state law are introduced at any time during the coverage period.

Benefit year is defined as *a 12-month period of health insurance coverage used for calculating deductibles, coinsurance, benefit limitations, and out of pocket maximums*. The benefit year may be the same as a calendar year starting over each January 1, or it may be based on your group's renewal date (i.e., first date of the coverage period). Claims are processed in the order received and not necessarily in the order that care is provided.

In addition to this COC, please refer to your Summary of Benefits and Coverage and Schedule of Benefits for specific coverage and cost sharing information. Individual and family deductibles are shown on the Summary of Benefits and Coverage document.

- If you have family coverage and are enrolled in a qualified high deductible health plan (HDHP) with a Health Savings Account (HSA), you have an aggregate deductible. **Aggregate deductible** means *the*

entire family annual deductible must be met before the plan pays benefits;

- If you have family coverage and are enrolled in a plan that is not an HSA-qualified HDHP, you have an embedded deductible. **Embedded deductible** means *each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, before the plan pays benefits.*

Deductible and coinsurance accumulations during the last three months of the benefit period do not carry over as credits to meet your deductible for the following year.

If you are an inpatient in a covered facility on the date your benefit year renews, then your benefit calculations and payment obligations for the services received will start over on the date of your new benefit year. Benefit calculations and payments will be based on the benefit plan in force on the day you receive your services.

Acupuncture

Covered Services

1. Acupuncture only:
    - For chronic pain management when other methods of pain management are not well tolerated;
    - For treatment of nausea/vomiting associated with pregnancy or chemotherapy; and,
    - When received from a licensed acupuncture provider or licensed physician.

Acupuncture is not covered for the treatment of any other conditions. Coverage is limited to 12 visits per benefit year.

Allergy Services

Covered Services

1. Initial diagnostic evaluation and standard allergy testing; and,
2. Allergy injections.

Non-Covered Services

1. Sublingual (under the tongue) allergy testing and treatment, except coverage is provided under the Prescription Drug Benefit if the medication is FDA-approved and has been designated as a Formulary Drug by Quartz's Pharmacy and Therapeutic Committee; and,
2. Repeated intradermal testing or testing which is considered experimental by us, including cytotoxin testing.

Ambulance Services

Covered Services

1. Emergently needed transportation by a professionally licensed ground or air ambulance service to the nearest hospital equipped to adequately treat your condition.

Covered with Prior Authorization

1. Scheduled or prearranged non-emergent ambulance transportation only when associated with covered hospice care.

Non-Covered Services

1. Ambulance services are not covered when the member is not actually transported by ambulance.

Bariatric Surgery

Covered with Prior Authorization
Bariatric surgery is covered when Quartz Medical Policy criteria are met and the service has been prior authorized.

Recognized bariatric surgical procedures are covered, including but not limited to pre-operative and post-operative care and the services of physicians, assistants and consultants that are necessary for the bariatric surgery. For a copy of Quartz Medical Policy criteria, please contact Customer Success at (800) 362-3310.

Removal of excess skin resulting from weight loss is excluded from coverage, , except that panniculectomy procedures may be covered following weight loss if determined to be medically necessary by Quartz.

Behavioral Health and Substance Use Disorders

Iowa Code 514C.22, 514C.27 and 514C.31

Covered Services

1. Emergency behavioral health services provided by an emergency room or crisis stabilization program certified by the appropriate credentialing body in their state are covered for persons who are experiencing a behavioral health crisis or who are in a situation likely to turn into a behavioral health crisis if emergency support is not provided;
2. Medically necessary inpatient treatment of nervous and mental disorders, or substance use disorders, while confined in a hospital or qualified treatment facility. A **qualified treatment facility** is defined as *a facility, institution, or clinic duly licensed and operating within the scope of its license*. This type of care would include programs approved under the following:
    - Medically managed detoxification;

- Medically monitored residential detoxification; and,
- A psychiatric unit including detoxification and psychiatric bed of an acute care general hospital;

3. Medically necessary outpatient treatment of nervous and mental disorders, or substance use disorders, while not confined to a hospital or qualified treatment facility. This type of care would include ambulatory detoxification service;
4. A range of digital care options may also be available and are covered when received through in-network providers or a Quartz-sponsored care management program;
5. Medications provided as part of an outpatient treatment program;
6. Office visits for the purpose of medication therapy management; and,
7. Treatment of biologically based mental illness (***Iowa Code 514C.22***), which includes the following psychiatric illnesses:
   - Schizophrenia;
   - Bipolar disorders;
   - Major depressive disorders;
   - Schizo-affective disorders;
   - Obsessive-compulsive disorders;
   - Pervasive developmental disorders;
   - Autism Spectrum Disorders (ASD). Members with a diagnosis of an Autism Spectrum Disorder (ASD) are eligible for services. ASD includes Autism Disorder, and pervasive developmental disorder not otherwise specified. Diagnosis must be established through a comprehensive evaluation by an appropriate provider with evidence that meets criteria for a diagnosis of ASD as outlined in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; and
8. Services provided in intensive outpatient programs by in-network providers who are certified by the appropriate credentialing body in their state.

Covered with Prior Authorization

1. Clinical therapeutic intervention for the treatment of Autism Spectrum Disorders, including but not limited to applied behavioral analysis (***Iowa Code 514C.31***):
    - Benefits may be managed through the use of preferred providers, utilization review, and other common methods to assure services are medically necessary and clinically appropriate;
    - Quartz may request a treatment plan as frequently as once every three months in the first year of the plan, and as frequently as every six months in subsequent years of the treatment plan;
2. Transitional treatment, offered by an in-network provider certified by the appropriate credentialing body in their state and received in an outpatient setting that is more intensive than traditional outpatient care, but less restrictive than traditional inpatient care. Approved treatment programs are required to provide a minimum of four hours of structured treatment daily. Transitional treatment applies to outpatient mental health benefits, and includes:
    - Services provided in day treatment programs by in-network providers who are certified by the appropriate credentialing body in their state;
    - Services for persons with chronic mental illness provided through a community support program certified by the appropriate credentialing body in their state;
    - Services provided in residential treatment programs certified by the appropriate credentialing body in their state;
    - Services provided in partial hospitalization programs by in-network providers who are certified by the appropriate credentialing body in their state; and,
3. Coverage for emergency court orders, detentions or commitments is limited to commitments or court orders. If a member is examined, evaluated or treated for a nervous or mental disorder pursuant to a detention, commitment or a court order, and an in-network provider is available, the covered expense will be payable in accordance with the terms and provisions of the Group Master Policy Agreement.

Non-Covered Services

1. Maintenance therapy or treatment that does not result in documented sustained improvement. **Maintenance therapy** is defined as *ongoing therapy delivered after the acute phase of an illness has passed. It begins when a patient's recovery has reached a plateau or improvement in their condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated*;
2. Any treatment or therapy which is court ordered, ordered as a condition of parole, probation, custody, or visitation evaluation, unless such treatment or therapy is normally covered by us;
3. Art, dance, music, or animal-based therapies;
4. Services provided by a therapist living in the patient's home or who is a member of the immediate family;
5. Services by a non-payable provider as determined by us, including providers practicing in non-certified facilities within the State of Iowa;
6. Residential treatment as a substitute for legal actions or to provide respite for the family;
7. Recreational or non-skilled services or activities conducted through wilderness and camp programs, therapeutic boarding schools and academy-vocational programs;
8. Group homes and halfway houses for supportive and maintenance care;
9. Shelter services, correctional services, detention services, group residential services and foster care services; and,
10. Crisis intervention programs and services that do not meet the requirements or are not licensed by the local Health and Human Services Department. Covered services must be medically necessary and provided by licensed psychiatrists, psychologists, social workers, marriage and family therapists or licensed alcohol and drug counselors as appropriate in each case.

Biofeedback

Covered Services

1. With prior authorization, biofeedback is covered for the treatment of:
   - Headaches;
   - Spastic Torticollis or Spasmodic Torticollis; and,
   - Pediatric voiding dysfunction. Biofeedback coverage for pediatric voiding dysfunction is limited to eight visits per lifetime.

Non-Covered Services

1. Biofeedback is not covered for the treatment of muscle wasting, muscle spasm, muscle weakness, adult urinary or stress incontinence, or any other condition not listed as covered.

Cancer Treatment

Covered Services

Routine Patient Care is defined as *medically necessary health care services, items, and drugs for the treatment of cancer, including cancer therapy, chemotherapy, infusion therapy, and radiation therapy*.

1. Routine care is covered during cancer clinical trials (***Iowa Code 514C.26***), including:
   - Health care services, items, and drugs that are typically provided in health care; including health care services, items, drugs provided to a patient during the course of treatment in a cancer clinical trial for a condition or any of its complications; and that are consistent with the usual and customary standard of care, including the type and frequency of any diagnostic modality; and,
   - Coverage of routine care not associated with the clinical trial is subject to all terms, conditions, restrictions, exclusions, and other coverage under our plan.
2. A cancer clinical trial must satisfy all of the following criteria:

- A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes;
- The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes and is medically appropriate;
- The trial has therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology;
- The trial does one of the following:
  - Tests how to administer a health care service, item, or drug for the treatment of cancer;
  - Tests response to a health care service, item, or drug for the treatment of cancer;
  - Compares the effectiveness of health care services, items, or drugs for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer; or,
  - Studies new uses of health care services, items, or drugs for the treatment of cancer;
- The trial is an approved phase I, II, III or IV clinical trial and approved by one of the following:
  - The National Institute of Health or one of its cooperative groups or centers, under the federal Department of Health and Human Services;
  - The Federal Food and Drug Administration (FDA);
  - The Federal Department of Defense; or,
  - The Federal Department of Veterans Affairs.

Coverage for orally administered cancer medication, which is provided through prescription drug benefits, will not be less favorable with respect to member cost sharing than intravenously or injected cancer medications (***Iowa Code 514C.24***). Please refer to the Oral Oncology Split Fill Program under the Prescription Drug section for more information on select medications.

Non-Covered Services

1. Routine patient care does <u>not</u> include the health care service, item, or investigational drug that is the subject of the cancer clinical trial. It

does not include any health care service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient. It does not include an investigational drug or device that has not been approved for market by the FDA;

2. Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that are associated with travel to or from a facility providing the cancer clinical trial;
3. Any services, items, or drugs provided by the cancer clinical trial sponsors free of charge for any patient;
4. Any services, items, or drugs that are eligible for reimbursement by a person other than us, including the sponsor of the cancer clinical trial; and,
5. Experimental clinical trials for cancer treatment.

Cardiac Rehabilitation

Covered Services

1. Cardiac rehabilitation therapy is covered for patients who have had:
   - A heart attack in the last 12 months;
   - Coronary bypass surgery;
   - Heart valve repair/replacement;
   - Percutaneous transluminal coronary angioplasty (PTCA) coronary stenting;
   - Stable angina pectoris;
   - A heart or heart-lung transplant; or,
   - Other open-heart surgery procedures;
2. Cardiac rehabilitation as provided in an inpatient program; and,
3. Cardiac rehabilitation as provided through an outpatient program in an outpatient department of a hospital, medical center or clinic program.

Cardiac Rehabilitation is limited to 90 days per benefit period.

Non-Covered Services

1. Phase III cardiac rehabilitation.

Chiropractic Services

Covered Services

1. Chiropractic services, including manipulative treatment and therapeutic procedures and modalities for the treatment of an illness or injury.

Non-Covered Services

1. Maintenance or palliative therapy; and,
2. Items including, but not limited to, pillows, nutritional supplements, exercise programs or equipment.

Maintenance therapy is defined as *ongoing therapy delivered after the acute phase of an illness has passed.* It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. We make the determination of what constitutes maintenance therapy after reviewing an individual's case history or treatment plan submitted by a provider of health care.

Clinical Trials

Covered Services

1. Routine costs, items and services associated with the clinical trial are covered to the same extent they would otherwise be eligible for coverage.
    - The clinical trial must be a Phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition;

- The member participating in the clinical trial must be eligible to participate in the trial according to the trial protocol and the referring health care professional's medical information establishing appropriateness; and,
- The trial must be approved by one of the following:
  - The National Institute of Health or one of its cooperative groups or centers under the federal Department of Health and Human Services;
  - The federal Food and Drug Administration (FDA);
  - The federal Department of Defense; or,
  - The federal Department of Veterans Affairs.

Covered with Prior Authorization

1. Clinical trials provided outside of the Quartz provider network, as well as outside the state in which the member resides, require prior authorization and referral by an in-network provider.

Non-Covered Services

1. Routine patient care does not include the health care service, item, or investigational drug that is the subject of the clinical trial. It does not include any health care service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient;
2. Investigational drug or device that has not been approved for market by the FDA;
3. Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that are associated with travel to or from a facility providing the cancer clinical trial;
4. Any services, items, or drugs provided by the clinical trial sponsors free of charge for any patient;
5. Any services, items, or drugs eligible for reimbursement by a person other than us, including the sponsor of the clinical trial; and,
6. Clinical trials that are experimental or are not approved Phase I, II, III or IV clinical trials.

Dental and Oral Surgery

Covered Services

1. Covered services include services required because of injury, accident, or cancer that damages sound natural teeth as long as the patient was covered under the policy during the time of the injury or sickness causing the damage. Care must be completed within 12 months of the occurrence. Associated radiology services are included;
2. Anesthesia and hospitalization charges for dental care for covered individuals upon determination by a licensed dentist and the individual's treating physician that such individual requires necessary dental treatment in a hospital or ambulatory surgical center due to a dental condition or a developmental disability for which patient management in the dental office has proved to be ineffective. Such coverage applies regardless of whether the services are provided in a hospital or dental office (***Iowa Code 514C.20***);
3. Anesthesia and hospitalization charges for dental care for covered individuals who, upon a determination by a licensed dentist and the member's treating physician, has one or more medical conditions that would create significant or undue medical risk for the member in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical center (***Iowa Code 514C.20***);
4. Anesthesia to include local anesthesia, general anesthesia and intravenous sedation when medically necessary and performed in association with an eligible procedure;
5. Excision of tumors and cysts of the oral structures for pathological examination;
6. Oral examinations, consultations and office visits when performed in association with a covered procedure or diagnosis;
7. Surgical procedures to correct bodily injury to the oral structures;
8. X-rays when performed in association with a covered procedure or diagnosis; and,
9. Surgical removal of partially or completely unerupted impacted teeth (e.g., wisdom teeth).

Covered with Prior Authorization

1. Osteotomies when performed to correct a functional defect; and,
2. Temporomandibular Joint Dysfunction (TMJ). **TMJ** is defined as *a disorder of the jaw joint(s) and/or associated parts, resulting in pain or inability of the jaw to function properly.* Coverage is provided for surgical and nonsurgical correction of TMJ, including reduction of dislocations and displacements.
    - Surgical procedures are covered when:
        - The condition is caused by a congenital, developmental, or acquired deformity, or a disease or injury;
        - The procedure is reasonable and appropriate for the diagnosis or treatment of the condition; and,
        - The procedure is being performed to control or eliminate pain, infection, disease or dysfunction;
    - Nonsurgical treatment including intraoral splint therapy is covered when considered medically necessary and approved by us.
4. Orthognathic surgical procedures, when Quartz determines medical necessity criteria are met for the correction of a severe and handicapping malocclusion of the mandible and/or maxillae.

Non-Covered Services

1. Dental treatment, services and supplies not specifically indicated as covered services, including but not limited to:
    - Apicoectomy (excision of apex of tooth root) and retrograde fillings;
    - Crowning or capping of teeth;
    - Crowns, bridges or dentures, and general dental procedures;
    - Excision of exostoses of the jaws and hard palate;
    - Extraction of teeth;
    - Fillings or dental restoration;
    - Frenectomy (incision of the membrane connecting the tongue, cheek or lip to associated dental mucosa);
    - Gingivectomy;
    - Nonsurgical extraction of teeth due to dental disease, even when recommended prophylactically as part of a medical plan of

treatment. This exclusion applies, but is not limited to, extraction of teeth prior to a surgical procedure or treatment necessary for a medical condition;
- Orthodontics and any other services related to correction of malocclusion or TMJ;
- Orthognathic surgery for the treatment of TMJ;
- Periodontal surgical and non-surgical procedures including grafting and osseous surgery if performed to correct a disease process to the extent which warrants surgical intervention;
- Replacement of lost teeth and all oral surgical services related to the replacement of lost teeth including dentures, and partial dentures, bridges and implants, unless the loss is accidental;
- Root canal procedures; and,
- Routine and prophylactic dental care.

Diabetes Services

Iowa Code 514C.18

Covered Services

1. Diabetic self-management education programs; and,
2. Preferred diabetic equipment and supplies, including:
   - Insulin blood glucose meters;
   - Insulin syringes;
   - Insulin injection aids;
   - Installation and use of insulin infusion pump (subject to prior authorization);
   - Prescribed oral agents controlling blood sugars;
   - Glucose agents;
   - Glucagon kits;
   - Insulin measurement and administration aids for the visually impaired and other medical devices for the treatment of diabetes;
   - Blood test strips and tablets (glucose and ketone);

- Urine test strips and tablets (glucose and ketone); and,
- Lancet and lancet devices when provided by an in-network pharmacy.

Diabetic supplies are limited to those listed in our current Drug Formulary/Diabetic Supply Listing. You can review the current listing, by visiting our website at QuartzBenefits.com/formulary.

3. Diabetes self-management training and education only under all of the following conditions:
   - The physician managing the individual's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge to participate in the management of the individual's condition;
   - The diabetic self-management training and education program is certified by the Iowa Department of Public Health. The department shall consult with the American Diabetes Association - Iowa Affiliate in developing the standards for certification of diabetes education programs; and,
   - Initial training shall cover up to 10 hours of initial outpatient diabetes self-management training within a continuous 12-month period for each individual that meets any of the following conditions:
     - A new onset of diabetes;
     - Poor glycemic control as evidenced by glycosylated hemoglobin of nine and five-tenths or more in the 90 days before attending the training; and,
     - A change in treatment regimen from no diabetes medications to any diabetes medication, or from oral diabetes medication to insulin.
4. Certain diabetes management outpatient services may be covered with no cost-sharing when you are participating in a Quartz care management program and these personalized prevention plan services are received from select in-network pharmacists. Services may be provided in person or via telehealth.

Covered with Prior Authorization

1. Installation and use of insulin infusion pump;
2. Repair or replacement of insulin pump due to normal wear and tear when out of warranty;
3. Continuous glucose monitor; and,
4. Non-preferred diabetic supplies may require a prior authorization for coverage.

Non-Covered Services

1. Repair or replacement of insulin infusion pump due to theft, loss, or damage;
2. Repair or replacement of blood glucose meters due to theft, loss, or damage; and,
3. Repair or replacement of continuous glucose monitor due to theft, loss or damage.

Dietary Counseling and Supplements

Covered Services

1. Dietary counseling when:
   - Provided in conjunction with treatment of an illness, such as diabetes, hypertension, or morbid obesity; and,
   - Ordered by an in-network provider consistent with the medical protocol for treatment of that diagnosis;
2. Dietary counseling visits for treatment of hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease; and,
3. Phenylketonuria testing, diagnosis, and treatment including dietary management, formulas (amino acid-based elemental formula for infants), care management, intake and screening, assessment, comprehensive care planning and service referral.

Covered with Prior Authorization

1. Enteral feedings, equipment, and supplies are covered when the following criteria are met:
   - Feedings must be ordered by an attending physician and/or registered dietician;
   - Meets all medical necessity criteria; and,
   - Prior authorization must be updated at least annually;
2. LINX Procedure when the following criteria are met:
   - The procedure is used to treat gastroesophageal reflux disease (GERD);
   - Meets all medical necessity criteria; and,
   - The procedure is prior authorized by us.

Non-Covered Services

1. Any weight loss treatment, including but not limited to medications, self-help groups, exercise and weight loss programs, and dietary supplements.

Disposable Medical Supplies

Covered Services

1. **Disposable medical supplies** are defined as *items that cannot withstand repeated use or are intended for one-time use, then discarded.* These items are covered when prescribed by a provider during their supervision of a medical illness or injury, and include, but are not limited to syringes, surgical dressings, and ostomy supplies.

Non-Covered Services

1. Medical supplies that do not require the order of an in-network provider and are usually stocked in the home for general use. Examples include, but are not limited to bandages, gauze pads, tape, incontinence supplies, disposable under pads, elastic bandages; and,
2. Medical supplies used in conjunction with a non-covered service.

Drugs and Biologicals

Coverage for self-administered prescription drugs is described in the "Prescription Drug Benefit" section, and follows the Prescription Drug Tiers listed on your Summary of Benefits and Coverage (SBC). Self-administered prescription drugs are obtained at pharmacies. Some pharmacies may be attached to or inside other facilities, like hospitals.

In contrast, certain drugs are administered by a health care provider and follow your medical benefits. For example, drugs received while confined in a hospital or administered in a facility on an outpatient basis are subject to your medical benefits.

Some drugs or biologic products covered under the medical benefit require prior authorization. To control costs, Quartz may require members to receive designated products from select in-network providers. If the drug is authorized, the authorization letter may identify for the member and prescribing physician where the designated medical benefit drug may be administered. Failure to obtain the drug at an approved in-network provider will result in a denial of coverage for the drug.

Durable Medical Equipment

Durable Medical Equipment is defined as *equipment that must*:

1. Be able to withstand repeated use;
2. Be primarily and customarily used to serve a medical purpose;
3. Not be generally useful to a person except for the treatment of an injury or illness; and,
4. Be medically necessary.

Examples include, but are not limited to mattresses, TENS/Neurostimulators, power operated vehicles, crutches, wheelchairs, hospital beds, equipment used in the administration of oxygen, orthosis and internal and external

prosthetic devices, including, but not limited to the initial acquisition of artificial limbs (***Iowa Code 514C.25***). Rental or purchase of items is at our option, based on cost effectiveness and the type of equipment.

In comparing equipment alternatives, we consider whether distinct medical advantages justify greater cost or more frequent replacement. Thus, we do not cover added costs for equipment that has no advantage over a suitable alternative other than convenience or personal preference. We also do not cover repair or replacement of equipment damaged because of negligent use or abuse. We reserve the right to determine whether to rent or purchase. If more than one piece of Durable Medical Equipment can meet your functional needs, benefits are available only for the equipment that meets the minimum specifications for your needs. Exhaustion of an active warranty is required before Quartz will replace Durable Medical Equipment.

Covered Services

1. Purchase or repair of medically necessary durable medical equipment. Certain durable medical equipment may require prior authorization for coverage. Please review your Summary of Benefits and Coverage (SBC) for information on prior authorization requirements;
2. Compression stockings when prescribed by an in-network provider, up to a maximum of two pairs (four stockings) per benefit year;
3. Standard breast prosthesis is limited to one per side every 24 months (***Iowa Reg. 191-35.35(1)***). Two mastectomy bras are allowed per benefit year when obtained from an in-network provider; and,
4. Replacement batteries for prosthetics and electric wheelchairs.

Covered with Prior Authorization

1. Purchase or repair of medically necessary durable medical equipment on the Prior Authorization list;
2. Equipment rental;
3. Prothrombin (INR) Time Home Testing System;
4. Home infusion therapy and associated services and supplies; and,
5. Mobility devices (scooter, stroller, or wheelchair). Only one type is covered at a time.

Non-Covered Services

1. Equipment, appliances, devices and supplies that are not prescribed to treat illness or injury, including but not limited to safety equipment, such as, helmets, some braces and safety seats. This exclusion does not apply to items provided to members who are eligible for and enrolled in a Quartz-sponsored clinical, care management or disease management program, or when items are provided through care management;
2. Automated external defibrillators (AEDs);
3. Equipment, models, or prosthetic devices, whether or not prescribed by an in-network provider, that have features over and above the standard model unless medically necessary as determined by us;
4. Medical supplies and durable medical equipment that are primarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by an in-network provider). This includes, but is not limited to air conditioners, air purifiers, vacuum cleaners, motorized transportation equipment, escalators, elevators, ramps, waterbeds, clothing, hypoallergenic mattresses, items for comfort or convenience, cervical or lumbar pillows or cushions, swimming pools, whirlpools, self-help devices not medical in nature, spas, exercise equipment, gravity lumbar reduction chairs, home monitoring devices, home blood pressure cuffs and kits, personal sound amplification products (PSAPs), personal computers, motor vehicles or customization of vehicles, lifts for wheelchairs and scooters, and stair lifts. This exclusion does not apply to items provided to members who are eligible for and enrolled in a Quartz-sponsored clinical, care management or disease management program, or when items are provided through care management;
5. Back-up supplies, equipment or prostheses (i.e., a second set);
6. Repairs and replacement of supplies, equipment or prostheses if lost, stolen or if unusable and non-functioning due to misuse, abuse or neglect; and,
7. Home testing and monitoring supplies and related equipment, except those used in connection with the treatment of diabetes and long-term anticoagulant therapy.

Emergency Services

Iowa Code 514C.16

An **emergency** is defined as *a medical condition involving acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child), impairment to bodily functions or serious dysfunction to one or more organs or body parts.*

The term **emergency services** means, with respect to an enrolled individual, *covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition*.

Covered Services

1. Emergency services, regardless of whether services are received from an in-network provider, when meeting the following definition of medical emergency:
    - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:
        - Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
        - Serious impairment to bodily functions; or,
        - Serious dysfunction of any bodily organ;
    - With respect to a pregnant woman who is having contractions:
        - That there is inadequate time to effect a safe transfer to another hospital before delivery; or,
        - That transfer may pose a threat to the health or safety of the woman or the unborn child;

- Voluntary HIV testing when performed while receiving emergency medical services.

Emergency services include items or services furnished after your condition has been stabilized as part of outpatient observation or an inpatient or outpatient stay at a hospital.

Non-Covered Services

1. Take-home medications and supplies which are outpatient drugs dispensed in a provider's office or non-retail pharmacy locations which can reasonably be purchased from an in-network pharmacy. This includes pharmacy supply fees and dispensing fees on medical benefit drugs dispensed for self-administration at the patient's home; and,
2. Follow up care received out-of-network.

Experimental, Investigative and Emerging Technology

Non-Covered Services

Experimental, investigative and emerging technology means drugs, devices, equipment, treatment, or procedures which do not meet one or more of the following criteria, as determined by Quartz:

1. Full and final approval has been granted by the U.S. Food and Drug Administration for the treatment of the patient's medical condition;
2. The research and experimental stage of the development of the treatment or service have been completed; and,
3. The scientific evidence must permit conclusions concerning the effect on health outcomes for the specific condition or indication it will be used for.

A procedure, treatment or device may be considered experimental or investigational even if the provider has performed, prescribed, recommended, ordered or approved it, or if it is the only available procedure or treatment for the condition. Quartz considers all services, procedures, and treatment with

Category III codes to be experimental, investigational and/or emerging technology.

Gender Dysphoria

Services for the treatment of gender dysphoria may require prior authorization**.**

Genetic Testing

Covered with Prior Authorization

1. Genetic testing for predisposition or carrier status for a genetic disorder when a certified genetic counselor has determined it is likely that you carry a gene mutation that substantially increases your risk of developing the disorder and the presence of a mutation will lead to modifications in future medical care;
2. Testing, when you are already diagnosed with the disorder if therapy or surveillance will be modified based on the presence of a mutation; and,
3. BRCA testing.

Non-Covered Services

1. Testing that is done for the purpose of identifying a mutation that is for the benefit of a non-covered family member; and,
2. Testing for reproductive planning.

Hearing Services

Covered Services

1. Initial hearing screening test(s), , limited to one per benefit year;
2. Hearing screenings payable under Preventive Services for children up to age 21;

3. Hearing examinations provided as part of the treatment for medical conditions; and,
4. Hearing aids, which include any externally wearable instruments or devices designed to enhance hearing, that are:
    - Prescribed by a physician or audiologist in accordance with accepted professional medical or audiological standards;
    - For members who have coverage under the policy or plan, and who are certified as deaf or hearing impaired by a physician or an audiologist;
    - Coverage for hearing aids is limited to one hearing aid per ear every three years; and,
    - Prescribed hearing aids must be obtained from an in-network provider and are limited to specific models. To obtain a list of covered hearing aid models, contact Customer Success or visit QuartzBenefits.com/hearingaids.
        - Quartz will also cover the cost of over-the-counter hearing aids in lieu of prescribed hearing aids;
        - If the hearing aid recommended is <u>not</u> on Quartz's list of covered hearing aid models, including over-the-counter models, coverage will be limited to $1,500 per hearing aid, per ear, every three years;
5. **Treatment** (defined as *services, diagnoses, procedures, surgery, and therapy provided by a health care professional*) related to hearing aids and cochlear implants is also covered.

Covered with Prior Authorization

1. Cochlear implants; and,
2. Any implantable instruments or devices (e.g., bone anchored hearing aids) designed to enhance hearing.

All implantable devices must be prescribed by a physician or audiologist in accordance with accepted professional medical or audiological standards for any member who has coverage under the policy or Plan, and who is certified as deaf or hearing impaired by a physician or an audiologist.

Non-Covered Services

1. Costs in excess of $1,500 for hearing aid models not listed on Quartz's list of covered hearing aid models, including over-the-counter models.

Home Care

Home care is defined as *medically necessary part-time or intermittent services to a homebound patient including skilled home nursing care and home health aide services, physical, speech and occupational therapy, medical supplies, drugs, and medication, laboratory services, and nutrition counseling.*

Skilled care is defined as *medical services rendered by a registered or licensed practical nurse, physical, occupational or speech therapist.* Patients receiving skilled care are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip, and patients requiring complicated wound care. In the majority of cases, skilled care is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, children, or other family or relatives. Examples of care provided by "nonskilled" persons include range of motion exercises, strengthening exercises, wound care, ostomy care, tube and gastrostomy feedings, administration of medications, and maintenance of urinary catheters. Daily care, such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets, assisting patients with taking their medicines, or 24-hour supervision for potentially unsafe behavior, do not require skilled care and are considered to be custodial.

Covered with Prior Authorization

1. Part-time or intermittent skilled home nursing care that is part of the home care plan, by or under the supervision of a registered nurse or medical social worker;

2. Private duty nursing;
3. Physical, respiratory, occupational, or speech therapy, or nutritional counseling;
4. Home infusion therapy; and,
5. Medical supplies, drugs, and laboratory services, covered to the same extent they would have been covered if you were confined in a hospital.

Non-Covered Services

1. Homemaker or caretaker services, including sitter or companion services, housecleaning, or household maintenance; and,
2. Skilled nursing care when the only purpose is to obtain a blood sample.

Hospice Services

Hospice Services are designed to meet the needs of a terminally ill patient, and are provided when a member's attending physician certifies the member has a life limiting condition. Approved services can be provided in a facility or in the home. We require notification only for the initial admission to hospice and any inpatient hospice admission.

Covered Services

1. Hospice care when provided by a hospice facility that is approved by us. There are four levels of care provided by a licensed hospice program: routine home care, continuous home care, inpatient respite care, and general inpatient care;
2. A hospice care program consists of, but is not limited to the following: hospice physician services, professional services of a registered nurse or licensed practical nurse, physical therapy, occupational and speech therapy, medical and surgical supplies, durable medical equipment, prescribed drugs, in-home laboratory services, medical social service consultations, and dietitian services;

3. Pastoral services and family counseling related to your condition including bereavement counseling for one year after your death; and,
4. Medically necessary ambulance transportation including non-emergent ambulance transportation.

Non-Covered Services

1. Private duty nursing when confined in a hospice facility;
2. Funeral arrangements;
3. Financial or legal counseling, including estate planning or drafting of a will;
4. Homemaker or caretaker services, including sitter or companion services, housecleaning, or household maintenance;
5. Services of a social worker other than a licensed clinical social worker;
6. Services by volunteers or persons who do not regularly charge for their services, including family members;
7. Services by a licensed pastoral counselor to a member of his or her congregation; and,
8. Room and board in a skilled nursing facility.

Hospital Services

Covered Services

Inpatient and outpatient hospital services are covered when provided by an in-network hospital or free-standing surgical facility.

Inpatient hospital services include:

1. Daily room and board in a semi-private room, ward, intensive care or coronary care unit, including general nursing care. Benefits for a private or single room are limited to the charges for a semi-private room in the hospital where you are confined unless medically necessary;
2. Hospital services and supplies furnished for your treatment during confinement, including drugs administered to you as an inpatient;

3. Inpatient confinement in an out-of-network hospital in the case of an emergency medical condition or with an approved referral; and,
4. Inpatient hospitalization for rehabilitation is included in the skilled nursing/swing bed benefit and is limited to 90 days per benefit period (***Iowa Code 514C.2***).

Outpatient hospital benefits include services, drugs and supplies when provided for the following:

1. Emergency treatment provided at the nearest facility equipped to care for your condition;
2. Surgical day care;
3. Treatment such as intravenous and oral medications, blood and blood products and their administration, anesthesia, chemotherapy, inhalation therapy, radiation therapy, physical therapy and kidney dialysis;
4. Diagnostic testing which includes laboratory, x-ray, and other diagnostic testing; and,
5. Observation level of care.

Non-Covered Services

1. Continued hospital stay, if the attending physician has documented that care could effectively be provided in a less acute care setting (e.g., skilled nursing facility);
2. Hospital or observation stays which are extended for reasons other than medical necessity, such as lack of transportation, lack of caregiver, and inclement weather;
3. Take-home prescription drugs and supplies that can be purchased on an outpatient basis, whether billed directly or separately by a hospital or other health care facility. This includes pharmacy supply fees and dispensing fees on medical benefit drugs dispensed for self-administration at the patient's home;
4. Convenience items such as guest trays;
5. Educational materials; and,
6. A private room that is not medically necessary, or is at your request.

Immunizations

Covered Services

1. Immunizations as recommended by the Centers for Disease Control (CDC) Advisory Committee in Immunization Practice, or the American Academy of Pediatric Committee on Infectious Disease.

Non-Covered Services

1. Immunizations solely for the purpose of travel, employment, or education regardless of whether they are recommended by the CDC.

Kidney Disease Treatment

Kidney disease treatment includes but is not limited to dialysis, transplantations, donor-related services, diagnostic and therapeutic testing, related outpatient medications, and related physician charges.

Covered Services

1. Treatment of kidney disease including kidney dialysis when provided by an in-network facility.

Covered with Prior Authorization

1. Kidney dialysis out-of-network for up to a two-week period each benefit year is covered and payable up to the in-network rate. Charges exceeding the in-network rate are your responsibility.

Maternity/Newborn

Iowa Code 514C.12 and 514C.1

Covered Services

Benefits are available to the same extent as benefits provided for other services.

1. Treatment of pregnancy includes the following:
   - **Prenatal care**, defined as *the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists*;
   - Support care that may be available through Quartz's contracted doula and midwifery service providers;
   - Coverage for inpatient hospital care and post-natal care;
   - Complications of pregnancy are payable as any other covered illness at the point the complication sets in;
   - 48 hours of inpatient hospital care following vaginal delivery and 96 hours of inpatient hospital care following a caesarean section delivery. The length of stay coverage begins is when a delivery occurs in a hospital (at the time of delivery). For deliveries outside the hospital, the stay begins at the time the mother and/or newborn are admitted. The decision of whether an admission is in connection with childbirth is a medical decision to be made by your attending provider, not us. Coverage will be provided for a shorter length of stay if the attending provider, in consultation with the mother, decides on an earlier discharge. Coverage will be provided for a longer length of stay if medically necessary. We are prohibited from requiring precertification for the minimum stay; however, we may impose continued stay approval for the portion of stay after the 48 or 96 hours; and,
   - If we terminate our contract with an in-network provider, or if an in-network provider moves out-of-network, we shall continue to provide coverage under the contract to a covered person in the second or third trimester of pregnancy for continued care from such health care provider. Such persons may continue to receive such treatment or care through postpartum care related to the childbirth and delivery (***Iowa Code 514C.12***);
2. Nursery room, board, and care;

3. Routine examination and other routine professional services rendered to the newborn child before release from the hospital;
4. Circumcisions;
5. Necessary care and treatment of all medically diagnosed congenital defects, birth abnormalities, prematurity, and the functional repair or restoration of any body part when necessary to achieve normal body functioning. **Congenital** means *a condition that exists at birth and is diagnosed within twelve months following birth*;
6. Well-baby care rendered after release from the hospital;
    - In the event of a discharge from the hospital prior to 48 hours following a vaginal delivery, or 96 hours following a delivery by cesarean section, a post discharge follow-up visit to the mother and newborn by providers competent in postpartum care and newborn assessment if determined medically appropriate as directed by the attending physician;
7. Breast feeding support, supplies, and counseling; and,
8. Purchase of basic electric breast pump or basic manual breast pump, and supplies, in conjunction with each birth.

Non-Covered Services

1. Continued stay after discharge for mother when infant remains hospitalized;
2. Continued stay after discharge for newborn when mother remains hospitalized;
3. Hospital-grade electric breast pumps; and,
4. Home delivery.

Physician/Clinician Services

A **qualified practitioner** is defined as *state licensed, practicing within the scope of their license, and practicing in a state licensed facility/office in accordance with the Health Plan standards and based on Iowa law.*

A physician is a person who is duly licensed by an appropriate government authority as Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatric Medicine (D.P.M.), Doctor of Optometry (O.D.), or Doctor of Chiropractic (D.C.), acting within the scope of their license.

A **clinician** is defined as *a physician assistant, clinical nurse practitioner, nurse midwife, medical technician, physical therapist, and other similar health care providers that provide services under the supervision of a physician.*

Covered Services

1. Office visits, including specialists;
2. Inpatient visits;
3. Surgery services;
4. Anesthesia services;
5. Services provided by licensed physician assistants and licensed advanced registered nurse practitioners (***Iowa Code 514C.11***); and,
6. Second opinion received from an in-network provider.

Per ***Iowa Code 514C.17***, if we terminate our contract with an in-network health care provider while you are undergoing a specified course of treatment for a terminal illness or a related condition, you may continue to receive treatment from that provider for the terminal illness or related condition, for a period of up to 90 days.

Podiatric Services

Covered Services

1. Podiatric services, including non-operative treatment for a condition of the foot, including but not limited to the following:
   - Mycotic nails;
   - Metabolic, neurologic or peripheral vascular disease; and,

- When performed as a necessary and integral part of an otherwise covered expense, such as diagnosis and treatment of ulcers, wound, or infections;
- Routine hygiene and maintenance care such as trimming corns, calluses, and nails; or
- Cutting, trimming, or other non-operative partial removal of toenails;

Non-Covered Services

1. Treatment of flexible flat feet; and,
2. Medications used to treat onychomycosis.

Prescription Drug Benefit

DEFINITIONS

1st Tier Drug
A Preferred Generic Drug appearing on Quartz's Formulary List as a Formulary Drug.

2nd Tier Drug
A Preferred Brand Drug appearing on Quartz's Formulary List as a Formulary Drug.

3rd Tier Drug
A Non-Preferred Drug appearing on Quartz's Formulary List as a Formulary Drug, whether Generic or Brand Name, that is not classified as a 4th Tier Drug.

4th Tier Drug
A medication appearing on Quartz's Formulary List as a Formulary Drug and designated as a 4th Tier Drug by Quartz, notwithstanding the preferred status and brand/generic status of that medication.

Biologic Reference
A biologic product approved by the U. S. Food and Drug Administration (FDA) based on, among other things, a full complement of safety and effectiveness data. A proposed **Biosimilar** is compared to and evaluated against the corresponding **Biologic Reference** product in the FDA approval process.

Biosimilar
A type of biologic product that is approved by the FDA as a Biosimilar because it is highly similar to an already FDA-approved biological product for which the patent is expired (known as the Biologic Reference) and has been shown to have no clinically meaningful differences from the Biological Reference product.

Brand Drug
A medication determined to be a Brand Drug by Quartz. A brand drug is typically a medication that is marketed by the innovator manufacturer and may or may not have Generic equivalents available. Both Biologic Reference and their Biosimilars may be considered Brand Drugs.

Covered Drug
Subject to Quartz's Formulary and any prior authorization or step therapy requirements, a Covered Drug is:

- Any Prescription Drug on Quartz's Formulary List as a Formulary Drug, including prescription contraceptives;
- Injectable insulin, insulin syringes, glucose test strips and certain continuous glucose monitors on Quartz's Formulary List as a Formulary Drugs;
- Any medication compounded by the in-network pharmacy that contains a Formulary Drug when appropriate commercially available alternatives are not available, the compounded medication does not contain any drug listed as a specific Exclusion, and the specific combination of ingredients included in the compounded prescription has adequate published evidence to support use for the patient's specific indication;

- An Over-the-Counter Medication that Quartz determines is a Formulary Drug, when the medication is obtained with a legal Prescription Order from a physician; or,
- A Medical Food Quartz determines is a Formulary Drug. The Medical Food must be listed on Quartz's Formulary List as a Formulary Drug and obtained from a pharmacy with a written Prescription Order from a physician who is supervising its use.

Formulary
Quartz's Formulary contains medications identified by our Pharmacy and Therapeutics Subcommittee as Formulary Drugs. Medications on the Formulary are reviewed for efficacy, adverse effects, and cost in an effort to maintain a high-quality, cost-efficient foundation for drug therapy. The Formulary List is frequently updated as we consider new medications. Please call Customer Success to obtain a current version of the Formulary List. You also can view the most current formulary by visiting our web site.

Formulary Drug
A medication designated as a Formulary Drug by Quartz's Pharmacy and Therapeutics Committee and listed on Quartz's Formulary List with a status other than "Non-Formulary."

Formulary List
A list of medications indicating formulary tier status or non-formulary status, as well as other coverage attributes. The Formulary List is frequently updated as we consider new medications. Please call Customer Success to obtain a current version of the Formulary List. You can also view the most current Formulary List by visiting our web site.

Generic Drug
A medication determined to be a generic by Quartz. A Generic Drug is typically a medication that has been approved by the FDA through an Abbreviated New Drug Application (ANDA) as equivalent to a FDA approved innovator product (Brand Drug). Authorized generics approved by the FDA through a New Drug Application (NDA) when there

are no generic competitors of the same medication approved through an ANDA may be considered to be Brand Drugs by Quartz.

HDHP $0 Drug
A medication that has been designated by Quartz as being covered at $0 before deductible for high deductible health plans (HDHPs).

HIV
Any strain of human immunodeficiency virus that causes acquired immunodeficiency syndrome.

In-Network Pharmacy
Any pharmacy that has contracted with Quartz, or Quartz's designee, to provide pharmacy services or supplies to Quartz members. Please refer to https://quartzbenefits.com/medimpactpharmacy for a list of in-network pharmacies.

Medical Food
A product approved by the FDA's Center for Food Safety and Applied Nutrition that is intended to meet the distinctive nutritional requirements of a disease or condition. A Medical Food is not considered a drug, although it may come as a tablet or capsule and require a prescription.

Non-Formulary Drug
A medication that (1) has not been designated by Quartz's Pharmacy and Therapeutics Committee as a Formulary Drug, (2) is listed on Quartz's Drug Formulary List with a status of "Non-Formulary" (but is not specifically listed as an exclusion on this rider), or (3) is not listed on the Formulary List. Medications new to the market are Non-Formulary Drugs until reviewed by Quartz's Pharmacy and Therapeutics Committee, at which point a formulary determination will be made.

Medically Necessary Prescription Drugs or Supplies
Prescription Drugs or Supplies provided by a pharmacy and required to identify or treat a Member's Illness or Injury, and which are, as determined by the Plan:

1. Consistent with the symptoms or diagnosis and treatment of a Member's Illness or Injury;
2. Appropriate under the standards of acceptable medical practice to treat that Illness or Injury;
3. Not solely for the convenience of the Member, Physician, Hospital or other health care Provider;
4. The most appropriate supply or level of service that can be safely provided to the Member and which accomplishes the desired end result in the most economical manner; and
5. Not primarily for cosmetic improvement of the Member's appearance, regardless of psychological benefit.

The Member's prescriber makes decisions regarding service and treatment. The Plan, using criteria approved by Quartz's Pharmacy & Therapeutics Committee, has the authority to determine whether a service, treatment, procedure, Prescription Drug, device or supply is Medically Necessary and eligible for coverage under the Plan.

Non-Preferred Drug
A Brand or Generic medication that is (1) designated by Quartz's Pharmacy and Therapeutics Committee as a Formulary Drug, (2) is on Quartz's Drug Formulary List with a status other than "Non-Formulary," and (3) has been designated by Quartz's Pharmacy and Therapeutics Committee as a Non-Preferred Drug.

Out-of-Network Pharmacy
Any pharmacy that does not have a contractual agreement to provide pharmacy services or supplies to Quartz members.

Over-the-Counter Drug
Medication that does not bear the FDA's legend "RX Only" on its label.

Preferred Drug
A Brand or Generic medication that (1) is designated by Quartz's Pharmacy and Therapeutics Committee as a Formulary Drug, (2) is listed on Quartz's Drug Formulary List with a status other than "Non-Formulary," and (3) has been designated as a Preferred Drug.

Prescription Drug
Any brand drug, generic drug, biologic or biosimilar that (1) the (FDA) has designated as a "Human Prescription Drug," (2) is required to bear the legend "RX Only" under the federal Food, Drug and Cosmetic Act, and (3) has been reviewed and approved for marketing by the FDA through either a New Drug, Abbreviated New Drug or Biologic License Application.

Prescription Order
The request for a Prescription Drug by a person legally licensed to prescribe drugs for his or her patients. A separate Prescription Order is required for each drug.

Preventive Medication
A medication, including both prescription and Over-the-Counter Drugs, determined by CMS to be a Preventive Health Service as defined in 45 CFR § 147.130.

Prior Authorization
The process by which Quartz gives prior written approval for coverage of specific covered services, treatment, Prescription Drugs, Durable Medical Equipment ("DME") and supplies. The purpose of Prior Authorization is to determine and authorize payment for the following:

- The specific type and extent of service, treatment, Prescription Drug, DME or supply that is necessary;
- The number of visits or the period of time during which care will be provided; and,
- The name of the Provider to whom the Member is referred.

Restricted Drug or Restricted Medication
A drug that is covered only when specific clinical criteria are met and Quartz issues a Prior Authorization for coverage of the drug. The clinical criteria for some Restricted Drugs require the failure of prerequisite therapies.

Smoking Cessation Medication
A medication, including both prescription and Over-the-Counter Drugs, that is approved by the FDA for tobacco cessation.

Specialty Pharmaceutical
A drug that is designated by the Pharmacy & Therapeutics Committee as being a Specialty Pharmaceutical. Drugs designated as Specialty Pharmaceuticals will be listed as such on Quartz's Formulary List at QuartzBenefits.com/formulary and are subject to change.

Step Therapy Drug
A drug which requires prior authorization and the prior authorization criteria include a requirement of trial of or contraindication to prerequisite medication(s). When prerequisite therapies can be identified in the claims history upon receipt of the electronic claim for a Step Therapy Drug, the claim may be approved based on the information in the claims system. When such history is not present, a Prior Authorization request must be submitted and approved for coverage.

Value Tier Drug
A Preferred Generic or Preferred Brand medication on Quartz's Formulary that has been designated by Quartz as a Value Tier drug.

BENEFITS

Prescription Drug benefits are available for Covered Drugs prescribed by or at the direction of a Provider. The Prescription Drug must be deemed Medically

Necessary by Quartz and must have an approved Prior Authorization. Non-Formulary Drugs are not Covered Drugs. Quartz provides a process for you or your provider to request coverage of a Non-Formulary Drug on an exception basis. An exception request can be made using Quartz's Medication Prior Authorization Form, available at QuartzBenefits.com, or by calling (888) 450-4884. The timeline for our review of an exception request will vary based on the urgency of your situation. We will inform you of our decision on a standard request within 72 hours of receipt. Urgent requests made in exigent circumstances will be reviewed within 24 hours. Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug. If a standard request is approved, we will authorize coverage of the non-formulary drug for the duration of the prescription, including refills. If an exigent request is approved, we will authorize coverage of the non-formulary drug for the duration of the exigency. Co-pay or co-insurance will be at the non-preferred or Tier 4 level, depending on the status of the medication.

Benefits are payable for charges made by an in-network pharmacy for each separate Prescription Claim. Restricted Medications require approved Prior Authorization for coverage. Continuation of therapy criteria may apply to members who were previously approved for coverage. Persons who were not previously approved for coverage but who instead initiated therapy using a manufacturer-sponsored free drug program, provider samples or vouchers will not be considered to have met continuation of therapy criteria for coverage.

Prescription Claims may be subject to Co-payment, Deductible, or Co-insurance. Members with Co-payment plans are subject to one Co-payment for each claim dispensed up to a 30-day supply (i.e., 1-30 day supply = 1 Co-payment, 31-60 day supply = 2 Co-payments, 61-90 day supply = 3 Co-payments). Some medications are packaged such that they cannot reasonably be dispensed in a 30-day quantity. For these medications, Members are charged one Co-payment for each 30-day claim covered by the medication (i.e., an inhaler is dispensed as a 60-day supply and can't

reasonably be reduced to a 30-day supply; two Co-payments would apply). In cases where the pharmacy dispenses a claim for less than a 30-day supply of a maintenance medication, as determined by Quartz, for the purposes of synchronizing refills for the member, a prorated Co-payment will apply based on the percentage of a 30-day supply dispensed.

Refer to your Schedule of Benefits for details or contact Quartz Customer Success. Prescription Claims for which the member used a pharmaceutical manufacturer program to off-set their out of pocket Co-payment, Deductible, or Co-insurance can be adjusted by Quartz to accurately reflect the true out of pocket amount paid by the member for that claim which will be used to determine the amount applied to Deductibles and out of pocket limits. If you have a High Deductible Health Plan designed to be compatible with a Health Savings Account (HSA), using cost-sharing assistance before the minimum deductible has been met may disqualify you from making compliant HSA contributions during the plan year.

In order for Quartz to keep prescription drug benefits affordable, cost-sharing for certain specialty medications may vary and be set to approximate the maximum of any available manufacturer-funded copay assistance programs. However, in no case will true out-of-pocket costs to the participant be greater than the maximum copayment published in the Summary of Benefits and Coverage (SBC). Finally, manufacturer-funded copay assistance received will not be credited to your annual deductible or maximum out-of-pocket requirement.

When prescribed by a physician or other health care provider, Formulary Drugs listed on Quartz's Formulary List as Preventive Medications are covered without member cost share. This includes coverage of Smoking Cessation Medications, when prescribed by a healthcare provider, for a 90-day treatment regimen for at least two tobacco cessation attempts per year.

After any applicable deductibles are met, orally-administered chemotherapy drugs are covered without additional cost-sharing for a 30-day supply.

Benefits are not payable for Prescription Drugs obtained (1) from an in-network pharmacy but not submitted electronically by the pharmacy through Quartz's pharmacy claims adjudication system, or (2) from an out-of-network pharmacy. Out-of-pocket payments for drugs obtained from an out-of-network pharmacy in the United States may be reimbursed on an exception basis. Your out-of-pocket costs are only eligible for reimbursement in cases of acute need when an exception request is submitted to Quartz with a completed Direct Member Reimbursement Form and an itemized paid prescription receipt. Amounts in excess of the Usual, Customary and Reasonable Charge are not covered benefits and are the responsibility of the member.

If Quartz determines you may be using prescription drugs in a questionable, harmful, abusive manner or frequency, we may require you to select a single in-network pharmacy to provide and coordinate all future pharmacy services. Benefit coverage will only be paid if the assigned single in-network pharmacy is used. If you do not make a pharmacy selection within 30 days of our notification, Quartz will select an in-network pharmacy for you. The date of notification will be the date the notification is mailed. We will use the most recent address information you provided to Quartz.

Prescription Drugs are subject to Quartz's Formulary List and must be Prior Authorized when required. The Quartz Formulary List is available at QuartzBenefits.com/formulary or you may contact Quartz Customer Success. Restricted Drugs require approved Prior Authorization for coverage. In-network pharmacies automatically verify that the Prescription Drug is covered under the Formulary. Quartz does not cover any Prescription Drug if there is a chemically equivalent drug available that does not require a prescription, except that Quartz may opt to continue to cover a Prescription Drug with a chemically equivalent drug that does not require a prescription on the Formulary as a cost-saving measure or to meet regulatory requirements. Members with a Quartz Prescription Drug Benefit as secondary coverage will be required to have an approved prior authorization for secondary coverage of Restricted Medications. Additionally, Quartz may require that the member has documentation of prior authorization denial, appeal denial, and independent review ("IRO") denial through the primary prescription drug

benefit prior to Quartz approving coverage through the Quartz secondary prescription drug benefit.

Brand Drugs for which there is an available equivalent Generic Drug are Non-Formulary and require an approved formulary exception for coverage immediately upon market availability of the Generic equivalent. As a cost-saving measure, Quartz may opt to cover a Brand Drug as the preferred option instead of the equivalent Generic Drug. In those select situations, the Brand Drug will be covered at the Copay Tier level the Generic Drug would have been covered at, and the Generic Drug will be non-formulary.

Biologic Reference products for which there is an approved Biosimilar are non-formulary and require an approved formulary exception for coverage immediately upon market availability of the Biosimilar product. As a cost-saving measure, Quartz may opt to cover the Biologic Reference as the preferred option instead of the Biosimilar. In those select situations, the Biologic Reference will be covered at the Copay Tier level that the Biosimilar would have been covered at, and the Biosimilar will be non-formulary.

LIMITATIONS

Supply Quantity Limits

Coverage for medications under this rider are limited to the quantity prescribed by the physician and one fill or refill cannot exceed:

- A 30-day supply; or,
- A supply of more than 30 days if dispensing a single commercially-prepared unit of an unbreakable quantity; or,
- A 90-day supply for medications meeting Quartz's current 90-day supply (Choice90) program requirements as described at QuartzBenefits.com/formulary; or,
  For 30-day supplies, two commercially-prepared units, if one unit does not provide a full 30-day supply.

Examples of a commercially-prepared unit include, but are not limited to (1) one inhaler, (2) one vial ophthalmic medication, and (3) one sumatriptan packet (nine tablets).

Some medications are packaged such that they will last more than 30 days. Or, they cannot reasonably be dispensed in a 30-day quantity. For these medications, Members are charged one Copayment for each 30-day time period covered by the medication.

Specialty Pharmaceuticals
A drug designated by the Pharmacy & Therapeutics Committee as a Specialty Pharmaceutical is covered only if obtained from pharmacies participating in Quartz's Specialty Pharmacy Network. If the drug is authorized, the authorization letter from Quartz will identify for the Member and prescribing physician where the Prescription Order can be filled. Failure to obtain the drug at a Quartz Specialty Pharmacy Network pharmacy will result in a denial of coverage for the drug.

EXCLUSIONS

Outpatient prescription drug benefits are not covered under this health plan for the following:

1. Any Non-Formulary Drug, unless an exception request has been approved by Quartz;
2. Any Formulary Drug when the formulary requirements for coverage have not been met. For example, Step Therapy not completed, Prior Authorization not approved, or specialty drugs obtained outside Quartz's Specialty Pharmacy Network, among others. See Quartz's Formulary List on our website for the requirements applicable to our Formulary Drugs;
3. Non-medical devices or substances such as therapeutic devices or substances, hypodermic needles, syringes (except insulin syringes and needles), support garments;

4. Any drug or medication that is administered or delivered to you by or in the presence of a health care provider (other than prescription drugs dispensed from a community pharmacy to be self-administered);
5. Any drug or medication that is to be taken by or administered to you while you are a patient at a healthcare facility, including a licensed hospital, rest home, extended care facility, convalescent hospital, skilled nursing home, emergency room or urgent care center, ambulatory clinic, infusion center, or similar institution;
6. Any drug labeled "Caution: limited by Federal Law to investigational use" or other wording with similar intent, experimental drugs, or FDA approved drugs being used in an experimental manner (non-evidence based indication, dosage regimen, etc.) even though a charge is made to you, except that coverage will be provided for any Prescription Drug that meets the following criteria:
    - Is prescribed for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection; and,
    - Is approved by the federal Food and Drug Administration for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection, including each investigational new drug that is approved under 21 C.F.R. 312.34 to 312.36, and that is in or has completed a phase-3 clinical investigation; and,
    - If the drug is an investigational new drug described in the second bullet above, is prescribed and administered in accordance with the treatment protocol approved for the investigational new drug under 21 C.F.R. 312.34 to 312.36;
7. Any refill of a Prescription Drug that is in excess of what is prescribed, or any refill dispensed beyond the legally-allowed time limits;
8. Anabolic Steroids and athletic performance enhancing medications;
9. Anti-obesity drugs, anorexients and any drug for which weight modification is the primary mechanism by which indicated results are achieved or is the primary purpose the medication is prescribed;
10. Medications used to prevent hair loss (e.g., topical minoxidil and finasteride);
11. Medications used to enhance or facilitate fertility;

12. Any Prescription Drug for a procedure not covered by your medical health insurance Certificate of Coverage;
13. Any Prescription Drug for an illness or injury not covered by your medical health insurance Certificate of Coverage;
14. Over-the-Counter Medications, with or without a Prescription Order, unless the medication has been approved by Quartz. Any such approved medication is listed on Quartz's Formulary List as a Formulary Drug;
15. Prescription Drugs that are covered, or the member is entitled to receive, from any Workers' Compensation law or any municipal state or federal program. This includes prescription drugs the member is entitled to receive without charge;
16. Nutritional products and special food or feedings;
17. Any Prescription Drug dispensed to a member prior to the member's effective date of coverage under the Plan or after the member's termination date;
18. Prescription Drugs used for cosmetic treatment, including but not limited to Tretinoic Acid (Retin A);
19. Irrigation solutions and supplies;
20. Early refills;
21. Homeopathic medications;
22. Medications used to facilitate, obtain, maintain, enhance or prevent pain with sexual performance;
23. Vaccines, unless the vaccine has been approved by Quartz for coverage under the drug benefit;
24. Any Prescription Drug that is a Restricted Medication or that requires Prior Authorization, unless Prior Authorization is requested and approved;
25. Medications purchased from a pharmacy or other establishment located outside the United States for consumption inside the United States;
26. Medical Foods not listed on Quartz's Formulary List as Formulary Drugs, regardless of whether they are prescribed to you;
27. Prescription Drugs obtained from an-in-network pharmacy but not submitted electronically by the pharmacy through Quartz's pharmacy claims adjudication system;

28. Medications used to treat growth retardation, including Growth Hormones, except if clinical criteria are met when (1) endogenous production of the growth hormone is inadequate or (2) for a diagnosis of Turner Syndrome. With the exception of Turner Syndrome, coverage is not extended for short stature syndrome or other related growth abnormalities;
29. Any compounded drug that is:
    - Otherwise available commercially in a dose form suitable for the patient;
    - Contains an ingredient drug that is specifically excluded;
    - Contains an experimental drug; or,
    - Contains a combination of ingredients in a dose form without adequate published evidence to support use for the patient's specific indication; and,
30. Products packaged for convenience when they combine components or ingredients that are otherwise readily available either as prescription drugs or over-the-counter drugs, including compounding kits and co-packaged products.
31. Prescription Drugs with open Drug Efficacy Study Implementation (DESI) proceedings with the FDA unless specifically selected by the Quartz P&T for inclusion on the formulary. These drugs were approved by the FDA before it was required to evaluate effectiveness for approval (pre-1963). Drugs with open DESI proceedings have yet to be approved by the FDA as effective despite still being available on the market.

Preventive Services

Preventive services are defined as *preventive medical services in the absence of symptoms, illness or injury.* Health plans are required to cover Grade A or Grade B level preventive services recommended by the U.S. Preventive Services Task Force (USPSTF). Most preventive services covered by this plan are outlined below, but you can view the complete list at healthcare.gov/coverage/preventive-care-benefits.

Preventive Services	**Medical/Diagnostic Benefits (Problem-related care)**
Preventive services are those received to help you stay "well" when no signs, symptoms or complaints are present. Preventive services are covered at 100% when completed at Quartz-affiliated provider offices at the frequencies listed below.	Medical services are those you received related to an illness or health condition. If, at a wellness/preventive exam, you and your doctor discuss a medical problem, there may be extra charges added to the visit. Therefore, you may be responsible for some amounts based on cost-sharing (deductible, coinsurance and copay amounts).

The services listed below are covered at 100% when you receive them related to preventive care.

1. **An annual adult wellness exam**
   The exam includes an age and gender appropriate history, full examination, and discussion about reducing risks to prevent future disease or illness.

   Examinations requested by a third party may be substituted for the annual wellness examination. Examples of physicals that may be substituted include school admission, sports competition, and for purposes of employment or licensing.

   Annual wellness exams commonly include screenings for blood pressure, obesity, alcohol and drug misuse, and other tests based on your risk profile (in absence of symptoms). For women, they may include gynecological exams (breast and cervical).

2. **Well child exams**
   Well child visits have no coverage limit through age two. Beginning at age three, one visit is covered per benefit year. Well child exams may

include developmental screenings and other tests, such as vision screenings.

3. **Blood Lead Screening**
   Annual blood lead tests are covered.

4. **Immunizations**
   Preventive services include routine immunizations such as:
   - COVID-19;
   - Hepatitis B (Hep B);
   - Diphtheria, Tetanus, Pertussis (Dtap and Tdap);
   - Inactivated Polio (IPV);
   - *Haemophilus influenzae* type B (Hib);
   - Pneumococcal (PCV);
   - Rotavirus (Rota);
   - Measles, Mumps and Rubella (MMR);
   - Varicella (VAR);
   - Hepatitis A (HepA);
   - Meningococcal (MCV);
   - Human Papilloma Virus (HPV) (**Iowa Code 514C.23**);
   - Influenza (flu shot); and,
   - Herpes Zoster (Shingles)

5. **Vision exams – one per benefit year for people with diabetes**

6. **Hearing exams – as recommended periodically until age 21**

7. **Preventive medications or supplements such as:**
   - Vitamin D supplementation to prevent falls in community-dwelling adults age 65 and older;
   - Tobacco cessation medication, limited to 180 days;
   - Folic acid supplements for women who may become pregnant;
   - Low-dose aspiring for women who are at a high risk for preeclampsia;
   - Fluoride supplements for children age six months to five years without fluoride in their water source;

- Iron supplements for children age six to 12 months at risk for anemia;
- HIV Preexposure Prophylaxis (PrEP) drugs, including support services recommended by the United States Preventive Services Task Force (USPSTF) for everyone ages 15 to 65, and others at increased risk;
- Metformin prescribed as a diabetic or pre-diabetic intervention for adults age 35 and older; and,
- Statin preventive medication for adults age 40 to 75 at high risk.

8. Screening labs and x-rays

The following list includes preventive screening labs and x-rays covered at 100% when completed in the absence of symptoms. These labs are also eligible for coverage if symptoms are present. However, when symptoms are present, your plan's cost-sharing will apply.

To learn about whether you may be due for a preventive screening, refer to the Preventive Care Guidelines at healthcare.gov/coverage/preventive-care-benefits.	
Screening Labs and X-rays	**Frequency Limit**
Mammogram to screen for breast cancer (***Iowa Code 514C.4***)	For women ages 40 and older
Pap smear to screen for cervical cancer	One per benefit year for women of all ages
Sexually Transmitted Disease testing ▪ Chlamydia ▪ Syphilis ▪ Gonorrhea ▪ HIV (***Iowa Code 514C.23***)	One of each per benefit year
Cholesterol screening (total lipid profile)	One every five benefit years for adults

Diabetes Screening - fasting glucose/blood sugar (***Iowa Code 514C.18***)	One every three benefit years for adults, or as recommended for non-pregnant women with a history of gestational diabetes
Osteoporosis Screening (bone mineral density)	One every two benefit years after age 60
Hepatitis C screening	For adults ages 18-79
Prostate Cancer Screenings ▪ Prostate specific antigen (PSA) ▪ Screening digital rectal exam	Each test is covered once per benefit year for men
Hemoglobin to screen for iron deficiency anemia	One at age one
Colorectal cancer screening	The following are covered for ages 45 - 75 when billed with a screening diagnosis: ▪ Colonoscopy screening exams as recommended by a doctor, including up to two colonoscopy preparation prescriptions per benefit year, and the first colonoscopy following a positive stool or direct visualization screening test; ▪ Sigmoidoscopy/barium enema (covered once every five benefit years); ▪ Fecal occult blood testing (covered once per benefit year).

Screening for gestational diabetes for pregnant women	One during weeks 24 - 28 of gestation and one if identified as high risk for diabetes
Human papillomavirus testing for women	One every three benefit years for ages 30 or older
Tuberculosis screening	For adults only
Bacteriuria urinary tract or other infection screening	For women
Lung cancer screening	For adults ages 50-80 who are heavy smokers or who quit smoking within the last 15 years

9. **Counseling for sexually transmitted infections**

10. **Preeclampsia screening for pregnant women**

11. **Urinary incontinence screening for women**

12. **Screening and counseling for interpersonal and domestic violence for women**

13. **Skin cancer counseling for infants, children and younger adults ages six months to 24 years who have fair skin**

14. **Perinatal depression screening for pregnant or postpartum women at increased risk**

15. **Anxiety screening, once annually**

16. **Tobacco use screening and cessation interventions**

17. **Certain oral medications for breast cancer prevention**

18. Screening for major depressive disorder (MDD) and suicide risk in adolescents 12 to 21 years of age

19. Screening for depression in the general adult population

20. Vision screening for amblyopia in children age six months to five years

21. Contraceptive methods and counseling

All Food and Drug Administration (FDA)-approved contraceptive methods, sterilization procedures and patient education and counseling for women as prescribed by your provider. This will include at least one service or item within each of the FDA identified methods for women. The following prescription drugs will be covered with no copayment to members:

- All generic contraceptive drugs;
- All brand name contraceptive drugs with no generic equivalent;
- Brand name contraceptive drugs, which have generic alternatives, only if the prescribing practitioner states that "Brand is Medically Necessary;" and,
- Physician-prescribed emergency over-the-counter contraception, such as Preven and Plan B.

22. Preventive counseling for a healthy diet

Up to three dietary counseling visits for the treatment of hyperlipidemia and other known risk factors for cardiovascular and diet related chronic disease. Additional counseling visits are covered under Dietary Counseling. Beginning at age 40, counseling for people who are normal weight will be covered without additional risk factors.

Pulmonary Rehabilitation

Covered Services

1. Medically necessary, medically supervised outpatient pulmonary rehabilitation.

Reconstructive Surgery or Procedures

Covered Services

1. Medically necessary correction of a functional defect caused by an injury or illness;
2. Reconstructive surgery performed as a result of an injury or illness if surgery is part of a continuous treatment plan from the time of injury or illness;
3. Reconstructive surgery for a congenital disease or anomaly of a child which results in a functional defect;
4. Breast reconstruction due to a congenital condition; and,
5. Breast reconstruction following mastectomy (***Iowa Reg.191-35.35(1)***)**:**
    - Reconstruction of the breast on which the mastectomy has been performed;
    - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and,
    - Prostheses and coverage of physical complications at all stages of a mastectomy including lymphedemas.

Non-Covered Services

1. Treatment, services and supplies for cosmetic or beautifying purposes, including removal of keloids resulting from piercing and hair restoration, except when associated with a covered service to correct a functional impairment related to congenital bodily disorders or conditions or when associated with covered reconstructive surgery due to an illness or accidental injury (including subsequent removal of a prosthetic device that was related to such reconstructive surgery). Psychological reasons do not represent a medical/surgical necessity.

Plastic or cosmetic surgery is defined as *any operative procedure performed primarily to improve physical appearance; to treat a mental or nervous disorder through a change in bodily form; to change or restore bodily form without correcting or materially improving a bodily function.*

Reproductive Health

Covered Services

1. Services necessary for the initial diagnosis of infertility, including sonoHSG and HSG, progesterone level outside pregnancy, FSH/estradiol, and semen analysis, and hysteroscopy (if performed before fertility medications are started). Each service is covered once per lifetime for the initial diagnostic evaluation of infertility);
2. Birth control devices/contraceptives unless otherwise specifically excluded;
3. Elective sterilizations, including vasectomies and tubal ligation;
4. Physician-prescribed emergency over-the-counter contraception, such as Preven and Plan B;
5. Treatment, services or supplies resulting from your services as a surrogate mother (this does not apply to a non-member that you contract as a surrogate mother); and,
6. Pregnancy resulting from your services as a surrogate mother (this does not apply to a non-member that you contract as a surrogate mother).

Covered with Prior Authorization

1. Elective abortions when the life of the mother would be endangered if the fetus were carried to full term, or if the pregnancy is the result of rape or incest; and,
2. Fertility and infertility services not listed above until you begin a course of treatment for artificial insemination, in vitro fertilization, or any related fertility or infertility treatment or transfer procedure.

Non-Covered Services

1. Donor sperm or embryo;
2. The reversal of elective sterilization procedures;
3. Treatment, services or supplies for a surrogate mother who is not a member under this plan;
4. Amniocentesis or chorionic villi sampling (CVS) solely for gender determination;
5. Infertility services including testing, treatment, evaluation and medication (oral and injectable), once you begin a course of treatment for infertility (other than the diagnostic tests listed in Covered Services);
6. Contraceptives which do not have a written prescription from a provider; and,
7. Counseling, treatment including but not limited to vacuum erection devices, implants, other erection devices, or medication for sexual or erectile dysfunction, whether or not prescribed or provided by an in-network provider.

Shoe Inserts/Orthotics

Covered Services

Orthopedic shoes, foot orthotics, and other supportive devices will be covered only under the following conditions:

1. Shoes only when the shoe is an integral part of a leg brace and its expense is included as part of the cost of the brace;
2. Custom-molded foot orthotics for treatment of diabetic-related foot conditions;
3. Custom-molded foot orthotics for treatment of foot conditions related to Peripheral Vascular Disease;
4. Therapeutic shoes for persons with diabetes or Peripheral Vascular Disease; and,
5. For children up to the age of three years old with the diagnosis of metatarsus adductus, atavistic great toe, and/or club feet. Covered

for infants up to one year old with diagnosis of severe calcaneal valgus.

Skilled Nursing Facility Care

A **skilled nursing facility** is defined as *an institution which is a licensed facility by the State of Iowa, or other applicable jurisdiction, that maintains and provides the following*:

1. Permanent and full-time bed care facilities for resident patients;
2. A physician's services available at all times;
3. A registered nurse or physician in charge and on full-time duty and one or more registered nurses or licensed vocational or practical nurses on full-time duty;
4. A daily record for each patient; and,
5. Continuous skilled care for ill or injured persons during convalescence from illness or injury.

A skilled nursing facility is <u>not</u>, except by coincidence, a rest home, a home for care of the aged, or a facility engaged in the care and treatment of alcoholics, drug addicts, or persons with mental disorders.

Confinement must be within 24 hours after discharge from a covered hospital confinement. You must be confined for continued treatment of the same condition for which you required hospitalization. Your doctor must certify that your confinement is medically necessary for skilled care or treatment of the injury or illness that caused the hospital confinement. Skilled nursing facility services are limited to 90 days per benefit year.

Skilled care is defined as *medical services rendered by a registered or licensed practical nurse, physical, occupational or speech therapist.* Patients receiving skilled care are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip, and patients requiring complicated wound care. In the majority of cases, skilled care is

necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, children, or other family or relatives. Examples of care provided by "nonskilled" persons include range of motion exercises, strengthening exercises, wound care, ostomy care, tube and gastrostomy feedings, administration of medications, and maintenance of urinary catheters. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets, assisting patients with taking their medicines, or 24-hour supervision for potentially unsafe behavior, do not require skilled care and are considered to be custodial.

Covered with Prior Authorization

1. Skilled nursing facility charges and costs associated with an approved skilled stay when provided by a state licensed or Medicare certified skilled nursing facility.

Non-Covered Services

1. Custodial care and services, including room and board while residing in an assisted living facility. The definition of **custodial care** is *a provision of room and board, nursing care, personal care or other care designed to assist an individual in the activities of daily living.* Such care does not entail or require the continuing attention of trained medical personnel, such as nurses. Custodial care includes those services which constitute personal care, such as help in walking, getting in and out of bed, assistance in bathing or eating, using the toilet, preparing special diets, 24-hour supervision for potentially unsafe behavior, or supervision of medication which usually can be self-administered. Care may still be custodial even though such care involves the use of technical medical skills if such skills can be easily taught to a layperson. In the case of an institutionalized person, custodial care also includes room and board, nursing care, or other care which is provided to an individual for whom it cannot reasonably be expected, in the opinion of the physician, that medical or surgical treatment will enable that person to live outside an institution. Custodial care includes: rest cures; respite care; and home care provided by family members;

2. State bed tax for skilled nursing facility stays; and,
3. Room and board charges associated with a hospice related stay.

Swing Bed Care

A **swing bed** is defined as a *distinct unit, or designated bed in a licensed hospital.* Swing beds are used primarily for short-term, post-acute hospital stays to resolve a short-term medical need or to continue rehabilitation for a limited period of time.

Skilled care is defined as *medical services rendered by a registered or licensed practical nurse, physical, occupational or speech therapist.* Patients receiving skilled care are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip, and patients requiring complicated wound care. In the majority of cases, skilled care is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, children, or other family or relatives. Examples of care provided by "nonskilled" persons include range of motion exercises, strengthening exercises, wound care, ostomy care, tube and gastrostomy feedings, administration of medications, and maintenance of urinary catheters. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets, assisting patients with taking their medicines, or 24-hour supervision for potentially unsafe behavior, do not require skilled care and are considered to be custodial.
Confinement must be within 24 hours after discharge from a covered hospital confinement. You must be confined for continued treatment of the same condition for which you required hospitalization. Your doctor must certify that your confinement is medically necessary for skilled care or treatment of the injury or illness that caused the hospital confinement. Swing bed services are limited to 90 days per benefit year. Benefits for swing bed services are included and count towards the skilled nursing facility maximum benefit limits.

Covered with Prior Authorization

Facility charges and costs associated with an approved swing bed stay when meeting the following criteria:

1. Your doctor must certify your stay as medically necessary and daily skilled needs are identified;
2. You must be confined and receive skilled treatment for which you were hospitalized. Confinement must be within 24 hours after discharge from a covered hospital confinement;
3. Intensity and frequency of skilled services requires 24-hour nursing intervention;
4. Frequent or daily physician monitoring is needed;
5. Skilled services will be for a short-term period and may not exceed seven days; and,
6. There is likely no further need for skilled nursing services post discharge.

Telehealth Visits

A **Telehealth Visit** *is a remote scheduled appointment with your usual provider during clinic hours using a telephone call or video chat.* Unless otherwise disclosed in your Schedule of Benefits, cost-sharing for a telehealth visit is the same as an in-person visit.

Telehealth visits with in-network providers are covered in the same manner as in-person visits. Contact your provider's office to see if a telehealth visit is available. If so, they'll schedule a time and give you details on how and when to connect with the provider. You may also have access to additional therapy telehealth visit options for mental health and substance use disorders. Contact Quartz Customer Success for more information.

Therapy (Physical, Speech & Occupational)

Iowa Code 514C.22

Covered Services

1. Medically necessary rehabilitative health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy and speech-language pathology in a variety of inpatient and/or outpatient settings. Therapy must be ordered by a qualified physician and be provided by a qualified provider. Therapies are limited to 20 visits per therapy discipline (speech, occupational and physical) per year;
2. Outpatient therapy for the treatment of mental health and substance use disorders is covered based on medical necessity; no specific visit limits apply to traditional therapy services. However, you may also have access to additional therapy telehealth visit options for mental health and substance use disorders. Contact Quartz Customer Success for more information; and,
3. Medically necessary habilitative health care services that help a person keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapy and speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Therapy must be ordered by a qualified physician and be provided by a qualified provider. Therapies are limited to 20 visits per therapy discipline (speech, occupational and physical) per year.

Covered with Prior Authorization

1. Rehabilitative therapies in excess of 20 visits per therapy discipline per year require prior authorization; and,
2. Habilitative therapies in excess of 20 visits per therapy discipline per year require prior authorization.

Non-Covered Services

1. Maintenance therapy or treatment that does not result in documented sustained improvement. **Maintenance therapy** is defined as *ongoing therapy delivered after the acute phase of an illness has passed. It begins when a patient's recovery has reached a plateau or improvement in their condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated;*
2. Art, dance, music, or animal-based therapies;
3. Therapy services such as recreational or education therapy, physical fitness or exercise programs, including Phase III of cardiac rehabilitation;
4. Any treatment or therapy which is court ordered, ordered as a condition of parole, probation, custody, or visitation evaluation, unless such treatment or therapy is normally covered by us;
5. Services provided by a therapist living in the patient's home or who is a member of the immediate family;
6. Services by a non-payable provider as determined by us, including providers practicing in non-certified facilities within the State of Iowa;
7. Residential treatment as a substitute for legal actions or to provide respite for the family;
8. Recreational or non-skilled services or activities conducted through wilderness and camp programs, therapeutic boarding schools and academy-vocational programs;
9. Group homes and halfway houses for supportive and maintenance care;
10. Shelter services, correctional services, detention services, group residential services and foster care services;
11. Crisis intervention programs and services that do not meet the requirements or are not licensed by the local Health and Human Services Department. Covered services must be medically necessary and provided by licensed psychiatrists, psychologists, social workers, marriage and family therapists or licensed alcohol and drug counselors as appropriate in each case; and,
12. Educational or vocational therapy, including but not limited to counseling, evaluation, testing, treatment, videos or video games, and books.

Tobacco/Smoking Cessation

Covered Services

1. Screening for tobacco use; and,
2. Two tobacco cessation attempts per year. Each cessation attempt includes coverage for:
   - Four tobacco cessation counseling sessions of at least 10 minutes each (including individual, group, and telephone counseling) or an approved tobacco/smoking cessation program (reimbursement upon receipt of completion certificate); and,
   - All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen, when prescribed by a healthcare provider.

Transplants

Covered Services

1. Cornea transplants.

Covered with Prior Authorization

1. Transplantation and re-transplantation of solid organ and bone marrow transplants as long as the procedure has been established to be reasonable by nationally recognized academic transplant centers and is approved by us.

Kidney	Kidney/Pancreas	Liver
Heart/Lung	Lung	Bone Marrow
Intestinal	Heart	Stem Cell

Claims for donor expenses are covered only when the transplant recipient is a Quartz member under this plan. The provider must submit claims for donor expenses under the transplant recipient's name.

Non-Covered Services

1. Purchase price of bone marrow, organ, or tissue that is sold rather than donated;
2. Lodging and transportation expenses; and,
3. Transplant services from providers and/or facilities not approved by us.

Urgent Care

Urgent care is defined as the *care that you need sooner than a scheduled physician's visit, but is not an emergency.* Some examples of urgent care are sprains, minor cuts and burns, drug reactions, and non-severe bleeding.

Covered Services

1. Urgent care provided by an in-patient provider or by an out-of-network provider.

Non-Covered Services

1. Services that do not meet the definition of urgent care.

Virtual Visits

A **Virtual Visit** *is an on-demand consultation with a provider using a computer or mobile device*; no appointment is needed. Based on your responses to a series of questions, the provider may give a diagnosis, suggest follow-up care, and/or prescribe medication. Compared to a telehealth or office visit, virtual visits may be covered at reduced cost-sharing, depending on your benefit plan.

Virtual visits are covered for the treatment of non-emergent medical conditions. Not all injuries or illnesses can be addressed using virtual visits. Cost-sharing under your plan will apply, even if the provider is not able to diagnose or treat you during the encounter. If necessary, you may be directed

to another location for evaluation or treatment. Quartz reserves the right to determine the electronic platform used for covered virtual visits.

Covered Services

1. Virtual visits for non-urgent illnesses, including but not limited to back pain, cough, fever, nausea/vomiting, heartburn, sinus problems, etc.

Vision Care

Covered Services

1. Eye exam provided as part of the treatment for medical conditions;
2. Routine eye exam (with or without refraction);
3. Initial lenses (standard glass, plastic, polycarbonate or contacts) after cataract surgery, one lens per surgical eye (frames not included), when provided within 12 months of surgery;
4. Contact lenses when determined to be ***medically necessary*** and appropriate in the treatment of patients affected by certain conditions. An initial external lens per eye may be covered when determined ***medically necessary*** for each of the following reasons: (1) to heal from surgery, (2) due to a malformation of the eye, and (3) due to an injury to the eye. Any subsequent contact lenses after the initial lens per eye for each reason (1) – (3) will not be covered. Medically necessary contact lenses are dispensed in lieu of other eyewear. ***In-network providers*** will obtain the necessary ***prior authorization*** for these services.
    - Examples of conditions for which contact lenses may be determined to be medically necessary include but are not limited to: Keratoconus, Keratoconjunctivitis sicca (severe dry eyes), Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, and Irregular Astigmatism; and,
5. Corrective eyewear for children under the age of 19 through in-network providers only. Includes coverage for:
    - One standard pediatric or standard adult frame per year; and,

- One pair of standard lenses (glass, plastic, or polycarbonate) lenses per year;
  - Standard lenses include single vision, bifocal, and trifocal lenses;
- Contact lenses may be substituted for eyeglasses and are limited to one pair of rigid lenses or up to 24 pairs of soft disposable lenses per benefit year.

Coverage under this section ends at the end of the month in which the member turns 19.

Non-Covered Services

1. Non-prescription eyewear;
2. Prescription eyewear for adults (persons age 19 and older);
3. Deluxe frames;
4. Professional services including measurement, fitting, and adjustments;
5. Vision therapy, or orthoptics treatment (eye exercises);
6. All refractive surgical procedures to correct visual acuity and refractive disorders of the eye; and,
7. Specialty intraocular lens implanted at the time of cataract surgery or as a separate subsequent surgical procedure. Specialty intraocular lenses include, but are not limited to toric astigmatism-correcting intraocular lenses and multifocal presbyopia-correcting intraocular lenses.

Well-Child Care

Iowa Reg. 191.80.5

Covered Services

1. Well-child exams from birth through age six years as recommended in the Preventive Care Guidelines or by the American Academy of Pediatrics, including vision and hearing screening done in conjunction with the exam;

2. Immunizations, as recommended by the Centers of Disease Control Advisory Committee in Immunization Practice or the American Academy of Pediatric Committee on Infectious Disease; and,
3. Charges for lab services including, but not limited to screening for lead exposure as well as blood levels for children through six years of age. The Department of Human Services (DHS) shall conduct tests in accordance with recommendations.

X-Ray & Laboratory Tests

Covered Services

1. Inpatient and outpatient diagnostic and therapeutic testing ordered because symptoms are present, or to monitor an existing medical condition or illness.

Section 5 – General Exclusions

An **exclusion** is defined as *any medical service or supply listed in this section, or not listed as a covered expense in Section 4 - Benefits: Covered and Non-Covered of this COC.*

The following are General Exclusions of your plan:

1. Any and all types of modifications to the home and the items associated with the modifications (e.g., ramps, grab bars, stair lifts, elevators);
2. Any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation;
3. Any loss caused while engaged in active military or reservist duties as a result of war or any act of war, declared or not;
4. Any services in excess of the maximum benefit limitations;
5. Any services requested by a third party;
6. Any treatment, service or supply not specifically listed as a covered benefit and all associated and related charges;
7. Any items or services provided out of network or outside the United States, except for emergency care, not prior authorized or approved in writing by us. Members should always bring their Quartz ID Card when travelling inside or outside the United States;
8. Any treatment or services rendered by a person residing in your household, or a member of your immediate family. **Immediate family** is defined *as spouse, mother, father, grandparents, children, grandchildren, brothers, sisters, mother-in-law, father-in-law, brothers-in-law, sisters-in-law, daughters-in-law, and sons-in-law. Adopted and step relationships are also included in immediate family.* However, if one of the persons described above is a licensed medical provider and you receive urgent or emergency services from that person in an urgent care facility or hospital, this exclusion does not apply;
9. Any treatment or services ordered or rendered by you, for you;

10. Any treatment or services rendered by, or at the direction, of a provider of health care services who is not licensed to provide the services, or who is not operating within the scope of that license;
11. Charges for drugs filled at out-of-network pharmacies;
12. Charges for services that were not rendered;
13. Charges for out-of-network provider services which exceed usual and customary;
14. Charges for the services of a blood donor;
15. Changes related to surrogate mother services when the surrogate is not a member under this plan;
16. Chelation therapy;
17. Child care fees;
18. Coma stimulation programs;
19. Communications, lodging accommodations, transportation, and travel time, unless otherwise indicated as being a covered expense;
20. Custodial care;
21. Customization of vehicles and/or lifts for wheelchairs and/or scooters;
22. Dermabrasion;
23. Donor charges related to transplant services when the recipient is not a Quartz member (even if the donor is a Quartz member);
24. Expenses for medical reports, including preparation and presentation;
25. Hair analysis;
26. Hair prosthesis, hair transplants or implants, wigs or any treatment of alopecia;
27. Hair removal, unless authorized by Quartz as part of covered gender-affirming care;
28. Wart removal;
29. Hypnotherapy;
30. Long term acute care (LTAC) facility;
31. Massage therapy when provided by a masseuse;
32. The medications eteplirsen (Exondys 51), golodirsen (Vyvondys 53), casimersen (Amondys 45), and vitolarsen (Viltepso);
33. Platelet-rich plasma treatment;
34. Prolotherapy. However, prolotherapy is covered when provided for the treatment of lateral epicondylosis, symptomatic knee osteoarthritis, or

sacroiliac (SI) joint pain. Prolotherapy is not covered for the treatment of any other conditions;

35. Psychological or neuropsychological testing for educational purposes;
36. Removal of excess skin resulting from weight loss, other than panniculectomy;
37. Rental or purchase of hospital-grade breast pumps;
38. Relationship counseling;
39. Robotic-assisted surgeries;
40. Services provided under another plan for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include medical payment coverage under no-fault or underinsured automobile insurance, or coverage required under similar legislation. If coverage under this legislation is optional for you because you could have elected it, or could have had it elected for you, benefits will not be paid for any injury or sickness that would have been covered under the other plan had it been elected. For situations involving occupational injury or hazard, also see the Workers' Compensation section under Subrogation Recovery Rights;
41. Services and supplies for which no charge is made or for which you would not have to pay without this coverage;
42. The amount of any copayment, coinsurance, and/or deductible:
    - **Copayment** is defined as *a specific dollar amount that you are responsible for before we assume any liability for the remaining part of the charges for that service*;
    - **Coinsurance** is defined as *a percentage of the allowed charge for covered expenses that you are required to pay*. You are responsible for the payment to the provider for any coinsurance amount;
    - **Deductible** is defined as *an amount of money that you must pay before benefits are payable by us*. The deductible applies to each member each benefit year. Only allowable charges that qualify as covered expenses may be used to satisfy the deductible. The amount of the deductible, if any, is stated on the Summary of Benefits and Coverage;

43. Treatment, services, and supplies furnished by the U.S. Veterans Administration, except for which we are the primary payer under applicable federal law; and,
44. Work hardening programs, health spas, health clubs, aerobic and strength conditioning, exercise equipment and all related material and products for these programs.

Section 6 – Claim Information

Time Limit on Filing a Claim

A claim for such benefits should be submitted to us within 60 days after the services are received, or as soon as it is possible. If we do not receive the claim within 12 months after the date it was otherwise required, we may deny coverage of the claim.

How to File a Claim

When filing a claim it is important to understand your rights and responsibilities. Some services require prior authorization from us pre-service. Failure to obtain necessary prior authorization may result in a denial of coverage, in which case the responsibility of payment may be yours. Please see Section 2 of this document for further information on the timing and process of how to obtain a pre-service prior authorization.

When obtaining treatment at a provider's office or a hospital, please present your health plan ID card to ensure proper claim filing. We will be billed directly post-service for your claim and will notify you of any applicable costs (deductible, copayments or coinsurance) or non-covered charges. If you receive services from an out-of-network provider, and are required to make payment, please obtain a claim form or provide us with the following information when requesting payment from us. If the provider is not able to provide you with a claim form, please refer to our website for complete instructions and our claim form. The following information is required when requesting payment of benefits:

1. Subscriber's name and address;
2. Patient's name and date of birth;
3. Number from your ID card;
4. Name and address of the provider of the service(s);
5. Name and address of any ordering physician;

6. A diagnosis from the physician;
7. An itemized bill that includes applicable procedure codes or a description of each charge;
8. The date of injury or sickness;
9. If you have other coverage, please include the name of the other insurance carrier(s); and,
10. Proof of payment.

Submit this information to the following address:

Quartz
Attn: Claims Department
2650 Novation Pkwy.
Fitchburg, WI 53713

You must agree to provide us with any additional information regarding your claim that we may require to process the claim. 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.

You have the right to appeal any decision we make that denies payment of your claim or your request for coverage of a health care service or treatment, including concurrent care decisions. Please see Section 7 of this document for the timing, notices, and process requirements for these rights.

How to File a Pharmacy Claim

When obtaining prescriptions, you must present your health plan identification (ID) card. It is your responsibility to use in-network pharmacies. If you receive any prescriptions and are required to make full payment, you may submit an itemized receipt to us. You will receive reimbursement for any covered prescription drug services outlined in Section 4 of this document,

minus the applicable copayment. Reimbursement will be at the current contracted rates; any difference between this rate and the amount that you paid will be your responsibility. Send us your itemized receipt, including the following information:

- Drug name and NDC number;
- Provider's name and NPI number;
- Date of service;
- Days' supply;
- Quantity filled; and,
- Pharmacy's NABP number.

Address the information to:

Quartz Pharmacy Program
2650 Novation Pkwy.
Fitchburg, WI 53713

Physician and Hospital Records

Physicians and hospitals must provide us with records to help us determine if services are covered. You agree to cooperate with us to execute releases, which authorize physicians, hospitals, and other providers of service to release all records to us regarding such services. It is also a condition of our payment of benefits. All information must be furnished to the extent that we determine necessary in a particular situation and as allowed by applicable law.

Care Management/Alternative Treatment

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, or by other organizations contracted with ***Quartz***. Examples of these services are clinical programs that address hypertension/blood pressure (Quartz InControl), diabetes, mental resiliency, 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.

If Your Claim Is Denied

45 C.F.R. § 147.136 and 29 C.F.R. § 2560.503(f)(g)
Department of Labor (DOL) Claim Regulations

Claims must be decided within a reasonable period of time, but no later than 30 days after we have received the claim. If a claim is denied, you will receive written notice from us within 30 days from our receipt of the claim, which can be extended 15 days if additional information is needed for review and you are notified of the extension. The notice of denial will contain:

1. The reasons for the denial;

2. A description of any additional material or information necessary to process the claim and a description of why the material is necessary; and,
3. A notice of your right to have the claim denial reviewed and an explanation of the grievance and the independent review rights.

Informal Inquiry

Customer Success is available for inquiries or informal resolution of complaints. A **complaint** is defined as *a verbal expression of any dissatisfaction with our administration, claims practices, or provision of services, expressed by you or your authorized representative.* Customer Success Representatives can explain benefit provisions and our administrative procedures. They act as an intermediary to resolve any of your questions, concerns, or problems. You may pursue the formal grievance procedure at any time.

Claim Procedures

Upon request, we will provide you or your authorized representative with a copy of our claim procedures free of charge.

Section 7 – Appeal & External Review Procedures

We encourage you to contact Customer Success Department if you have an inquiry, a concern, or a complaint against us or one of our in-network providers. The Customer Success Representative acts as an intermediary for us to resolve any of your issues. If they are unable to resolve the issue to your satisfaction, they will advise you of your right to appeal an adverse benefit determination in writing or verbally with the Appeals Specialist. You have the right to review the claim file and present evidence and testimony as part of the internal appeals process. The Appeals Specialist is a person who is employed by us who specializes in the appeal process. The Appeals Specialist will receive and record your written appeal. He or she will investigate your appeal and assist you through the appeals procedure. They will also advise you or your authorized representative (herein referred to as "AR") of the disposition of the appeal and the action taken.

Time Limit on Filing an Appeal

Each time Quartz denies a claim or benefit request, Quartz shall notify you of your right to file an appeal. An appeal must be submitted to us within 180 days following receipt of a notification of an initial adverse benefit determination. If the 180-day time frame in which to file an appeal has expired, the appeal request will not be granted.

An expedited appeal may be requested to change an initial adverse benefit determination for urgent care. Pre-service denials in which you have not received the service will result in a decision within 72 hours of your request.

If your appeal request is for a post-service benefit, you will receive a decision within 30 days of your request.

Definitions

Authorized Representative (AR)
The definition of an **authorized representative** is *an individual authorized by you to act on your behalf in pursuing payment of a claim, obtaining a referral/prior authorization or in dealing with all levels of the appeals process. They may (1) obtain any information about your claims to the same extent that you are able to, (2) submit any evidence, (3) make any statements about fact or law, and (4) make any request or give any notice about the appeal proceedings.* If you appoint your AR to file an appeal for you, you and your AR may, but are not required to use our Personal Representative Appointment and Authorization to Release Protected Health Information form. We will accept any authorization form that confirms your request for representation during the appeal procedure.

Adverse Benefit Determination
The definition of **adverse benefit determination** is *a denial, reduction, or termination of, or failure to provide or make payment for a benefit, including denial, reductions, or termination of, or failure to provide or make payment based on a determination of a member's eligibility to participate in a plan, and including denial, reductions, or termination of, or failure to provide or make payment for a benefit, resulting from the application of any utilization review, as well failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.* A rescission of coverage is an adverse benefit determination, as is a determination that Quartz's application of non-quantitative treatment limitations is compliant with federal mental health parity law.

In addition, an adverse benefit determination includes a determination that "surprise billing" protections do not apply to an item or service you have received, including:

- Patient cost-sharing and surprise billing for emergency services;
- Patient cost-sharing and surprise billing protections related to care provided by out-of-network providers at in-network facilities;

- Whether patients are in a condition to receive notice and provide informed consent to waive No Surprises Act (NSA) protections; and,
- Whether a claim for care received is coded correctly and accurately reflects the treatments received, and the associated NSA protections related to patient cost-sharing and surprise billing.

If we fail to adhere to all of the requirements listed with respect to a claim, you are deemed to have exhausted our internal claims and appeals process and may initiate an external review.

Appeal
The definition of an **appeal** is *any dissatisfaction with the provision of services or claims practices by us, or any administration of services by us, which is expressed in writing by you or on your behalf.*

Continued Coverage through Completion of Appeal Process

The health plan will allow members to have continued coverage under their medical benefit plan pending the outcome of an internal grievance/appeal. Continued coverage only applies to concurrent care decisions if the health plan has approved an ongoing course of treatment (e.g., inpatient care, SNF, home health care, physical therapy) and any denial, reduction or termination of such course of treatment by the health plan before the end of such period of time or number of treatments. If the member requests continuation of time or number of treatments, the ongoing course of treatment must continue, pending the appeal outcome. If the insured files and appeals for an extension of the treatment and that appeal is being reviewed beyond the end of the currently approved treatment, coverage will continue through completion of the appeal process.

The health plan must continue to provide coverage and make payment for the currently approved ongoing course of treatment while the internal appeal/grievance is under review. The health plan is obligated to provide coverage up to the end of the currently approved treatment or final

determination, whichever comes first, subject to regulatory and contractual obligations of the health plan.

Grievance and Appeals Committee and Goals

We have established a Grievance and Appeals Committee to review and act upon all member appeals. It reviews all written appeals made by you. It makes a final determination based on your benefit plan and all documentation that is present upon review. We are committed to giving you an opportunity to exercise your right to a fair and quick resolution to any and all appeals. Our appeal procedure has been developed to meet the following goals:

1. To ensure that you receive a fair, just and prompt resolution to appeals;
2. To allow you to be treated with dignity and with respect through the entire appeal process;
3. To inform you of your full rights as they relate to appeal resolution including your right to appeal at each level;
4. To provide a review that takes into account all comments, documents, records, and other information submitted by you, regardless of whether such information was submitted or considered in the initial benefit determination; and,
5. To comply with all state and federal regulatory guidelines and policies with respect to member appeals.

The appeal procedures as described in this section will demonstrate our ability to meet the goals stated above.

Standard Appeal Procedure

You or your AR must submit your appeal in writing to the Appeals Specialist. Please forward your appeal to the following address, unless otherwise directed in a determination letter:

Quartz
Attn: Appeals Specialists
2650 Novation Pkwy.
Fitchburg, WI 53713
Telephone: (800) 362-3310 or (608) 644-3430
Fax Number: (608) 644-3500
Email: AppealsSpecialists@QuartzBenefits.com

Within five business days of receipt of your written appeal, the Appeals Specialist will:

- Provide you with a written notice acknowledging receipt of your written appeal. They will advise you or your AR of the date and the place of the Committee meeting;
- Notify you or your AR of the right to appear in person or via teleconference before the Committee. This is to present written or verbal information and to question those responsible for making the initial determination that resulted in the appeal;
- Resolve and provide written or electronic notification in a culturally and linguistically appropriate manner of your pre-service appeal within 30 calendar days of receipt; and,
- Resolve and provide written or electronic notification in a culturally and linguistically appropriate manner of your post-service appeal within 60 calendar days of receipt.

If we are unable to resolve your pre-service appeal within 30 calendar days of receipt, we may extend the time period an additional 30 calendar days if we obtain verbal or written authorization from you or your AR. If authorization is not obtained, we will make a determination based on the information available. The Appeals Specialist will notify you or your AR in writing prior to the expiration of the 30 calendar days of the following:

- That we have not resolved your appeal;
- The reason why additional time is needed; and,
- When resolution can be expected. The extended time period needed for resolution of your appeal shall not exceed 30 calendar days.

The Appeals Specialist will provide you or your AR with written notification of the Grievance and Appeals Committee's final decision. The written notice will include the rationale for the decision. It will also include your right to further appeal if the decision is unfavorable to you.

Expedited (Urgent Care) Appeal Procedure

You have the right to access the expedited appeal review process.

An **expedited appeal** is *an appeal where any of the following applies*:

1. The standard appeal resolution could:
   - Seriously jeopardize your life or health or your ability to regain maximum function; or,
   - In the opinion of a physician, with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the appeal; or,
2. It is determined to be an expedited appeal by a physician with knowledge of the member's medical condition.

Expedited Appeal Procedure

1. You, your AR, or your physician may verbally request an expedited appeal by contacting the Appeals Specialist at (800) 362-3310. Expedited appeals may be submitted either in writing or verbally to the Appeals Specialist. The Appeals Specialist will verbally notify you, your AR, or your physician as to whether or not the expedited appeal request will be granted. An expedited appeal will be resolved as quickly as your health condition requires, but no later than 72 hours of our receipt of the request;
2. The Appeals Specialist will:
   - Notify you or your AR by telephone of our decision within 72 hours of our receipt of the expedited (urgent care) appeal; and,

- Follow-up in writing or electronically in a culturally and linguistically appropriate manner within two business days of our decision;

3. If you fail to provide sufficient information to determine covered/payable benefits for your urgent care claim, the plan will:
   - Notify you within 24 hours of the information necessary to complete the claim;
   - Give you at least 48 hours to provide the specified information; and,
   - Provide you with notice of our decision within 48 hours of the earlier of:
     - Receiving the specified information; or,
     - At the end of the time period provided to return the specified information;
4. If our decision is to uphold the initial adverse benefit determination, in whole or in part, the Appeals Specialist will provide you or your AR with a written notification including the date and place of the Grievance and Appeals Committee meeting; and your right to appear in person or via teleconference before the Grievance and Appeals Committee. This is to present written or verbal information and to question those persons responsible for making the initial denial that resulted in the expedited appeal. After the Committee has made a decision, you or your AR will be notified of the decision in writing. If the Committee decision is to uphold the initial adverse benefit determination, in whole or in part, the Appeals Specialist will provide you or your AR with a final decision letter. The final decision letter will include the specific reason for the denial, make reference to the benefit provision guideline, protocol or other criteria used to make the decision, or will include claims related information (e.g., date of service denied, health care provider or network, the claim amount denied as it related to your diagnosis and its meaning; as well as treatment code, if applicable);
5. The Appeals Specialist will provide you or your AR with a written notification of the Committee's final decision. The written notice will include the rationale for the decision and your right to further appeal if the decision is not favorable to you; and,

6. If we determine that your expedited appeal request is not time sensitive, the request will be processed under the standard appeal procedure. The Appeals Specialist will verbally notify you or your AR of our decision to deny the request for an expedited review. We will also provide you with written notification of our decision not to expedite the review within 72 hours of the request.

Submission and Receipt of Information

At any time during the standard or expedited appeal process, you or your AR may provide us with any written comments, documents, records or any other information regarding your issue. You or your AR can present such evidence in person, in writing, via teleconference, or by fax. Upon your request, we will provide you or your AR with copies of all documents, records, and other information relevant to your appeal issue(s). This information will be provided to you free of charge.

Legal Actions

No action can be brought against us to pay benefits until at least 60 days after written proof of loss is furnished. No action can be brought more than three years after the date that the written proof of loss is made. If you pursue review through the voluntary levels of appeal, then the three-year limitation does not begin until the last voluntary level of appeal has been exhausted.

Voluntary Option Appeal

Upon your request we will provide you or your AR with additional information that is related to the voluntary levels of appeal. This information will enable you to make an informed judgment about whether or not to submit your issue in dispute to a voluntary level of appeal. No fees or costs are imposed on you as part of the voluntary level of appeal.

Other Voluntary Options of Appeal

1. **Iowa Insurance Division**

   You may contact the Iowa Insurance Division, a state agency that enforces Iowa's insurance laws, and you may file a complaint. You can contact the Iowa Insurance Division by writing to:

   Iowa Insurance Division
   601 Locust St. - 4th Floor
   Des Moines, IA 50309

   You may also call (515) 281-5705 or toll-free at (877) 955-1212, or email iid.marketregulation@iid.iowa.gov to request a complaint form.

2. **External Review**, explained in the following section.

External Review

Notification of Right to External Review

If we denied your request for the provision of or the payment for a health care service or a course of treatment or you did not receive a decision within 30 days following the date you or your AR filed an appeal involving an adverse benefit determination then you have a right to have our decision reviewed by independent health care professionals who have no association with us. This process is called "external review."

You may obtain an external review if:

- Our decision involved an admission, the availability of care, a continued stay, or other health care service that is a covered benefit;
- We denied, reduced or terminated the payment for the service because we determined it did not meet our requirements for medical necessity, health care setting, appropriateness, level of care or effectiveness of the health care service or treatment you requested;

- Our decision was based on a determination that the service or treatment is investigational or experimental;
- We determined that "surprise billing" protections do not apply to an item or service you have received;
- Upon agreement by us to waive your request for exhaustion of the internal appeal process requirement. If waived by us, you or your AR may file a request in writing for a standard external review; or,
- Rescission of health care insurance policy or certificate (rescission means the plan retroactively cancels your policy because it maintains that you did not answer the health questions on the application of insurance completely and accurately).

Exhaustion of Internal Appeal Process

Except for requests for expedited external review, a request for external review shall not be made until the member or their authorized representative have exhausted the health plan's internal appeal process and have received a final internal adverse benefit determination.

A member or their authorized representative shall be considered to have exhausted the health plan's internal appeal process if:

- The member or their authorized representative filed an appeal involving an adverse benefit determination; or,
- The health plan failed to issue a written decision within 30 days following the date the member or their authorized representative filed an appeal involving an adverse determination, unless an extension has been requested by the member or by the health plan with the member's verbal permission.

A member or their authorized representative may file an expedited external review of an adverse benefit determination without exhausting the health plan's internal appeal process under the following circumstances:

- The time frame for completion of the internal appeal process would seriously jeopardize the life or health of the member or their ability to regain maximum function;
- The adverse benefit determination involves a denial of coverage based on the requested service or treatment being experimental or

investigational and the treating physician certifies in writing that the service or treatment would be significantly less effective if not promptly initiated; and,

- Upon agreement by the health plan to waive the member's request for exhaustion of the internal appeal process requirement. If waived, the member or their authorized representative may file a request with the commissioner in writing for a standard external review.

Filing a Request for External Review

Except for expedited review requests, you or your AR shall request an external review with the Iowa Insurance Division. You or your AR will need to complete an External Review Request Form. This form can be obtained from the Iowa Insurance Division at:

Iowa Insurance Division
601 Locust St. - 4th Floor
Des Moines, IA 50309

Telephone: (515) 281-5705 or (877) 955-1212
Fax: (515) 281-3059
Web site: iid.iowa.gov

A written request for an external review must be submitted within four months of our notice containing an adverse benefit determination or a final adverse benefit determination. You should submit your request for an external review to the Iowa Insurance Division at:

Iowa Insurance Division
601 Locust St. - 4th Floor
Des Moines, IA 50309

Telephone: (515) 281-5705 or (877) 955-1212
Fax: (515) 281-3059
Email: iid.marketregulation@iid.iowa.gov

When you or your AR file a request for an external review, you will be required to authorize the release of any medical records that may be required to conduct the external review. Your authorization can be provided by utilizing the External Review Request Form.

Standard External Review Request

Within five business days of receipt of your external review request from the Iowa commissioner, we will complete a preliminary review to determine if the external request meets the following eligibility requirements:

- Evidence you were covered by the plan at the time the service was proposed or received;
- Evidence the service is a covered benefit under your benefit plan, and based on a determination by us the proposed or received service or the treatment does not meet our requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment being requested; and,
- Evidence that you or your AR provided all the information and forms required to process the external review request.

Within one business day after completion of the preliminary review, we will notify the Iowa commissioner, you or your AR in writing if the request is complete and eligible for external review.

If we determine the request is not complete, we will notify you or your AR and the Iowa commissioner in writing that the request is not complete and what information and materials are needed to make the request complete.

If we determine the request is ineligible for an external review, we will issue a notice of initial determination in writing that will inform you or your AR and the Iowa commissioner of the reason(s) why the request is ineligible for review and a statement informing you or your AR that the initial decision of ineligibility may be appealed to the Iowa commissioner. The Iowa commissioner may determine that a request is eligible for external review, even if we determined that the request was ineligible, and he or she may refer the request for external review.

Eligible External Review Request

Within one business day after receipt of our notice of an eligible external review or upon the determination by the Iowa commissioner that a request is eligible for external review, the Iowa commissioner shall:

- Assign an external review organization (IRO) from the list of approved IROs maintained by the Iowa commissioner;
- Assign an IRO on a random basis among the list of approved IROs qualified to conduct a review based on the nature of the service of the adverse benefit determination or final adverse benefit determination; and,
- Provide written notification to you or your AR that the request was eligible and accepted for external review; the name of the assigned IRO, and that you or your AR may submit in writing to the IRO within five business days following receipt of such notice from the Iowa commissioner, additional information the IRO shall consider when conducting the external review. The IRO may accept and may consider any additional information submitted by you or your AR after five business days.

Within five business days after receipt of notice from the Iowa commissioner of the assigned IRO, we will provide the assigned IRO all documents and information considered in making the adverse benefit determination or final adverse benefit determination.

The assigned IRO will review all the information and the documentation received from us and the information received in writing from you or your AR. Upon receipt of any additional information from you or your AR, the IRO within one business day, will forward the information to us for review.

- Upon receipt of the additional information from the IRO, we may reconsider the adverse benefit determination or the final adverse benefit determination that is the subject of external review;
- Reconsideration by us will not delay or terminate the external review. The external review will only be terminated if we decide, upon completion of the reconsideration, to reverse the decision and to provide coverage or payment for the service or the treatment that is

the subject of the adverse benefit determination or the final adverse benefit determination;

- Within one business day after making a decision to reverse the adverse benefit determination or the final adverse benefit determination, we will notify you or your AR, the IRO, and the Iowa commissioner in writing of our decision; and,
- The IRO will inform the plan and you in writing of its decision within 45 days from the receipt of the request for review.

Expedited (Urgent Care) External Review

You or your AR can request an oral or a written external review with the Iowa commissioner when the following criteria are met:

- An adverse benefit determination involves a medical condition in which the timeframe for completion of the internal appeal process would seriously jeopardize your life or health or your ability to regain maximum function;
- A final adverse benefit determination that involves a medical condition in which the time frame for completion of the standard external review would seriously jeopardize your life or health or your ability to regain maximum function;
- A final adverse benefit determination that concerns an admission, availability of care, a continued stay, or the services which the member received on an emergency basis, and has not been discharged from a facility; and,
- A final adverse benefit determination that concerns a denial of coverage based on a decision that the recommended service or treatment is experimental or investigational, and your treating health care professional certifies in writing that the recommended service or the treatment would be significantly less effective if not promptly initiated.

Upon receipt of an expedited external review, the Iowa commissioner will immediately send written notification of the request to us. We will immediately complete a preliminary review to determine if the expedited external request meets the following eligibility requirements:

- Evidence you were covered by the Plan at the time the service was proposed or was received;
- Evidence the service is a covered benefit under your benefit plan, and based on a determination by us that the proposed or received service or treatment does not meet our requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness; and,
- Evidence you or your AR provided all the information and the forms required to process the external review request.

After our completion of the preliminary review, we will immediately notify the Iowa commissioner, you or your AR in writing if the request is complete and eligible for an external review. If we determine the request is not complete, then we will immediately notify you or your AR, and the Iowa commissioner in writing that the request is not complete and what information and materials are needed to make the request complete.

If we determine the request is ineligible for an expedited external review, then we will immediately issue a notice of initial determination in writing informing you or your AR and the Iowa commissioner of the reason(s) why the request is not eligible for review and a statement informing you or your AR that our initial decision of ineligibility may be appealed to the Iowa commissioner. The Iowa commissioner may determine that a request is eligible for external review, even if we determined that the request was ineligible, and refer the request for external review.

Eligible Expedited External Review

Upon the receipt of an eligible external review or upon the determination by the Iowa commissioner that a request is eligible for expedited external review, the Iowa commissioner shall:

- Assign an IRO from the list of all approved IROs maintained by the Iowa commissioner and notify us, you or your AR of the name of the assigned IRO; and,
- Assign an IRO on a random basis among the list of approved IROs qualified to conduct the review based on the nature of the service of

the adverse benefit determination or final adverse benefit determination.

Upon receipt of the notice from the Iowa commissioner of the assigned IRO, we will provide the assigned IRO all documents and all information considered in making our adverse benefit determination or a final adverse benefit determination.

The assigned IRO will then review all the information and the documentation received from us. Information received in writing from you or your AR will also be reviewed. Upon the receipt of additional information from the IRO, we may reconsider the adverse benefit determination or the final adverse benefit determination that is the subject of the external review.

- Reconsideration by us shall not delay or terminate the external review. The external review will only be terminated if we decide, upon completion of the reconsideration, to reverse the decision and provide coverage or payment for the service or treatment that is the subject of the adverse benefit determination or final adverse benefit determination; and,
- Within one business day after making a decision to reverse the adverse benefit determination or the final adverse benefit determination, we will notify you or your AR, the IRO, and Iowa commissioner in writing of the decision. The IRO will terminate the external review upon receipt of our notice.

IRO Decision Time Frames for External Review

Standard
For standard external reviews, a decision will be made within 45 days after the IRO receives your request.

Expedited
If you have a medical condition that would seriously jeopardize your life or your health or would jeopardize your ability to regain maximum function if any treatment would be delayed, you may be entitled to request an

expedited external review of our denial. A decision will be made within 72 hours after the IRO receives your request.

Upon receipt of the IRO's decision to reverse the adverse benefit determination or the final adverse benefit determination, we will immediately authorize coverage or provided payment of the services or treatment in dispute.

Effects of External Review Decisions

- The IRO review decision is binding on us and the findings of fact by the IRO are conclusive and binding on appeal and in any subsequent proceeding or action involving the same facts;
- The insured subscriber has the right to pursue other remedies as permitted by law or regulation to the fullest extent of those remedies. These remedies cannot be restricted or limited by the External Appeal Process;
- We shall pay for costs of retaining the IRO to conduct the external review;
- We shall comply with the review IRO decision of the court on appeal; and,
- We and your treating health care provider shall not be subject to any penalties, sanctions, or award of damages for following and complying in good faith with the external review decision of the court on appeal.

External Review – Formulary Exceptions

Quartz provides a process for you or your provider to request coverage of a non-formulary drug on an exception basis. If you or your prescribing provider submitted a non-formulary exception request and it was denied, you may request that our decision be reviewed by an Independent Review Organization (IRO). The request for an external review of our decision must be submitted within four months of the date you received a denied formulary exception request. To make this request, please contact the Appeals

Specialists using any of the methods listed below, unless otherwise directed in a determination letter:

Quartz
Attn: Appeals Specialist
2650 Novation Parkway
Fitchburg, WI 53713

Telephone: (800) 362-3310, extension 101901
Fax Number: (608) 644-3500
Email: AppealsSpecialists@QuartzBenefits.com

The timeline for this external review will vary based on the urgency of your situation.

You or your prescribing provider could also request an appeal of our decision to deny your formulary exception request. This request must be submitted within 180 days of the date you received a denied formulary exception request.

Standard Non-Formulary Exception

If your initial request for a non-formulary drug was not urgent, the request for external review of the denial will follow the standard non-formulary exception request timeline. We will notify you or your authorized representative and the prescribing provider of the IRO's decision no later than 72 hours after we receive your request. If the IRO approves your request for coverage of the non-formulary drug, we will cover the drug until your prescription expires, including refills.

Expedited Non-Formulary Exception

If your initial request for a non-formulary drug was handled as an urgent or exigent request, the request for external review of the denial will follow the expedited non-formulary exception request timeline. Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or

ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

We will notify you or your authorized representative and the prescribing provider of the IRO's decision no later than 24 hours after we receive your request. If the IRO approves your request for coverage of the non-formulary drug, we will cover the drug for the duration of the exigency.

Section 8 – Coordination of Benefits

Applicability

Coordination of Benefits (COB) is defined as *a method of integrating benefits payable under more than one plan so that benefits from all sources do not exceed 100% of allowable expenses.*

For purposes of this COB section only, a Plan means any of the following which provide 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 pre-payment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage; and,
- 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;

Coordinating Medical Benefits

We coordinate benefits with other insurance plans. The purpose of coordinating benefits is to control costs by reducing the benefits otherwise payable in certain situations under the Group Master Policy Agreement. Coordination of benefits occurs when you are covered under the Group Master Policy Agreement and:

1. Have other insurance;
2. Are eligible for Part A and Part B of Medicare;

3. Are eligible for governmental programs or coverage required or provided by statute unless the law requires that the Group Master Policy Agreement is primary; or,
4. Have liability coverage (i.e., automobile, home, or other liability), that has provided benefits for any healthcare costs related to the accident or injury.

A reduction in benefits will not apply if the benefits from all such plans, in total, do not exceed what is defined as an allowable expense. The definition of an **allowable expense** is *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.* Reductions will be made to the extent required to prevent benefits from exceeding the allowable expense.

Coordinating Pharmacy Benefits

We will coordinate pharmacy benefits with other insurance plans. When coordinating benefits as a secondary payer, in all circumstances you will be subject to the copayments and applicable coinsurance under this plan. Your copayment and/or applicable coinsurance under this plan will apply to each prescription filled in a quantity not to exceed a 30-day supply or quantity limits established by us. If no payment was made by your primary insurance, we will process your claim. We will also still apply your copayments and/or coinsurance according to your prescription benefits.

Prescription claims submitted for coordination of benefits (COB) by you will be processed and be reimbursed through our Pharmacy Benefits Manager (PBM) at our current contracted rates. Contracted rates may be a lower amount than what you have paid at your pharmacy. Any difference between the contracted rate and the amount you paid will be your responsibility.

Any current limitation on the medication submitted for coordination will apply, such as step therapy, quantity level limit and any other formulary restrictions.

Pharmacy benefit coordination will be consistent with this COB section, and it will follow all provisions in relation to medical claim coordination of benefits.

Order of Benefit Determination Rules

The order of benefit determination rules decides whether the benefits of the Group Master Policy Agreement apply before or after those of the other insurance plan.

General

When there is a basis for a claim under the Group Master Policy Agreement and another plan:

1. The Group Master Policy Agreement is a secondary plan with benefits payable after those of the other insurance plan, unless:
   - The other plan has rules coordinating its benefits with those of the Group Master Policy Agreement; and,
   - Both rules of the other insurance plan and the Group Master Policy Agreement require that the Group Master Policy Agreement's benefits be determined before those of the other insurance plan;
2. The primary plan shall furnish or pay for all allowable services in accordance with the terms of such plan until those benefits are exhausted. Thereafter, if benefits under a secondary plan are greater the secondary plan is responsible for further benefits until its benefits are exhausted;
3. The order of the benefit determination rules do not apply to any insurance plan providing the benefits or the services pursuant to Workers' Compensation or similar laws, a no-fault automobile insurance act or similar law, or any Federal, state, or local government program, including Medicare. Such other insurance shall always be primary unless otherwise required by law; and,
4. If a person is covered by more than one secondary plan, the order of the benefit determination rules decides the order in which the benefits are determined in relation to each other. The benefits of each

secondary plan may take into consideration the benefits of the primary plan or plans and the benefits of any other insurance plan, which has its benefits determined before those of that secondary plan.

Noncomplying Other Insurance Plans

Except for services covered by Workers' Compensation, employer's liability insurance, Medicare, Medical Assistance, or traditional automobile "fault" contracts, we may coordinate the benefits of the Group Master Policy Agreement with a noncomplying other insurance plan. Benefits are coordinated as follows:

1. If the Group Master Policy Agreement is primary, it will pay benefits first;
2. If the Group Master Policy Agreement is the secondary, it will pay its benefits first but the amount of the benefits payable will be determined as if the Group Master Policy Agreement were secondary. In such a situation, the payment will be the limit of the Group Master Policy Agreement's liability;
3. If the noncomplying other insurance plan does not provide the information we need to determine benefits within a reasonable time after we make the request, we will assume that the benefits of the noncomplying other insurance plan are identical to our own, and we will pay benefits accordingly. However, we will adjust any such payments made whenever information becomes available as to the actual benefits of the noncomplying other insurance plan;
4. We will pay on your behalf an amount equal to the difference if the noncomplying other insurance plan reduces its benefits so that you receive less in benefits than you would have received had we paid benefits as secondary, and the noncomplying other insurance plan paid its benefits as primary; and,
5. In no event shall we advance more than we would have paid had we been primary less any amount we previously paid. In consideration of such advance, we shall be subrogated to all of your rights against the noncomplying other insurance plan. Such advance by us shall also be without prejudice to any claim we may have against the

noncomplying other insurance plan in the absence of such subrogation.

Determination of Primary Coverage

The following rules govern the determination of which plan is primary. The first applicable rule applies. If the other plan does not have the same determination of primary coverage provision, the rules set forth in that other plan shall determine the order of benefits.

1. **Non-Dependent/Dependent**
   The benefits of the Group Master Policy Agreement that cover the person as a member are determined before those of the Group Master Policy Agreement that covers the person as a dependent;
2. **Dependent Child/Parents Not Separated or Divorced**
   The benefits of the plan of the parent whose birthday (day and month) occurs first during the calendar year are primary. If both parents have the same birthday, the benefits of the plan that covered the parent longer is primary;
3. **Dependent Child/Separated or Divorced Parents**
   Custodial parent is defined as *either the parent awarded custody of a child by a court decree, or in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year.* If the parents are divorced, separated, or not living together, whether or not they have ever been married:
   - If a court decree states that one parent is responsible for the dependent child's benefits, that plan is primary;
   - If the parent with responsibility for health coverage does not have benefits for the dependent child, but the spouse of that parent does, the plan of that parent's spouse is the primary plan;
   - If the court decree states both parents will be responsible for the dependent child, benefits should be coordinated according to item 2 above; or,
   - If the court decree states the parents have joint custody without specifying that one parent is responsible for the dependent child, benefits should be coordinated according to item 2 above;
   - If there is no court decree, responsibility of benefits is as follows:
     - The plan covering the custodial parent;

    - The plan covering the spouse of the custodial parent;
    - The plan covering the non-custodial parent; and,
    - The plan covering the spouse of the non-custodial parent;
  - If the dependent child is covered under a plan of an individual other than the parents, the order of benefits is determined as if those individuals were the parents of the child. The custody rule is applicable to anyone who has legal custody of the dependent child;

4. **Active/Inactive Employee**
   The benefits of a plan that covers a person as an employee who is neither laid off nor retired, or as that employee's dependent is primary. If the other insurance 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. **Longer/Shorter Length of Coverage**
   If none of the above rules determines the order of benefits, the benefits of the plan that covered a person longer are primary;
   - Dependents under age 26 that have coverage under both a parent's and a spouse's health plan: the plan under which the dependent has been covered longer would be the primary plan. If coverage under both plans began on the same date, the plan of the parent or spouse, as applicable, whose birthday falls first in the calendar year, is the primary plan;
6. **Continuation Coverage**
   If a person has continuation coverage under federal or state law and is also covered under another insurance plan, the benefits of a plan covering the person as a member is primary, and the benefits under the continuation coverage is secondary. 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 shall not apply.

Effect on the Benefits of Plan

Definition of Allowable Expense

Allowable expense means *any necessary, reasonable and customary item of expense for health care, at least a portion of which is covered under 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 provided shall be considered both an allowable expense and benefit paid.

When This Section Applies

This section applies when, in accordance with Order of Benefit Determination Rules, the Group Master Policy Agreement is a Secondary Plan. In that event, the benefits of the Group Master Policy Agreement may be reduced under this section. Quartz will apply these provisions when you incur allowable expenses during a claim determination period for which benefits are payable under any other plan. The provisions will apply only when the sum of the allowable expenses under this plan and any other plan would, in the absence of this "COB" provision or any similar provision in the other plan, exceed the allowable expenses.

Benefits provided under this plan during a Claim Determination Period for allowable expenses incurred will be determined as follows:

1. If benefits under this plan are to be paid after any other plan, the benefits under this plan will be reduced so total benefits payable by all plans will not exceed the total of the allowable expenses, or the patient responsibility amount of the other plan, whichever is less, and this plan will not pay an amount the other plan did not cover because you did not follow its rules and procedures;

2. If benefits under this plan are to be paid before benefits are paid under any other plan, benefits under this plan will be paid without regard to the other plan.

Allowable expenses under any other plan include the benefits that would have been payable had claim been duly made.

Reimbursement will not exceed 100% of the total allowable expenses incurred under this plan and any other plan included under this provision.

Reduction in Plan's Benefits

The benefits of the Group Master Policy Agreement will be reduced when the sum of the benefits exceeds the covered services in a claim determination period. The definition of **claim determination period** is *a benefit year*. It does not include any part of a year during which a person was not covered under the Group Master Policy Agreement.

The sum of the benefits includes:

1. The benefits that would be payable for the covered services under the Group Master Policy Agreement in the absence of this coordination of benefits provision; and,
2. The benefits that would be payable for the covered services under the other insurance plans, in the absence of a coordination of benefits provision, whether or not a claim is made.

Under this provision, the benefits of the Group Master Policy Agreement will be reduced so that they and the benefits payable under the other insurance plans do not total more than the allowable expenses. When the benefits of the Group Master Policy Agreement are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the Group Master Policy Agreement.

Payment as a Secondary Plan

The amount by which a secondary plan's benefits are reduced shall be used by the secondary plan to pay covered services not otherwise paid which were incurred during the claim determination period. As each claim is submitted,

the secondary plan determines its obligation to pay for covered services based on all claims that were submitted up to that point in time during the claim determination period.

Right to Receive and Release Information

There is certain information needed to apply coordination of benefit rules. We may receive any needed information from another organization without your consent, but only as needed to apply coordination of benefits rules. Medical records remain confidential as provided by state law. You must provide us any information we need to pay claims. If the requested information is not provided, we will not be able to process your claim.

Coordination of Benefits with Medicare

In all cases, coordination of benefits with Medicare will conform to federal statutes and regulations. Except as required by federal and state statutes and regulations, this plan will pay benefits on a secondary basis to Medicare.

If you are eligible for Medicare on a primary basis, you should enroll in and maintain coverage under both Medicare Part A and Medicare Part B. If you do not enroll and maintain that coverage when we are the secondary plan, we will pay benefits as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid, and you will incur a larger out-of-pocket cost. These additional amounts will not apply to your annual maximum out-of-pocket limit.

Medicare is the secondary coverage to group health plans in a variety of situations. The following provisions apply if you have both Medicare and employer group health coverage under this certificate and your employer has the specified minimum number of employees.

Working Aged
Generally, if you are age 65 or older and covered by a group health plan due to your current employment or the current employment of a spouse (of any age), Medicare is the secondary payer if the employer has 20 or more employees.

Working Disabled
Generally, if you are under age 65, covered by a group health plan due to your current employment, have Medicare due to a disability, and your employer has less than 100 employees, Medicare is primary.

If your employer has 100 employees or more, you are covered by a group health plan based on current employment or current employment of a spouse (any age), Medicare is the secondary payer.

End-Stage Renal Disease (ESRD)
The ESRD provision applies to group health plans of all employers, regardless of the number of employees. Under these provisions, Medicare generally is the secondary payer during the first 30 months of Medicare coverage.

Medicare and Continuation

1. If you or your spouse are age 65 or older and have continuation coverage, Medicare is the primary payer;
2. If you or a family member has Medicare based on disability and continuation coverage, Medicare is the primary payer; and,
3. If you or a family member has Medicare based on ESRD and continuation coverage, the continuation coverage is the primary payer, and Medicare is the secondary payer for the first 30 months of Medicare eligibility based on ESRD.

The above information is only a general summary of the Medicare coordination of benefit regulations.

Facility of Payment

A payment made by another insurance plan may include an amount that should have been paid under the Group Master Policy Agreement. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under the Group Master Policy Agreement. We will not have to pay that amount again. The term "payment made" or "amount of the payment made" means the reasonable cash value of the benefits provided in the form of services.

Subrogation Recovery Rights

Quartz retains both the right of subrogation against a Third Party and the right of reimbursement from members to the extent of benefits paid to Quartz and the reasonable cash value of the services paid on a capitated basis. 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 reimbursement 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 permitted by law, be entitled to be reimbursed from all 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 has a first priority right to receive reimbursement from any Third Party, regardless of whether a member has been fully compensated. Quartz's subrogation and

reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to a member or the member's representatives, estate, heirs and beneficiaries. 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 coverage or against any Third Party, to the full extent of the benefits paid by Quartz and the reasonable cash value of the services paid.

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. Paid claims represent the reasonable cash value of the services paid on a capitated basis. Reasonable cash value is determined by utilizing actuarial methodologies.

Workers' Compensation

A. When the Member Sustains a Work-Related Injury or Illness unrelated to the Group Policyholder of this Health Plan.

Benefits for treatment, services, and supplies are excluded under this health plan when:

1. A member sustains a work-related injury or illness that does not involve the Group Policyholder of this health plan; and,
2. The member is eligible to receive Workers' Compensation for an injury or illness sustained in the course of an occupation or employment.

This exclusion applies to any illness or injury arising out of, or in the course of, any activity for pay, profit, or gain. This exclusion applies regardless of whether benefits under Workers' Compensation or Occupational Disease laws have been claimed, paid, waived or compromised.

B. The Member Sustains a Work-Related Injury or Illness Allegedly Related to the Group Policyholder of this Health Plan.

Beneficiary in this section means *a person who may be eligible for compensation under a Group Policyholder's Workers' Compensation policy*.

For purposes of this Workers' Compensation section, each employer that is part of an association health plan is treated the same as a Group Policyholder.

1. **When the Member is a Beneficiary under the Group's Workers' Compensation Policy.**
   When the Group Policyholder has Workers' Compensation coverage and the member is a beneficiary under the Workers' Compensation policy, benefits under this health plan are excluded for all treatment, services, or supplies for any illness or injury arising out of, or in the

course of, any activity for pay, profit or gain. This exclusion applies regardless of whether benefits under Workers' Compensation or Occupational Disease laws have been claimed, paid, waived, or compromised.

2. **When the Member is <u>not</u> a Beneficiary of the Group's Workers' Compensation Policy.**
   Quartz will <u>not</u> deny claims solely based on the existence of the Group Policyholder's Workers' Compensation policy when <u>all</u> the following statements are true:
   - A member sustains a work-related injury or illness that allegedly involves the Group Policyholder of this health plan; and,
   - The Group Policyholder has Workers' Compensation coverage; and,
   - The member is <u>not</u> a beneficiary under the Workers' Compensation policy.

3. **When the Group Policyholder is under no obligation to Carry Workers' Compensation Coverage.**
   Quartz will <u>not</u> deny claims on the basis that the Group failed to maintain Workers' Compensation coverage if all the following statements are true:
   - The Group has no Workers' Compensation coverage; and,
   - The Group was <u>not</u> required to have Workers' Compensation coverage under applicable state law at the time the injury or illness arose.

4. **Group Policyholder Fails to Carry Required Workers' Compensation Coverage.**
   When the Group Policyholder fails to maintain Worker's Compensation coverage required by law, Quartz will <u>not</u> deny member claims solely on the basis that the Group failed to maintain Workers' Compensation coverage. Quartz retains all rights to recover as described under the Recovery Rights provision of the Coordination of Benefits Section.

The Group Master Policy Agreement is not issued in place of Workers' Compensation coverage and does not affect any requirement for an employer to carry Workers' Compensation coverage.

If this policy covers injury or illness sustained in the course of any occupation or employment, and we determine that you also received Workers' Compensation for the same incident, we have the right to recover as described under the Recovery Rights provision of the Coordination of Benefits Section. We will exercise the right to recover.
The recovery rights will be applied even though:

- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that the injury or illness was sustained in the course of or resulted from your employment;
- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by you or the Workers' Compensation carrier;
- The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

In the event the Workers' Compensation carrier denied a claim, we will cover the resulting charges only if you have followed the guidelines outlined in this Certificate of Coverage. See Section 2: Access to Health Care for guidelines you must follow.

You agree that, in consideration for the coverage provided by the Group Master Policy Agreement, you will notify us of any Workers' Compensation claim made and agree to reimburse us as described above. This provision shall also apply to coverage that you may receive under any Occupational Disease Act or law.

Right of Recovery

We are entitled to:

1. Determine whether, and to what extent, the other insurance plan provides benefits or services;
2. Determine which plan is primary;
3. Require that services or benefits be covered by the primary insurance plan. In the event we covered such services or benefits, and we were not primary, we will recover the reasonable value of services or benefits covered by us from the other insurance plan or the member; and,
4. To process claims as the secondary payer.

We reserve the right to recover any payment made for an allowable expense under this plan in the amount by which the payment exceeds the maximum amount Quartz is required to pay under these provisions. This right of recovery applies to Quartz against the following:

1. Any person(s) to, for or with respect to whom, such payments were made; or,
2. Any other insurance company or organization which, according to these provisions, owes benefits due for the same allowable expense under any other plan. Quartz shall determine against whom this right of recovery will be exercised.

If the amount of our payments is more than it should have been under this coordination of benefits provision, we may recover the excess payment from one or more of the following:

1. The member or dependent we have paid, or for whom payment was made;
2. Insurance companies; or,
3. Other organizations.

You consent to the release of medical and/or legal information to us for you and your dependents when the enrollment form is signed. We have the right

to deny any health care services or refuse to pay for the health services of any member who will not consent to release medical information to us.

You authorize and direct any person or institution that has examined or treated you to furnish to us upon our request, any and all information and records, or copies of records, relating to the examination or treatment rendered to you. We agree that such information and records will be considered confidential to the extent required by law. We have the right to submit any and all records concerning health care services rendered to you to appropriate medical review personnel.

We also have the right to review any employment records, including but not limited to, those maintained by your employer, to make certain that the employer and you are entitled to coverage under the Group Master Policy Agreement.

Right to Require Exhaustion of Primary Plan Appeal Process

If this plan is the secondary plan, Quartz has the right to require exhaustion of the primary plan's appeal process and Independent Review Organization (IRO) process prior to making payment for an allowable expense under this plan.

Quartz may require evidence of a prior authorization denial, an appeals denial, and an IRO denial prior to approving coverage.

Section 9 – Continuation of Coverage

There are Federal and State laws that apply to continuing your coverage when you are no longer in active status under the Group Master Policy Agreement.

Continuation of Coverage (COBRA) – Federal Law

20 EMPLOYEES OR MORE

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that requires your employer to offer you and your dependents the opportunity to elect an extension of health coverage. This section is intended to inform you of your rights and your obligations under COBRA.

You and your dependents are referred to as qualified beneficiaries if you lose your health care coverage due to one of the qualifying events listed below. Qualified beneficiaries who lose coverage due to a qualifying event can elect to continue their health care benefits. Coverage will be the same as that offered to active employees and their dependents.

Each qualified beneficiary can make a separate election. The option elected at the time of the qualifying event can remain in effect for the entire period of coverage. Qualified beneficiaries can terminate coverage at any time.

QUALIFYING EVENT	COBRA LENGTH OF COVERAGE (MAXIMUM)
Termination of your employment (other than for gross misconduct) or reduction in working hours	18 months
Death of an employee	36 months
Divorce or legal separation	36 months

QUALIFYING EVENT	COBRA LENGTH OF COVERAGE (MAXIMUM)
Child ceases to qualify as a dependent	36 months
Dependent's loss of coverage because you become entitled to Medicare	36 months
Disability as defined by the Social Security Administration	29 months

Your employer will provide notification of your continuation rights to you and your dependents in the event of termination of employment, reduction in work hours, entitlement to Medicare, or death.

In the event of a divorce or a legal separation, or when a child ceases to qualify as a dependent, it is your or your dependent's responsibility to notify your employer within 60 days of the date of the qualifying event. Failure to notify your employer within 60 days of a qualifying event will eliminate your option for COBRA.

Following notice of the event, you will be notified by your employer within 14 days if you or other qualified beneficiaries are eligible to elect COBRA and the terms of such coverage. You, or your other qualified beneficiaries will then have 60 days from the latter of the following dates to make your election:

1. The date of the qualifying event;
2. The date your employer sends you the notice; or,
3. The date coverage would otherwise end because of the qualifying event.

Your employer may charge up to 102% of the current monthly premium for COBRA coverage. The first payment must be within 45 days of your election. Your first payment must cover the period from your COBRA effective date through the month coinciding with the date you make your first payment. There is a 30-day grace period for a late payment. The payment of COBRA premiums must be made to your employer.

Social Security Disabled Individual

Disabled members may qualify for an extension of COBRA coverage that expands the 18-month COBRA coverage to 29 months of COBRA coverage. To be eligible for 29 months of COBRA coverage all of the following must be met:

1. You or your dependent must be determined under the Social Security Act, to have been disabled prior to or at any time during the first 60 days of COBRA coverage;
2. The Social Security determination of disability can be made at any time before the end of the 18-month period, however, the actual disability must have existed at any time during the first 60 days of COBRA coverage; and,
3. If you or a dependent is determined to have been disabled you must notify your employer of the determination within 60 days of the determination and before the end of the original 18-month COBRA coverage period.

For any coverage beyond the original 18-month COBRA coverage your employer may charge you up to 150% of the current monthly premium. The current monthly premiums may change during the period of your COBRA coverage. There is a 30-day grace period for late payment. Payment of COBRA premiums must be made to your employer.

Multiple Qualifying Events

If COBRA is being continued for up to 18 months and a subsequent qualifying event occurs, then the 18-month period may be increased for covered qualified beneficiaries. In no event will the total COBRA period of coverage exceed 36 months.

Dependents acquired after the initial qualifying event (e.g., a new spouse) may be added to the qualified beneficiary's coverage provided they meet the definition of dependent. However, any subsequent qualifying event will not apply to any dependents acquired after the initial qualifying event, except child born to, adopted by, or placed for adoption with you.

COBRA Termination

COBRA coverage will end the earlier of:

1. The date premiums are due, if you fail to pay the premium by the end of the grace period;
2. The date the qualified beneficiary becomes covered under another group health plan;
3. The first of the month following 30 days after the date Social Security determines the individual is no longer disabled;
4. The date your employer terminates all its group health plans; or,
5. The end of the period of COBRA coverage.

COBRA coverage is subject to you and your dependents meeting the qualified beneficiary's eligibility requirements. We reserve the right to retroactively terminate coverage if you or your dependents are determined to be ineligible qualified beneficiaries.

Continuation of Coverage

Applies to groups of 20 employees or less (***Iowa Code 509B.3***).

A member whose coverage would otherwise terminate shall have the right to continue the coverage of this plan for himself and for all of his covered dependents under Iowa State Continuation. You may be eligible to continue your health care coverage for up to nine months if the following are true:

1. You lose the medical coverage you have been receiving through your employer;
2. You have been covered by your health care plan continuously for the past three months;
3. You are not covered under Medicare; and,
4. You are not covered under another group insurance plan.

If you lose your coverage due to a divorce, an annulment, or death of the employee, you must notify your employer within 31 days from the qualifying event. All insured members each have individual continuation election rights.

Your employer must provide you with written notice advising you of your right to continue your coverage within 10 days of the last day you are considered employed or within 10 days from the date your coverage ends.

After receiving the notice, you have 10 days to notify your employer or your group sponsor that you want to continue your coverage. Your right to continue your coverage ends 31 days after the date of termination of your employment or the date you were given notice of your right to continue this coverage, whichever comes later.

If you elect to continue medical coverage, you must pay to your employer, on a monthly basis in advance, the amount of premium required. The required monthly premium shall not be more than the group rate in effect for active employees.

Continuation coverage will terminate:

1. When you or your dependent become eligible for Medicare coverage;
2. When you or your dependent becomes insured under another group insurance policy;
3. When nine months of continuation coverage has expired;
4. At the end of the period for which the required premium has been paid, if the member fails to make payment of the required premium;
5. If the person is a former spouse, and remarries; or,
6. The date the group policy is terminated.

The following events are not qualifying events:

1. A dependent child ceasing to be a dependent;
2. Loss of continuation rights under COBRA; and,
3. Multiple qualifying events are not recognized.

Section 10 – General Information

Consent to Release Information

You consent to release to us medical and/or legal information for yourself and your dependents when you sign the Enrollment Form. We have the right to deny any health care services or to refuse to pay for the health services if you will not consent to release to us medical information or other information that is necessary to pay a claim, coordinate benefits or exercise our right of reimbursement.

You authorize and direct any person or institution that has examined or treated you to furnish to us at any reasonable time, upon request, any and all information and records or copies of records relating to the examination or treatment rendered to you. We agree that such information and records will be considered confidential to the extent required by law. We have the right to submit any and all records concerning health care services rendered to you to appropriate medical review personnel.

We also have the right to review any employment records. This includes but is not limited to those maintained by your employer, to make certain that the employer and you are entitled to coverage under the Group Master Policy Agreement.

Advance Directives

If you are over age 18 and of sound mind, you have the right to make decisions regarding your health care and medical treatment. Your decisions and your wishes for medical treatment and health care can be spelled out in a document called an Advance Directive. You may also designate another person to make health care decisions on your behalf if you become mentally or physically unable to do so.

The Power of Attorney for Health Care appoints someone to make all health care decisions for you if you lose the ability to make these decisions for yourself. You may also include a description of your treatment preferences and special desires in this document in order to guide the person making decisions for you. A Living Will describes the kind of life-sustaining care you would want if you had a life-threatening condition and were no longer able to communicate with those around you.

The decision to complete an Advance Directive takes thought, discussion and planning. We encourage you to discuss your questions and concerns regarding your future health care with your physician.

Conformity with State Statutes

Any provisions, which on the Group Master Policy Agreement effective date are in conflict with the laws of the state in which the Group Master Policy Agreement is issued, are amended to conform to the minimum requirements of those laws.

Incontestability

After you are insured for two years, we cannot contest the validity of coverage on the basis of any statement you made regarding your insurability. We cannot contest any statement made by you unless it is in a written form signed by you.

Rescission

Iowa Code 514A.3

A rescission is 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.

We have the right to rescind coverage if a material misrepresentation was made on your application for insurance. A material misrepresentation is an untrue statement that leads us to insure you when we would not have done so under the terms, conditions and limitations of the Group Master Policy Agreement if we had known the truth. We will provide all impacted members a 30-day notice prior to the rescission of coverage.

Quartz may investigate information provided by you in applying for coverage for two years after the original effective date of coverage. After this two-year period expires, no misstatements may be used to void coverage or to deny a claim that arises after the two-year period expires. This time limit does not apply to fraudulent misstatements made in the application for coverage under this plan. This plan 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.

Assignment

Assignment of benefits may be made only with our consent. You assign benefits when you authorize us to pay your provider directly. An assignment is not binding until we receive and acknowledge in writing the original copy of the assignment before payment of the benefit. We do not guarantee the legal validity or effect of such assignment.

Clerical Error or Misstatement

If it is determined that information about you or your dependents was omitted or misstated in error, claims will be adjusted accordingly and a premium adjustment will be made. This provision applies equally to you and to us. If the error was determined after six months from the effective date of your coverage, no adjustment will be made.

Group Master Policy Agreement Inspection

The Group Master Policy Agreement is available for inspection upon your request. You should direct your request to inspect the Group Master Policy Agreement to us or to your employer.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

This federal law requires all employers to provide a cumulative total of five years of military leave during your employment with the employer. During the military leave, your employer must provide up to 24 months of COBRA-like health benefit continuation coverage.

If you elect to continue coverage, you will not pay more than 102% of the full premium for coverage. However, if your military service lasts for 30 days or less, you will not be required to make a premium contribution that is greater than the contribution paid by active employees.

Continued coverage under this provision terminates on the earlier of 24 months from the date your leave began, or the date you fail to return to active status with the employer following completion of the military leave.

You must return to active status within (1) the first full business day of completing military service for leaves of 30 days or less, (2) 14 days of completing military service for leaves of 31–180 days, or (3) 90 days of completing military service for leaves of more than 180 days.

Your coverage and your dependents' coverage under the Group Master Policy Agreement will be reinstated immediately upon your honorable discharge from military service and your return to active status. This is if you return within the necessary time periods stated above. If you cannot return to work within the necessary time periods due to illness or injury incurred or aggravated in the line of duty, you may take up to two years to recover from such illness or injury. If you are unable to return to work within two years for reasons beyond your control, you must return to work as soon as reasonably possible.

If your coverage under the Group Master Policy Agreement is reinstated, a waiting period or exclusions will not be imposed if health coverage would have been provided to you had you not taken military leave. This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by the military leave as determined by the Veterans Administration.

Family Medical Leave Act – Federal Law

If you are on family or medical leave of absence, we will continue coverage under the Group Master Policy Agreement in accordance with your employer's human resources policy on family and medical leaves of absence. Coverage will continue as if you were in active status, if the premium is paid; and your employer has approved your leave in writing.

Coverage under the Group Master Policy Agreement for you and your dependents will continue for up to the greater of (1) the leave period required by the federal Family and Medical Leave Act (FMLA) of 1993, if applicable, and any amendment thereto, or (2) the leave period provided by your employer if agreed to by us.

With respect to the rules concerning a significant break in coverage, if an employee takes FMLA leave and does not continue group health coverage for any part of the leave, the period of FMLA leave without coverage is not taken into account in determining whether a significant break in coverage has occurred for you or any dependents.

ERISA Statement

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine without charge, at your employer's office and at other specified locations, all plan documents, including insurance contracts and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
2. Obtain copies of all plan documents and other plan information upon written request to your employer. Your employer may make a reasonable charge for the copies; and,

3. Receive a summary of the plan's annual financial report. Your employer is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of your employer or Quartz. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

This plan is financed and administered under a contract of insurance issued by Quartz to your employer. We provide payment of claims and other administrative services relating to the plan, including determination of all decisions regarding payment of claims.

If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may

order you to pay these costs and fees, for example, if it finds your claim is frivolous.

In the event of a material reduction in covered services or benefits provided under your plan, we must furnish you with a description of the modification of change 60 days in advance of the date of change.

If you have questions about this statement or your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Ave. NW, Washington, DC 20210.

Quartz-Sponsored Wellness Programs

Quartz may provide a wellness program to members which may include health management and fitness. Terms and conditions may apply. Participation in Quartz's wellness program(s) is voluntary. No co-payment or co-insurance is required to join Quartz's wellness program(s). From time to time, Quartz may offer incentives to encourage you to participate in a wellness program. The program components and incentives are not covered services and do not alter or affect your covered services. You and your Primary Care Provider can discuss whether participation is right for you. If you think you may be unable to meet a standard for an incentive offered through a wellness program, you may qualify to earn the same incentive by different means. Contact Quartz Customer Success at (800) 362-3310 and we will work with you (and, if you wish, your doctor) to find an alternative with the same incentive that is right for you in light of your health status.

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.