Offered by Quartz Health Insurance Corporation,
an Illinois-licensed insurer
2650 Novation Parkway
Madison, WI 53713

Preferred Provider Organization (PPO)

Group Certificate of Coverage

State of Illinois

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Preferred Provider Organization (PPO) Plan

Certificate of Coverage

In this ***Certificate of Coverage***, Quartz Health Insurance Corporation refers to our company as "Quartz," "we," "us," and "our," and we refer to the company that ***you*** work for as the "Group" or "Employer." The Definitions Section outlines the meaning of many of the terms used in this ***certificate***.

WARNING: LIMITED BENEFITS WILL BE PAID WHEN OUT-OF-NETWORK PROVIDERS ARE USED.
YOU CAN EXPECT TO PAY MORE THAN THE COST-SHARING AMOUNT DEFINED IN THE POLICY IN NON-EMERGENCY SITUATIONS. Except in limited situations governed by the federal No Surprises Act or Section 356z.3a of the Illinois Insurance Code (215 ILCS 5/356z.3a), ***out-of-network providers*** furnishing non-emergency services may bill ***members*** for any amount up to the billed charge after the ***plan*** has paid its portion of the bill. If ***you*** elect to use an ***out-of-network provider***, plan benefit payments will be determined according to ***your policy's*** fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined in this ***certificate***. ***In-network providers*** have agreed to ONLY bill ***members*** the cost-sharing amounts.

Your out-of-pocket cost for ***emergency care*** received from an ***out-of-network provider*** will be no greater than if ***you*** received ***emergency care*** at an ***in-network provider***.

You may obtain further information about the network status of professional ***providers*** and information on ***out-of-pocket*** expenses by calling (800) 362-3310 or by visiting our website at ***QuartzBenefits.com***.

With ***your*** consent, we will deliver ***policy*** documents to ***you*** electronically. ***You*** may request a paper copy at any time by calling ***Quartz*** Customer Success.

You can withdraw ***your*** consent to receive ***policy*** documents electronically at any time.

Employer's Group Master Policy Agreement. ***Quartz*** has entered into an agreement with ***your*** employer to provide ***you*** with this PPO ***benefit plan***.

Quartz has issued and delivered to ***your*** employer a ***Group Master Policy Agreement*** which outlines the duties and obligations of the parties. ***You*** and any ***dependents*** who are insured under the ***Group Master Policy Agreement*** are listed on an enrollment form that ***your*** employer has submitted to ***Quartz***.

This ***Certificate of Coverage*** is incorporated into and made part of the ***Group Master Policy Agreement***. If the terms of this ***Certificate of Coverage*** differ from the terms of the ***Group Master Policy Agreement***, the ***Group Master Policy Agreement*** will govern. This ***certificate*** replaces any previous ***certificate*** that ***Quartz*** may have issued to ***you***. ***You*** may contact ***your*** employer's benefits manager if ***you*** wish to review the *G**roup Master Policy Agreement***. For clarity:

- The insurance ***policy*** under which this ***certificate*** is issued is <u>not</u> a ***policy*** of Workers' Compensation insurance and does <u>not</u> replace Workers' Compensation insurance. ***You*** should consult ***your*** employer to determine whether ***your*** employer is a ***subscriber*** to the Workers' Compensation system; and,
- This is <u>not</u> a ***policy*** of Long Term Care insurance.

Quartz insures and administers the benefits ***you*** receive under this ***plan***. This ***certificate*** explains the terms and conditions of ***your*** insurance coverage. Please read it carefully. If ***you*** have questions, contact ***your*** employer's benefit manager or ***Quartz*** Customer Success.

Entire Contract and Changes. The ***Group Master Policy Agreement***, including this ***certificate***, endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this ***policy*** shall be valid until approved by an executive officer of the company and unless such approval

be endorsed hereon or attached hereto. No agent has authority to change this ***policy*** or to waive any of its provisions.

We will only modify a contract at renewal as long as the modification is consistent with Illinois law and consistent on a uniform basis among all persons with that ***policy*** form.

Any provision of this ***policy*** which, on its ***effective date***, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Usual, Customary, and Reasonable Charge. This PPO plan limits benefits for services received from ***out-of-network providers*** to the ***usual, customary and reasonable charge***. This amount may be less than the ***billed charge***. Please see the Definitions section and the Obtaining Services section of this ***certificate*** for more information.

Pre-existing Condition Exclusions. This ***Certificate of Coverage*** contains no pre-existing condition ***exclusions***.

Rescissions. ***We*** will not ***rescind*** coverage unless an enrollee performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the ***policy***. In the event of a rescission, ***Quartz*** will provide at least 30 days' advance written notice to each enrollee who would be affected before coverage may be rescinded.

Genetic Information. We will not seek information derived from genetic testing for impermissible, nontherapeutic purposes. For example, ***we*** will not use or disclose protected health information that is genetic information for underwriting purposes.

Civil Unions. This ***certificate*** provides parties to a civil union and a marriage identical benefits and protections, as required by the Illinois Religious Freedom Protection and Civil Union Act, 750 ILCS 75.

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Section 1: Definitions

The following terms are used in this ***Certificate of Coverage***:

Activities of Daily Living (ADL)
The basic tasks of everyday life, such as eating, bathing, dressing, toileting, and transferring.

Adverse Benefit Determination (Adverse Determination)
A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including any quantity, frequency, duration, or other measure of a benefit. This includes any such denial, reduction, termination, or failure to provide or make payment resulting from the application of utilization review, as well as a 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. If an ***ongoing course of treatment*** had been approved by ***Quartz*** and ***Quartz*** reduces or terminates such treatment (other than by amendment or termination of this ***policy***) before the end of the approved treatment period, this is also an ***adverse benefit determination***. A ***rescission*** of coverage is also 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.

An adverse determination includes a decision to approve an alternative health care service in place of a requested health care service without consent by the ***member*** or ***member's provider*** (excluding substitutions performed under Section 18.5 or 25 of the Pharmacy Practice Act), or require that the ***member*** first try an alternative health care service, if either of the following apply:

- The service is requested as a medical exception; or,
- The requested service is not explicitly excluded under this ***policy*** by name, description or service category, and the alternative service poses no greater risk to the ***member*** based on generally accepted

standards of care, and the alternative service is at least a likely to produce the same or greater effect on the ***member's*** health as the requested service based on generally accepted standards of care.

Adverse determination also includes determinations made in response to an authorization request submitted by a ***provider***, even if they did not obtain consent from the ***member*** to submit the request.

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.

Allowed Amount
The amount ***in-network providers*** charge ***Quartz*** for ***covered health care services*** and the amount ***out-of-network providers*** charge for ***emergency services***. This may be called "eligible expense," "payment allowance," or "negotiated rate." If an ***out-of-network provider*** charges more than the ***allowed amount***, ***you*** may have to pay the difference. See **Balance Billing**.

Ambulatory Surgery Center
A facility that provides treatment and care when an overnight stay is not necessary.

Ancillary Provider
Anesthesiologist, radiologist, pathologist, emergency room ***physician*** and medical laboratory.

Appeal
A formal request, either orally or in writing, to reconsider an ***adverse benefit determination.***

Attending Physician
The ***physician*** or other health care professional who is treating ***you***. This includes licensed dentists.

Autism Spectrum Disorder
Includes any of the following:

- Autism disorder; and,
- Pervasive developmental disorder not otherwise specified.

Balance Billing
When a ***provider*** bills ***you*** for the difference between the ***provider's charge*** and the ***allowed amount***. For example, if the ***provider's charge*** is $100 and the ***allowed amount*** is $70, the ***provider*** may bill ***you*** for the remaining $30. ***Balance billing*** may also occur when ***Quartz*** denies a claim that was coded improperly, and the ***provider*** bills ***you*** the unpaid amount.

An ***in-network provider*** may not ***balance bill you*** for covered services, but an ***out-of-network provider*** may. An ***out-of-network provider*** may not ***balance bill you*** for covered ***emergency services***. With ***your informed consent***, an ***out-of-network provider*** may ***balance bill you*** for non-emergent services received at an ***in-network*** facility.

Behavioral Health and Substance Use Disorder Services
The treatment of psychiatric ***illness*** or substance use disorders. This treatment is provided on an inpatient, outpatient, and emergency care basis.

Benefit Period
The 12-month period during which ***deductibles***, ***out-of-pocket expenses***, visit limits, and other limitations accumulate. The ***benefit period*** may be based on the ***benefit year*** or the calendar year. ***Your Schedule of Benefits*** indicates

whether ***deductibles*** and ***out-of-pocket expenses*** accumulate on a ***benefit year*** or calendar year basis. All benefit limits listed in the policy documents will accumulate on the same basis unless specified otherwise.

Benefit Year
The coverage period shown on ***your Schedule of Benefits***.

Benefit Rider or Rider
An amendment to the ***Group Master Policy Agreement*** that adds or modifies ***plan benefits*** outlined in this ***Certificate of Coverage***.

Care Management
The collaborative process that promotes quality health care in a cost-effective manner and which enhances the physical, psychological and social health of individuals. The goal of ***care management*** is to assist patients and families in obtaining quality health care at an appropriate cost, in the appropriate setting, and to achieve positive outcomes through coordinated efforts with ***your*** health care ***providers***. ***Care management*** services are provided by a staff of health care professionals. ***Quartz*** reserves the right to use these services to optimize the clinical outcome, the standards of care and the cost-effectiveness of care, and to remove barriers to well-living.

Certificate of Coverage (or Certificate)
This document, including any ***benefit rider***, issued to ***you*** which sets forth the terms, conditions and limitations of ***your health plan***.

Charge (or Billed Charge)
The fee charged by the ***provider*** for the service or item provided.

Chemotherapy
Drugs and biologics that kill cancer cells directly, including antineoplastics, biologic response modifiers, hormone therapy, and monoclonal antibodies, and that are used to do any of the following:

- Cure a specific cancer;

- Control tumor growth when cure is not possible;
- Shrink tumors before surgery or radiation therapy;
- Destroy microscopic cancer cells that may be present after a tumor is removed by surgery to prevent a cancer recurrence.

Child (or Children)
The ***subscriber's***:

- Natural blood-related child;
- Stepchild;
- Legally-adopted child;
- Child pursuant to an interim court order of adoption;
- Child placed in the custody of the ***subscriber*** who is to be the adoptive parent;
- Foster child; or
- A child for whom the ***subscriber*** or the ***subscriber's*** covered spouse, or partner in a ***civil union***, has been appointed as legal guardian.

Adopted children become ***dependents*** as soon as (1) the court order for adoption is signed, (2) an interim court order of adoption is signed, or (3) when the ***child*** is placed in the custody of the ***subscriber*** who is to be the adoptive parent.

Civil Union
A legal relationship between two persons, of either the same or opposite sex, established pursuant to 750 ILCS 75.

Claim(s)
A demand for payment due in exchange for health care services provided. A ***claim*** must have this minimum information: patient name and address, ***provider*** name and address, description of services provided, date of service, reason for providing service and amount charged.

Co-insurance
Your share of the costs of a covered health care service, calculated as a percent of the ***allowed amount*** for the service. ***You*** pay ***co-insurance*** plus any ***deductibles you*** owe. For example, if the health insurance or ***plan's allowed amount*** for an office visit is $100 and ***you've*** met ***your deductible***, ***your co-insurance*** payment of 20% would be $20. The health ***plan*** pays the rest of the ***allowed amount***.

You are responsible for paying ***co-insurance*** directly to the ***provider***.

Complaint
Any expression of dissatisfaction to ***Quartz*** by ***you***, or a person acting on ***your*** behalf, about ***Quartz*** or ***Quartz's in-network providers***.

Complex Rehabilitation Technology
A ***medically necessary*** complex wheelchair as defined in the Complex Rehabilitation Technology Act, and associated accessories that are individually configured for an individual to meet specific and unique medical, physical, and functional needs and capacities for basic ***activities of daily living*** and instrumental ***activities of daily living***.

Confidential Matter
Personal information concerning the medical, personal or financial affairs that ***Quartz*** may acquire about ***you*** in the course of administering Plan Benefits. ***Confidential matters*** also include proprietary information and financial and other information relating to ***Quartz*** and its ***providers***.

Confinement (or Confined)
The period of time between the admission to an inpatient or outpatient health care facility through the time of dis*charge*. The health care facility may be a ***hospital***, a substance use disorder treatment center, a ***skilled nursing facility*** or a licensed ambulatory surgical center. The time spent receiving ***emergency services*** for ***illness*** or ***injury*** in a ***hospital***.

A ***hospital*** swing bed ***confinement*** is considered the same as ***confinement*** in a ***skilled nursing facility***. In the event a ***member*** is transferred from one facility to another for the continued treatment of the same or a related condition, it is considered one ***confinement***.

Congenital
A condition that exists at birth.

Coordination of Benefits (COB)
A process that allows ***Quartz*** to determine its respective payment responsibility. Through COB, ***Quartz*** determines which insurance plan has primary payment responsibility when an individual is covered by more than one plan.

Co-payment
A fixed amount ***you*** pay for a covered health care service, usually when ***you*** receive the service. The amount can vary by the type of covered health care. ***You*** are responsible for paying the *co-**payment*** directly to the ***provider***.

Covered Expense
A ***charge*** incurred for a ***covered service***.

Covered Service
A ***medically necessary*** treatment, service or supply that has been specified as a benefit in this ***Certificate of Coverage*** or the ***Schedule of Benefits***.

Custodial Care
The provision of room and board, nursing care, personal care or other care that is designed to assist an individual in the ***activities of daily living*** (e.g., eating, dressing, assistance in walking and preparing meals). ***Custodial care*** is care and treatment that is generally received by an individual who has reached the maximum level of recovery in the opinion of the ***plan***. In the case of an institutionalized person, ***custodial care*** also includes room and board, nursing care or such other care provided to an individual for whom it cannot

reasonably be expected, in the opinion of the ***attending physician***, that medical or surgical treatment will enable that person to live outside an institution. ***Custodial care*** includes rest care, respite care and home care provided by family ***members***. Care may be considered ***custodial care*** by the ***plan*** even if (1) the ***member*** is under the care of a ***physician***, (2) the ***physician*** prescribes services to support and maintain the ***member's*** condition, or (3) services and supplies are being provided by a registered nurse or licensed practical nurse.

Deductible
The amount ***you*** owe for health care services ***your*** health insurance or plan covers before ***your*** health insurance or plan begins to pay. For example, if ***your deductible*** is $1,000, ***your*** plan won't pay anything until ***you've*** met ***your*** $1,000 ***deductible*** for covered health care services subject to the ***deductible***. The ***deductible*** may not apply to all services. Only ***charges*** that qualify as ***covered expenses*** may be used to satisfy the ***deductible***. The amount of the ***deductible*** is stated on ***your Schedule of Benefits***.

For some family plans, services for an individual ***member*** may begin to pay when the single ***deductible*** is met. For other family plans, the entire family ***deductible*** must be met before ***your*** plan begins to pay. Refer to ***your Schedule of Benefits*** for details on how ***your deductible*** works.

Dependent
One or more of the following:

- A ***subscriber's*** lawful spouse. A spouse includes a ***subscriber's*** partner in a ***civil union***;
- A ***subscriber's child*** under the age of 26; or
- A ***subscriber's child*** under the age of 30 who is an honorably-discharged Military veteran and Illinois resident; or,
- Parent or stepparent of a ***member*** if the parent or stepparent meets the definition of a qualifying relative under 26 U.S.C. 152(d) and lives or resides within ***Quartz's service area*** (215 ILCS 5/356z.73).

A spouse and stepchildren will cease to be ***dependents*** on the last day of the month in which a divorce decree is granted, and coverage may be terminated, subject to continuation rights. Other children cease to be ***dependents*** at the end of the calendar month in which they reach age 26, except ***disabled dependents***.

Disabled Dependents: Children who are currently covered under the ***Group Master Policy Agreement*** and 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:

- Dependent on ***you*** for support and maintenance; and,
- 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 an individual.* Physical impairments include a physical disorder or condition, cosmetic disfigurement or anatomical loss affecting one or more of the major body systems.

Coverage may be continued as long as ***you*** remain insured under the ***Group Master Policy Agreement*** and ***your dependent*** remains, incapacitated and dependent upon ***you***. ***You*** must provide ***us*** with written proof of incapacity within 31 days after the ***dependent'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 dependent***. Following that two-year period, such examinations may occur on an annual basis. ***You*** must notify ***us*** immediately of a cessation of incapacity or dependency.

Developmental or Learning Disability or Delay
A condition due to a ***congenital*** abnormality, trauma, deprivation or disease that interrupts or delays the sequence and rate of normal growth, development and maturation, but excluding ***Autism Spectrum Disorder***.

Disenrollment
Coverage under the ***plan*** has ended or has been revoked by ***Quartz***.

Dual Choice Enrollment Period
A period of time when ***members*** who are currently enrolled in any of the employer's other group ***health insurance benefit plans*** will be allowed to enroll for coverage under a ***Quartz health plan***. The establishment of such an enrollment period must be by the mutual agreement of the employer and ***Quartz***.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care ***provider*** for everyday or extended use. Coverage for ***DME*** may include but is not limited to oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Early Acquired Disorder
A disorder resulting from ***illness***, trauma, ***injury***, or some other event or condition suffered by a ***child*** prior to that ***child*** developing functional life skills such as, but not limited to, walking, talking or self-help skills. ***Early Acquired Disorder*** may include but is not limited to autism or an ***Autism Spectrum Disorder*** and cerebral palsy.

Effective Date
The date on which an ***employee*** becomes enrolled in a ***Quartz health plan*** and entitled to the benefits specified in the ***Certificate of Coverage***.

Eligible Employee(s)
An ***employee*** who meets the requirements for eligibility as specified in the ***Group Master Policy Agreement*** and the ***Group Application***.

Unless otherwise agreed to by the ***policyholder*** and ***Quartz***, the class of ***eligible employees*** is ***employees*** who work 30 or more hours per week or, if less than 30 hours, at least as many hours as specified in the ***Group Application***.

This term also includes a sole proprietor, a business owner, including the owner of a farm business, a partner of a partnership, a ***member*** of a limited liability company, if the sole proprietor, business owner, partner, or ***member*** is included as an ***employee*** under the ***health plan*** of an employer, as defined by state and federal law.

The term ***eligible employee*** does not include an ***employee*** who works on a temporary or substitute basis.

Emergency Ground Ambulance Service
Ground ambulance service provided by a ground ambulance service provider, regardless of whether the patient was transported, if the service was provided pursuant to a method of summoning emergency services, or if the service provided was provided when a patient's condition, at the time of service, was considered to be an **emergency medical condition** as determined by a physician licensed under the Medical Practice Act of 1987.

Emergency Medical Condition
A medical condition manifesting itself by acute symptoms of sufficient severity (including but not limited to 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:

- 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;
- Serious dysfunction of any bodily organ or part;
- Inadequately controlled pain; or,
- With respect to a pregnant woman who is having contractions, inadequate time to complete a safe transfer to another hospital before delivery or a threat to the health or safety of the woman or unborn ***child*** should a transfer be attempted.

Emergency Room Care
Emergency services you get in an emergency room.

Emergency Services
Evaluation of an ***emergency medical condition*** and treatment to keep the condition from getting worse. These 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***.

Emergent/Urgent Transportation
Emergency ground ambulance services, urgent ground ambulance services, or air ambulance services for an ***emergency medical condition***.

Employee
An individual whose employment or other status is the basis for his or her eligibility to enroll in this ***health plan***.

Employer's Certification of Group Health Plan Coverage
A form that is provided to an individual following the termination of their coverage under the ***plan***. This form is evidence that the individual had coverage under the ***plan*** and the duration of such coverage. ***Quartz*** will issue the form directly to the individual following termination of coverage.

Enrollment Application Form (or Enrollment Form or Application)
The form signed by an ***eligible employee*** to signify that he/she and any eligible ***dependents*** wish to become ***members*** of the ***plan***.

Enrollment Change Form or Application Form
The form ***you*** complete to provide or change your enrollment information. For example, an ***Enrollment Change Form*** is used if ***you*** wish to add or remove ***dependents*** from ***your plan***. ***You*** may also submit certain changes electronically by logging on to ***QuartzBenefits.com***.

Essential Health Benefits
Essential Health Benefits under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations. Such benefits generally include the following categories:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and Habilitative Services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and,
- Pediatric services, including oral and vision care.

Exclusion
Any service or supply listed in the Exclusions and Limitations section or described elsewhere as not covered by this ***plan***. Those services or supplies listed as ***exclusions*** are not covered by ***Quartz***, regardless of their ***medical necessity***.

Expedited Appeal
An ***appeal*** where the standard resolution process might lead to:

- Serious jeopardy to the life or health of the ***member*** or the inability of the ***member*** to regain maximum function;
- A situation where, in the opinion of the ***physician*** with knowledge of the ***member's*** medical condition, the ***member*** would be subjected to severe pain that could not be adequately managed without the care or treatment that is the subject of the ***appeal***; or,
- It is determined to be an ***expedited appeal*** by a ***physician*** with knowledge of the ***member's*** medical condition.

Expedited Review (or Expedited Independent Review)
A review process used when the standard review process would jeopardize ***your*** life, health or ability to regain maximum function.

Expense
The ***charge*** for a ***covered service*** or supply that ***Quartz*** determines is the ***usual, customary and reasonable charge***. An ***expense*** is incurred on the date ***you*** receive the service or supply.

Experimental or Investigational
Drugs, devices, equipment, treatment, or procedures which do not meet one or more of the following criteria, pursuant to ***Quartz*** medical policy:

- Full and final approval has been granted by the U.S. Food and Drug Administration for the treatment of the patient's medical condition;
- The research and experimental stage of the development of the treatment or service have been completed;
- 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 CPT codes to be ***experimental or investigational***.

Explanation of Benefits (EOB)
A statement sent by ***Quartz*** to a ***member*** explaining what medical treatments and/or services were paid on their behalf.

Extended Care Facility
A health care facility, or a distinct part of a health care facility, which has been accredited for that purpose by the Joint Commission on Accreditation of

Healthcare Organizations (JCAHO), Community Health Accreditation Program or ***Medicare*** as a ***skilled nursing facility***.

External Review (IRO)
A review of ***Quartz's*** decision conducted by an ***Independent Review Organization*** **(IRO)**.

Foreign Claims
Items or services obtained or provided outside of the 50 United States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Gender Dysphoria
Psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity.

Grievance
Any written ***complaint*** submitted to ***Quartz*** by or on behalf of an enrollee regarding any aspect of ***Quartz*** relative to the enrollee, but shall not include any complaint by or on behalf of a ***provider***. Any dissatisfaction with the provision of services or ***claims*** practices or the administration of a ***Quartz health plan*** that is expressed in writing to ***Quartz*** by or on behalf of a ***member***.

Ground Ambulance Service
Medical transportation service and/or medical non-transportation service provided in a vehicle that is licensed as an ambulance under the Emergency Medical Services (EMS) Systems Act, or by EMS Personnel assigned to a vehicle that is licensed as an ambulance under the EMS Systems Act. ***Ground ambulance service*** may include any combination of the following: **emergency ground ambulance service**, **urgent ground ambulance service**, evaluation without transport, treatment without transport, and paramedic intercept.

Group
The employer to which ***Quartz*** has issued a ***Group Master Policy Agreement***. ***Group*** membership is the basis for ***eligible employees*** and their ***dependents*** to become entitled to coverage under the ***health plan*** described by this ***Certificate of Coverage***.

Group Application
The form that is completed by a ***group*** when it requests coverage from ***Quartz*** for individuals in the ***group***.

Habilitative Services
Health care services and devices that help a person keep, learn or improve skills and functioning for daily living.

Habilitative services include occupational therapy, physical therapy, speech therapy, and other services prescribed by the insured's treating physician pursuant to a treatment plan to enhance the ability of a ***child*** to function with a ***congenital***, genetic, or early acquired disorder. Examples include therapy for a ***child*** who isn't walking or talking at the expected age.

Hippotherapy
The use, by a licensed occupational therapist, physical therapist, or speech-language pathologist, in conjunction with a professional horse handler and a therapy horse, of equine movement to engage sensory, neuromotor, and cognitive systems to promote functional outcomes.

Home Health Care
Health care services a person receives at home.

Home Health Care Services
Services to treat an ***illness*** or ***injury*** for which a ***member*** was or could have been hospitalized or ***confined*** in a ***skilled nursing facility***.

Home Saliva Cancer Screening
Outpatient test that utilizes an individual's saliva to detect biomarkers for early-stage cancer.

Hospice Care
Palliative care services provided to a ***member*** whose ***attending physician*** certifies that they have a life-limiting condition. Care is available on an intermittent basis with on-call services available on a 24-hour basis. ***Hospice care*** services ease pain and make the ***member*** as comfortable as possible. *Hospice care* must be provided through a licensed ***provider*** approved by ***Quartz***.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal ***illness*** and their families.

Hospital
An acute care facility which:

- Provides inpatient diagnostic and therapeutic services for surgical or medical diagnosis, treatment and care of injured and sick persons by or under the supervision of staff or duly licensed ***physicians***; and,
- Provides continuous nursing service by or under the supervision of registered professional nurses; and,
- Is not a federal ***hospital*** or, other than incidentally, a place for rest, a place for the aged or a nursing home; and,
- Operates as an acute care general or psychiatric ***hospital*** under applicable state or local laws.

Hospitalization
Care in a ***hospital*** that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a ***hospital*** that usually doesn't require an overnight stay.

Identification Card
The card that ***Quartz*** issues to ***members*** to indicate that they are entitled to receive ***covered services***.

Illness (or Sickness)
A condition or disease that causes the loss of, or affects, a normal body function, other than those conditions that result from an ***injury***.

Immediate Family
The spouse of the ***subscriber***, and the ***dependents***, parents, grandparents, brothers and sisters of the ***subscriber*** and their spouses.

Informed Consent
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.

Independent Review Organization (IRO)
An entity certified under State or Federal law to review ***Quartz's*** decisions. Please refer to the Complaint, Grievance and Appeal Section for a description of the independent review process.

Infertility
A disease, condition or status characterized by:

- For women 35 and younger, a failure to establish a pregnancy or to carry a pregnancy to live birth after 12 months of regular, unprotected sexual intercourse; or,
- For women older than 35, a failure to establish a pregnancy or to carry a pregnancy to live birth after six months of regular, unprotected sexual intercourse; or,

- A person's inability to reproduce either as a single individual or with a partner without medical intervention; or,
- A licensed physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

Note that conception resulting in a miscarriage does not restart the six month or 12-month term for determining infertility.

Injury
Harm or damage to ***you*** resulting from an accident, independent of all other causes.

In-Network Benefit Level
The level of reimbursement for services performed by ***in-network providers***, including ***specialists*** and ***hospitals***, and ordered by ***in-network provider specialists***. See the ***Schedule of Benefits*** for details on ***your in-network benefit level*** reimbursement.

In-Network Co-insurance
The percent ***you*** pay of the ***allowed amount*** for covered health care services to ***in-network providers***. ***In-network co-insurance*** usually costs ***you*** less than ***out-of-network co-insurance***.

In-Network Co-payment
A fixed amount ***you*** pay for covered health care services to ***in-network providers***. ***In-network co-payments*** usually are less than ***out-of-network co-payments***.

In-Network Provider
Any person or entity, public or private, that:

1. Has entered into a contract to provide or arrange for the provision of ***plan benefits*** to ***Quartz members***; or,
2. Provides services through and in accordance with the ***provider network*** associated with the ***member's benefit plan***; or,

3. Is an ***ancillary provider*** providing services through an ***in-network provider***.

Long-term Therapy
Any therapy that is not ***short-term therapy***.

Maintenance and Supportive Care and/or Therapy
These terms are often used interchangeably to refer to therapies that seek to prevent disease in the absence of significant symptoms or to prevent deterioration of a condition once maximum therapeutic benefit has been achieved, even if symptoms are still present. The determination of what constitutes ***maintenance and supportive care and/or therapy*** is made by our Utilization Review Program in accordance with 215 ILCS 134/80 and after reviewing the ***member's*** case history and/or treatment plan.

Medicaid
A program instituted pursuant to the federal "Grants to States for Medical Assistance Program." This program is governed by Title XIX of the United States Social Security Act, as it is now or hereafter amended.

Medical Director
A ***physician*** appointed by ***Quartz*** to serve as the ***plan's*** final decision-maker for determining whether a service, device, treatment or supply is eligible for coverage under the ***plan***.

Medically Necessary
Health care services or products which address the specific needs of an individual for purposes of screening, preventing, diagnosing, managing, treating, or minimizing the progression of an ***illness***, ***injury***, or condition or its symptoms and comorbidities, in a manner that is all of the following:

- In accordance with generally accepted standards of care to treat that ***illness*** or ***injury***;

- Not primarily for the economic benefit of ***Quartz*** or for the convenience of the ***member***, ***physician***, ***hospital*** or other health care ***provider***, caregiver, family member, or other interested party; and
- Clinically appropriate for the ***member***, in terms of type, frequency, extent, site, and duration.

The ***member's attending physician*** or service provider makes decisions regarding service and treatment. The ***plan***, through its ***Medical Director*** 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.

Medicare
Title XVIII, Parts A, B, C and D of the United States Social Security Act, as it is now or hereafter amended.

Member or Members
The ***subscriber*** and any ***dependents*** covered under a ***policy*** issued by ***Quartz***.

Ongoing Course of Treatment
The treatment of a condition or disease that requires repeated health care services pursuant to a plan of treatment by a ***physician*** because of the potential for changes in the therapeutic regimen.

Open Enrollment Period (or Open Enrollment)
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***. The establishment of an enrollment period must be by mutual agreement of the employer and ***Quartz***.

Out-of-Network Provider
A ***provider***, supplier or facility that:

1. Does not have a signed contract to provide or arrange for the provision of ***plan benefits*** to ***Quartz members***; or,
2. Has a contract to provide or arrange for the provision of ***plan benefits*** to ***Quartz members*** but is not part of the ***provider network*** associated with the ***member's benefit plan***; or,
3. Is an ***ancillary provider*** providing services through an ***out-of-network provider***.

Out-of-Network Benefit Level
The level of reimbursement for services performed by ***out-of-network providers***.

Out-of-Network Co-insurance
The percent ***you*** pay of the ***allowed amount*** for ***covered health care services*** to ***providers*** who do not contract with ***your health insurance plan***. ***Out-of-network co-insurance*** costs ***you*** more than ***in-network co-insurance***.

Out-of-Network Co-payment
A fixed amount ***you*** pay for ***covered health care services*** from ***providers*** who do not contract with ***your health insurance plan***. ***Out-of-network co-payments*** are more than ***in-network co-payments***.

Out-of-Pocket
A portion of a ***covered expense*** for which the ***member*** is responsible for making payment. The ***expense*** may be incurred because of applicable ***co-insurance***, ***co-payment*** or ***deductible*** amounts, or because a ***charge*** exceeds the ***usual, customary and reasonable charge***.

Out-of-Pocket Limit
The most ***you*** pay during a ***benefit period*** before ***your*** plan begins to pay 100% of the ***allowed amount***. This limit never includes ***your premium***, ***balance-billed charges*** or health care ***your*** plan doesn't cover. Some health

insurance or plans do not count all of ***your co-payments***, ***deductibles***, ***co-insurance*** payments, ***out-of-network*** payments or other ***expenses*** toward this limit.

Physician
A person holding an active, unrestricted license to practice medicine, surgery, or dentistry under Illinois law or under the laws of the state in which he or she practices.

Physician Services
Health care services a licensed medical ***physician*** provides or coordinates.

Plan
A benefit ***your*** employer, union or other ***group*** sponsor makes available to ***you*** to pay for ***your*** health care services.

Plan Benefits
Medical, Hospital, Behavioral Health and Substance Use Disorder, Chiropractic, Home Health Care, Skilled Nursing Facility, Emergency Care and other covered services as defined in the ***Certificate of Coverage***, ***Schedule of Benefits*** and ***benefit riders*** to which a ***member*** is entitled by membership in the ***plan***.

Policy or Group Master Policy Agreement
An agreement between ***Quartz*** and a ***group*** wherein ***Quartz*** agrees to provide a ***group health plan*** to the employer's ***eligible employees*** and their eligible ***dependents***. The ***policy*** sets forth all the obligations, rights and responsibilities of the parties. The ***policy*** includes all the following:

- ***Group Master Policy Agreement***;
- Any amendments to the ***Group Master Policy Agreement*** the group elected;
- ***Certificate of Coverage***;
- Any ***Benefit Riders*** to the ***Certificate of Coverage*** the group elected;
- ***Schedule of Benefits***;
- ***Group Application***;

- ***Enrollment Forms***; and,
- The ***Provider Network Directory***.

Premium
The amount that must be paid for membership in ***your health insurance plan***. ***You*** and/or ***your*** employer usually pay it monthly, quarterly or yearly.

Pregnancy Event
A birth, miscarriage, or abortion.

Prescription Drug Coverage
A component of a ***health insurance plan*** that helps pay for ***prescription drugs*** and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Prior Authorization
A decision by ***Quartz*** that a health care service, treatment plan, ***drug,*** supply, or ***durable medical equipment (DME)*** is ***medically necessary*** and meets certain criteria for coverage. The purpose of ***prior authorization*** is to review the following against ***Quartz's*** criteria for coverage:

- The specific type and extent of care, ***DME***, drug or supply that is ***medically 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 being referred.

Quartz may require ***prior authorization*** for certain services before ***you*** receive them, except in an ***emergency***. ***Prior authorization*** is not a promise ***your*** health insurance will cover costs because all benefits are determined based on the actual ***claim*** submitted by ***your provider***. Services and items requiring ***prior authorization*** are listed on ***Quartz's*** website at

QuartzBenefits.com. Contact ***Quartz*** Customer Success for details on the ***prior authorization*** process.

Primary Care Provider (PCP)
A ***physician***, physician assistant (PA), or nurse practitioner who provides, coordinates, or helps a patient access a range of health care services. PCPs are listed in ***Quartz's Provider Network Directory***.

Prostate Cancer Screening
Medically viable methods for the detection and diagnosis of prostate cancer, including a digital rectal exam, the prostate-specific antigen test, and associated laboratory work. This includes ***medically necessary*** subsequent follow-up testing as directed by a ***health care provider***, including, but not limited to, urinary analysis; serum biomarkers; and medical imaging, including, but not limited to, magnetic resonance imaging.

Provider
A ***physician***, health care professional or health care facility licensed, trained, certified or accredited as required by state law.

Provider Network (or Network)
The facilities, ***providers***, organizations and suppliers who have contracted with or on behalf of ***Quartz*** to provide ***plan benefits*** to ***members***. Visit QuartzBenefits.com/FindADoctor or contact ***Quartz*** Customer Success for assistance in navigating the ***provider network***.

Provider Network Directory
A list of ***physicians*** and other ***providers*** who are available to provide health care services to ***members***. Printable directories can be found at https://quartzbenefits.com/ProviderDirectoryPDFs.

Qualifying Payment Amount
The amount that ***we*** use to calculate ***your*** cost-sharing for:

- Emergency services received ***out-of-network***;

- 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***.

It is based on the median contracted rate for ***in-network providers*** in the geographic region. 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***.

However, when all of the following circumstances are true, ***your*** cost-sharing will be based on the "recognized amount" under 215 ILCS 5/356z.3a:

- ***You*** receive care at an ***in-network hospital*** or an ***in-network*** ambulatory surgical treatment center; and,
- ***You*** do not willfully receive a radiology, anesthesiology, pathology, neonatology, or emergency department service from an ***out-of-network provider*** at that facility when that service is available from an ***in-network provider***.

Quartz
Quartz is the shorthand name for the administrator of this ***policy*** and the insurance underwriting company, Quartz Health Insurance Corporation. This term may also be used to refer to the plan administrator or subcontractors performing administrative tasks on behalf of ***Quartz.***

QuartzBenefits.com
A comprehensive website resource to guide ***you*** through ***your health plan*** benefits and educate ***you*** about ***Quartz's*** health and wellness programs. The web address is ***QuartzBenefits.com***.

Reconsideration Committee
Individuals who have been appointed by ***Quartz*** to respond to ***grievances*** that have been filed on ***appeal*** from ***Quartz's*** simplified ***complaint*** process. At least 50% of the individuals on this committee shall be enrollees who are consumers.

Reconstructive Services
Treatments performed on structures of the body damaged by trauma to restore physical appearance.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions. ***Reconstructive surgery*** includes breast reconstruction following a covered mastectomy or to correct a functional impairment caused by a ***congenital*** condition.

Rehabilitative Services
Rehabilitative services include but are not limited to Speech Therapy, Physical Therapy and Occupational Therapy. Treatment, as determined by ***your physician***, that must be either (1) limited to therapy which is expected to result in significant improvement in the condition for which it is rendered, except as specifically provided for under the ***Autism Spectrum Disorder(s)*** provision and the plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of the therapy and indicate the diagnosis and anticipated goals, or (2) prescribed as preventive or Maintenance Physical Therapy for ***members*** affected by multiple sclerosis. ***Rehabilitative services*** must be expected to help a person regain, maintain or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to ***illness***, ***injury*** or disabling condition.

Rescission/Rescind
A cancellation or discontinuance of ***coverage*** that has retroactive effect. However, a cancellation or discontinuation 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***.

Residential Treatment Facility
A facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, and structure and is licensed by the appropriated state and local authority to provide such service. It does not include half-way houses, supervised living, group homes, wilderness and camp programs, therapeutic boarding schools, boarding houses, academy-vocational programs, or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24-hour medical availability and 24-hour onsite nursing service for patients with mental ***illness*** and/or substance use disorder. ***Quartz*** requires that any mental ***illness*** and/or substance use disorder ***residential treatment center*** must be licensed in the state where it is located, or accredited by a national organization that is recognized by ***Quartz*** as set forth in its current credentialing ***policy***, and otherwise meets all other credentialing requirements set forth in such ***policy***.

Rider (or Benefit Rider)
A document that adds ***covered services*** to the ***Certificate of Coverage***.

Schedule of Benefits
A summary of the ***covered services*** provided by the ***policy***. The ***Schedule of Benefits*** lists the ***co-payment***, ***co-insurance*** and ***deductible*** amounts that may apply to the ***covered services*** under the ***policy***.

Service Area
The geographic area within which ***Quartz*** and its affiliated entities are authorized to do business and where there are enough ***in-network providers*** to serve ***Quartz's members***.

Short-term Therapy
Physical, speech, occupational, manipulative or respiratory therapy that is likely to significantly improve a ***member's*** condition within 60 days from the date the therapy begins, pursuant to ***Quartz*** medical policy.

Skilled Nursing Care (or Skilled Care)
Services from licensed nurses in ***your*** own home or in a nursing home. ***Skilled care*** services are from technicians and therapists in ***your*** own home or in a nursing home. ***Skilled care*** must be ***medically necessary*** pursuant to ***Quartz*** medical policy. Services to support ***activities of daily living*** **(ADL)**, even if provided by a licensed, registered or practical nurse, are not ***skilled care***.

Skilled Nursing Facility
A facility that is licensed by the State of Illinois, or another state, that maintains and provides all the following:

- Permanent and full-time bed care facilities for resident patients;
- ***Physician*** services available at all times;
- 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;
- A daily record for each patient; and,
- Continuous ***skilled nursing care*** for patients during convalescence from ***illness*** or ***injury***.

A ***skilled nursing facility*** is not, except by coincidence, any of the following:

- 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 psychiatric disorders.

Skilled Nursing Facility Services
The health care services provided by a ***skilled nursing facility*** or ***extended care facility*** as part of its licensed operations. These services must be designated as ***covered services*** by ***Quartz***.

Special Enrollment Period
A 31-day period of time during which an eligible person is allowed to enroll in the ***health plan***. The ***special enrollment period*** begins on the date the eligible person:

- Involuntarily loses coverage under a health insurance ***benefit plan*** or other ***health plan***;
- Gains or becomes eligible as a ***dependent*** through marriage, birth, legal guardianship, adoption or placement for adoption (does not apply to a ***member*** that gains eligibility as a dependent parent or stepparent under 215 ILCS 5/356z.71); or
- Loses coverage under another employer's group health ***plan*** because the eligible person did not elect to continue coverage during the other ***plan's open enrollment period***, when the other ***plan's open enrollment period*** does not overlap with the ***open enrollment period*** of this ***plan***.

Specialist
A ***physician specialist*** focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician ***specialist*** is a ***provider*** who has more training in a specific area of health care.

Subscriber
An ***eligible employee*** who is enrolled in a ***health plan*** issued by ***Quartz*** to his or her employer under a ***Group Master Policy Agreement***.

Surrogate
A woman who attempts to carry and give birth to a child created through in vitro fertilization using the gamete or gametes of at least one of the intended

parents, whether or not the woman has made a genetic contribution to the child.

Telehealth
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. Cost-sharing for ***telehealth*** will never be greater than if ***you*** received the same service in-person.

Third Party Examinations, Services and/or Supplies
Services and/or supplies that are provided primarily at the request of, for the protection of, or to meet the requirements of a party other than the ***member***. These services and supplies are not considered to be ***covered services*** unless:

- The service and/or supply is otherwise ***medically necessary***; or,
- The service and/or supply is mandated by state or federal law.

Total Disability (or Totally Disabled)
For a ***subscriber***, this term means that, because of an ***illness*** or ***injury***, they are at all times unable to perform the duties of the job or occupation for which they are reasonably qualified for wage or profit. ***Total disability*** also means that the ***subscriber*** cannot engage in any job or occupation for wage or profit.

For a ***dependent child, total disability*** means a disabling condition makes the ***child*** incapable of self-sustaining employment and is dependent on his or her parents or other care providers for lifetime care and supervision. In accordance with 215 ILCS 125/4-9.1, "dependent on other care providers" means the ***dependent child*** requires a Community Integrated Living Arrangement, group home, supervised apartment, or other residential services licensed or certified by the Department of Human Services, the Department of Public Health, or the Department of Healthcare and Family Services.

Urgent Care Services
Those services that are warranted by ***illness***, ***injury*** or symptoms where delay in the receipt of the care or treatment would jeopardize the ***member's*** health or result in a disability. These services include treatment received from health care professionals and health care facilities.

Urgent Care Situation
An ***illness***, ***injury*** or condition serious enough that a reasonable person would seek care right away, but not so severe as to require ***emergency room care***.

Urgent Ground Ambulance Service
Ground ambulance service that is deemed ***medically necessary*** by a health care professional and is required within 12 hours after certification of the need for the service.

Usual, Customary and Reasonable (UCR)
The amount paid for a medical service in a geographic area based on what ***providers*** in the area usually charge for the same or similar medical service. The ***UCR*** amount sometimes is used to determine the ***allowed amount***.

Usual, Customary and Reasonable Charge
The reasonable dollar amount ***charge*** for the services and supplies provided by a health care ***provider***. The ***usual, customary and reasonable charge*** is not more than the following:

1. The ***usual charge***, which is the fee charged by the ***provider*** for a service or item to the majority of their patients;
2. The ***customary charge***, which is the fee that falls within a range of the ***usual charges*** of most ***providers*** in a geographic area that will generate a statistically credible claims distribution for the same or similar service;
3. The ***reasonable charge***, as calculated by ***Quartz***, which considers the complexity of a given treatment required for a particular case;
4. 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; or,

5. A ***charge*** negotiated by ***Quartz*** with an ***in-network provider***. If a ***provider*** is not an ***in-network provider***, ***Quartz*** will pay based on the ***usual, customary and reasonable*** amount as calculated by ***Quartz***.

You may request the amount of the ***usual, customary and reasonable charge*** by completing a Determination of Benefits Worksheet available at ***QuartzBenefits.com*** or by contacting ***Quartz*** Customer Success. ***You*** must furnish the ***provider's*** name, address, the actual ***charge***, the appropriate procedure code and the 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.

Virtual Visit
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.

We or Us or Our
Quartz Health Insurance Corporation or ***Quartz***. These shorthand terms may also be used to refer to the plan administrator or subcontractors performing administrative tasks on behalf of ***Quartz***.

You or Your
A ***member*** enrolled in a ***Quartz health plan***.
Other definitions that apply to specific coverages are defined within this ***certificate***.

Section 2: Obtaining Services

As a ***member*** of ***Quartz's*** Preferred Provider Organization (PPO) Plan, ***you*** are entitled to benefits that are ***covered services*** in accordance with the guidelines in this ***Certificate of Coverage***. ***You*** should seek services from ***in-network providers*** in order to receive the highest level of coverage from ***your health insurance plan***. Services received from ***out-of-network providers*** will be covered at the ***out-of-network benefit level***. ***Covered service*s** are described in this ***certificate***, the ***Schedule of Benefits*** and any ***Benefit Rider*** attached to this ***certificate***.

Benefits for elective (non-emergency) health care services are paid at different levels depending on the ***provider*** you use. If you receive services from an ***in-network provider***, claims will be paid at the ***in-network benefit level***. If you receive services from an ***out-of-network provider***, claims will be paid at the ***out-of-network benefit level***.

If ***your plan*** includes a ***deductible***, then the ***deductible*** must be paid in full before ***Quartz*** will pay benefits for ***covered service*s** subject to the ***deductible***. Once the ***deductible*** has been satisfied, any ***co-payment*s** or ***co-insurance*** required will apply toward satisfaction of the ***out-of-pocket limit***. For specific benefit information, refer to the ***Schedule of Benefits***.

Levels of Benefits

This PPO Plan offers ***you*** two benefit levels:

- The ***in-network benefit level*** applies when ***you*** obtain ***covered services*** from ***in-network providers***. To receive the ***in-network benefit level***, ***you*** must also obtain ***prior authorization*** from ***Quartz*** whenever ***prior authorization*** is required. The ***in-network benefit level*** is described in the "In-Network" column of ***your Schedule of Benefits***; and,

- The ***out-of-network benefit level*** applies when ***you*** use ***out-of-network providers***. Out-of-Network benefits are covered up to the ***usual, customary and reasonable charge***, and ***you*** pay a greater share of the cost through higher ***deductible*** and ***co-insurance*** amounts. ***You*** will also be responsible for amounts in excess of the ***usual, customary and reasonable charge***. The ***out-of-network benefit level*** is described in the "Out-of-Network" column of the ***Schedule of Benefits***.

Prior Authorization

The Prior Authorization Program is an important part of this ***health plan***. It allows ***us*** to review ***your*** arrangements for elective (non-emergency) outpatient procedures and ***hospital*** stays so we may determine in advance whether benefits are available. Please read this section very carefully. The procedures outlined below apply whether ***covered services*** are obtained from ***in-network providers*** or ***out-of-network providers***. As an insured under ***Quartz's*** PPO ***plan***, ***you*** are ultimately responsible for obtaining ***prior authorization***. If a ***prior authorization*** is not obtained when one is required, the service will not be considered a ***covered service*** and ***you*** will be responsible for payment.

Prior authorization does not guarantee that benefits will be fully covered. Coverage is determined by the terms and conditions of this ***policy***. If ***you*** receive ***prior authorization*** for services through an ***out-of-network provider***, ***you*** may be subject to ***balance billing***.

Prior Authorization for Elective Inpatient Admissions to Hospitals and Skilled Nursing Facilities

At least three business days before ***you*** are admitted to a ***hospital*** or a ***skilled nursing facility*** for elective (non-emergency) care, ***you*** must call (888) 829-5687. This starts the ***prior authorization*** process. ***We*** will authorize

coverage for ***your*** admission if it is ***medically necessary*** or deny coverage if it is not ***medically necessary***. As an insured under ***Quartz's*** PPO ***plan***, ***you*** are ultimately responsible for obtaining ***prior authorization***.

If a ***prior authorization*** is not obtained when one is required, the service will not be considered a ***covered service*** and ***you*** will be responsible for payment. Benefits are calculated according to the ***policy*** provisions. ***You*** must pay any ***deductible*** and ***co-insurance*** amount before ***Quartz*** will pay for ***covered services***.

If ***you*** are admitted to an ***in-network hospital*** for inpatient mental health treatment, ***prior authorization*** is not required as long as the hospital (1) notifies us within 48 hours of your admission, and (2) provides ***your*** initial treatment plan within 48 hours of admission.

Prior Authorization for Certain Covered Services

Prior authorization may be required for ***you*** to receive coverage for certain ***covered services***. A request for ***prior authorization*** must be made before ***you*** obtain the services. As an insured under ***Quartz's*** PPO ***plan***, ***you*** are responsible for obtaining ***prior authorization***. If a ***prior authorization*** is not obtained when one is required, the service will not be considered a ***covered service*** and ***you*** will be responsible for payment.

A list of services requiring ***prior authorization*** is available at ***QuartzBenefits.com***. ***You*** may also contact ***Quartz*** Customer Success for information about ***prior authorization***.

The services listed below require ***prior authorization***. ***We*** maintain complete, accessible, and up-to-date lists of services requiring ***prior authorization*** at ***QuartzBenefits.com/PPOPAList***; choose the list that matches the name of the network and logo on ***your*** ID card (Cigna PPO or PHCS/MultiPlan PPO/HealthEOS). Per 215 ILCS 200, ***Quartz*** will provide advance notice of changing ***prior authorization*** requirements, and will not apply a change in

coverage or approval criteria for a previously-authorized service sooner than the end of the plan year.

Below is a list of services requiring ***prior authorization*** when ***your*** plan uses the PHCS/MultiPlan PPO/HealthEOS network:

Durable Medical Equipment (DME)
Purchase or rental of DME items may require ***prior authorization***. See www.QuartzBenefits.com/ILPAList or call (800) 362-3310 for additional information.

Inpatient Admissions

- Elective hospital admissions require prior authorization before admission and notification when admitted (***prior authorization*** is not applicable to ***in-network*** inpatient mental health treatment, notification of admission is applicable to inpatient mental health treatment; see above for other requirements that apply)
- Hospitals, Acute Inpatient Care
- Inpatient Rehabilitation Facilities
- Long Term Acute Care Hospital (LTACH)
- Psychiatric Admissions (***out-of-network*** only)
- Skilled Nursing Facility/Swing Bed

Behavioral Health Services

- Elective hospital admissions require notification when admitted
- ***Experimental or Investigational*** Treatments
- Inpatient mental health (***out-of-network*** only) or substance use hospitalization
- Residential Treatment (only if not part of an inpatient discharge plan)

Other Services

- Advanced Wound Therapy (e.g., Bioengineered Skin Substitutes)
- Ambulance Services (non-emergent/urgent)
- Biofeedback (coverage limited to treatment of spastic torticollis, headache or pediatric urinary incontinence)
- Cell and gene therapies
- ***Experimental or Investigational*** Treatments

Surgical Procedures

- Bariatric Surgery
- Blepharoplasty
- Breast Surgery (excluding mammoplasty and covered reconstruction)Cochlear Implants
- Gender Affirming Surgery
- Implantable Nerve Stimulators
- Laser re-surfacing for non-cosmetic procedures (cosmetic procedures are excluded)
- Laser treatment of actinic keratosis or other benign skin lesions
- Left Ventricular Assist Devices (LVAD) for Treatment of Heart Failure
- Orthopedic Procedures (including Artificial Cervical and Lumbar Disc Surgery, OATS Procedures)
- Panniculectomy
- POEM (per-oral Endoscopic Myotomy) Procedure
- Removal of port wine stains and hemangiomas
- Rhinoplasty and septorhinoplasty
- Robotic Assisted Procedures
- Scar revision and repair (cosmetic procedures are excluded)
- Extracorporeal Shockwave Therapy
- Fractional Flow Reserve Calculation after Coronary CT Angiography (FFR-CT)
- Genetic Testing
- Home Health Care (including Home Infusion Services and Other In-Home Therapy Services)
- Hospice/Palliative Care
- Hyperbaric Oxygen Therapy
- Infertility Treatment
- Orthopedic Shoes for Diabetes or Peripheral Vascular
- Proton Beam Therapy
- Treatment of Urinary and Fecal Incontinence

- Surgical Treatment of Obstructive Sleep Apnea
- Temporomandibular Joint Disease surgical treatment
- Transplants including donor and other related charges (excludes corneal, except for artificial corneal transplants)
- Varicose Vein Procedures (including Sclerotherapy, Radiofrequency Ablation, Vein Stripping and Ligation)

Below is a list of services requiring ***prior authorization*** when ***your*** plan uses the Cigna PPO network:

- Behavioral Health Services:
  - Inpatient mental health hospital
  - Mental health residential
  - Inpatient substance abuse hospital
  - Substance abuse residential
- Chiropractic
- Cochlear Implants
- Diagnostic Radiology
- Durable Medical Equipment
- Erectile Dysfunction
- Gastric Bypass
- Home Health Care
- Home Infusion Therapy
- Injectable Medications
- Acute Inpatient
  - Acute inpatient rehabilitation
  - Long term acute care hospital (LTACH)
  - Skilled nursing facility
- Orthotics and Prosthetics

- Outpatient Procedures (select specialty outpatient procedures)
- Potential ***experimental or investigational***
- Transplant
- Unlisted Procedures

You or ***your provider*** should contact ***Quartz*** Customer Success at (800) 362-3310 to determine if an item or service requires ***prior authorization***.

Continued Stay Authorization

We will contact the ***hospital*** or ***skilled nursing facility*** on or before ***your*** expected discharge date. If ***you*** are to remain inpatient longer than originally authorized, ***we*** will request the medical reasons for the continued stay. After reviewing these reasons, if ***we*** determine that continued stay is not ***medically necessary***, ***we*** will notify ***you***, the ***hospital*** or ***skilled nursing facility*** and the ***physician***. ***Quartz*** will not cover ***charges*** for unauthorized days, except to provide continued coverage pending the outcome of an ***appeal***.

Behavioral Health Services

For assistance in accessing ***behavioral health services***, contact Behavioral Health Care Management at (800) 683-2300.

Non-Emergency Care

Elective (non-emergency) health care services must be obtained in accordance with any applicable ***prior authorization*** requirements. Coverage is subject to all the terms, conditions, limitations and ***exclusions*** stated in the ***Certificate of Coverage*** and ***Schedule of Benefits***.

Benefits for elective (non-emergency) services are paid at different levels depending on the ***provider*** you use:

- If ***you*** obtain ***covered services*** from ***in-network providers***, claims will be processed at the ***in-network benefit level***; and,
- If ***you*** obtain ***covered services*** from ***out-of-network providers***, claims will be processed at the ***out-of-network benefit level***.

If ***you*** have made a good faith effort to utilize an ***in-network provider*** for a ***covered service***, and it is determined ***Quartz*** does not have access to the appropriate providers in the network, ***you*** may seek prior approval to see an ***out-of-network provider*** at no greater cost-sharing than if the provider had been contracted with ***Quartz***.

Emergency Care

If ***you*** experience an ***emergency medical condition***, seek immediate care at the nearest health care ***provider***.

Follow-up care will not be covered as ***emergency services***. ***Out-of-network*** medical treatment for an ***illness*** or ***injury*** that is not an ***emergency medical condition*** is covered at the ***out-of-network benefit level***.

Urgent Care

If ***you*** need ***urgent care services***, call ***your primary care provider*** for instructions if possible. Otherwise, seek treatment at the nearest urgent care facility.

If ***you*** receive ***urgent care services*** from an ***out-of-network provider***, ***you*** should notify ***Quartz*** within three business days of receiving the care, or as

soon as is medically feasible. Contact ***Quartz*** Customer Success to provide this notice.

Special Provision Relating to Full-Time Students on Medical Leave

If a ***dependent*** over age 26 who is a full-time student must take a ***medically necessary*** leave of absence from school due to ***illness*** or ***injury***, ***Quartz*** will continue to provide coverage for the ***dependent*** if he or she, or an individual acting on his or her behalf, submits documentation and certification of ***medical necessity*** for the leave of absence from the ***dependent's attending physician***. The date on which the ***dependent*** ceases to be a full-time student due to the ***medically necessary*** leave of absence is the date on which continuation of coverage under this provision begins.

Quartz will continue to provide coverage to the ***dependent*** until any one of the following events occurs:

- The ***dependent***, or an individual acting on his or her behalf, advises ***Quartz*** that the ***dependent*** does not intend to return to school full-time;
- The ***dependent*** becomes employed full-time;
- The ***dependent*** obtains other health insurance coverage;
- The ***dependent*** marries;
- Coverage of the person through whom the ***dependent*** has coverage under this ***plan*** is discontinued or not renewed;
- One year has elapsed since the ***dependent's*** coverage continuation began and the ***dependent*** has not returned to school on a full-time basis.

Full-time student status is defined by the school in which the student is enrolled. ***Quartz*** may require proof of attendance.

Coverage begins on the day the student becomes a full-time student and ends on the day he or she is no longer a full-time student, or the last day of the month in which he or she attains the limiting age, whichever occurs sooner.

Section 3: Covered Services

Members are entitled to ***covered services***, subject to the terms and conditions described in this ***Certificate of Coverage***, the ***Schedule of Benefits***, and any ***Benefit Riders*** attached to this ***certificate***.

Services and supplies are covered at the ***in-network benefit level*** only if they are (1) ***medically necessary***, (2) provided by or at the direction of an ***in-network provider***, and (3) provided in accordance with the guidelines in the Obtaining Services section of this ***Certificate of Coverage***. Treatment, services, and supplies that exceed any maximum benefit limit specified in this ***policy*** are not covered. Plan benefits are described in this ***certificate***, the ***Schedule of Benefits*** and any ***Benefit Riders***.

Some or all ***covered services*** may be subject to ***co-payment***, ***co-insurance*** and ***deductible*** amounts. For specific information, refer to the ***Schedule of Benefits***.

If ***you*** incur a cost in excess of the ***in-network*** cost-sharing for a ***covered service*** from a ***provider***, facility, or ***hospital*** that was listed as an ***in-network provider*** in ***Quartz's provider network directory*** prior to or at the time of the provision of services, ***you*** may file a complaint with the Illinois Department of Insurance. See the Filing Complaints with the Illinois Department of Insurance paragraph of the Complaint, Grievance Appeal Procedure section. If the Department concludes that the ***provider*** was incorrectly included in ***our provider network directory*** when the appointment was made or the service was provided, ***Quartz*** will adjust ***your claim*** to ensure that ***your out-of-pocket*** cost for the services received from the ***provider*** do not exceed the ***in-network*** cost-sharing. The amounts paid by ***you*** will apply towards the ***in-network deductible*** and ***out-of-pocket limit***, if any. Note that this provision does not apply to amounts you may be billed for ***non-covered services***.

WHEN SERVICES ARE NOT AVAILABLE FROM AN IN-NETWORK PROVIDER
If ***you*** must receive ***covered services*** which are unavailable from an ***in-network provider***, benefits for the ***covered services you*** receive from an ***out-of-network provider*** will be provided such that ***you*** will have no greater cost than if ***you*** received the ***covered services*** from an ***in-network provider***. ***You*** must obtain ***prior authorization*** from ***Quartz*** for ***out-of-network*** services to be covered at the ***in-network benefit level*** in these situations.

If ***you*** cannot find an ***in-network provider*** to provide needed treatment for mental, emotional, nervous, or substance use disorders or conditions and ***Quartz*** grants a network exception, ***we*** will also provide reasonable reimbursement for food, lodging and travel if ***you*** submit a claim for reimbursement within 60 days of the last date of service for which travel was undertaken. ***We*** may, however, deny reimbursement if the ***provider's*** office is neither within the state of Illinois nor within 100 miles from ***your*** residence, unless ***you*** were unable to find a ***provider*** within those parameters to provide the ***medically necessary*** care within ten business days after a request for an appointment. (215 ILCS 124/10(d-5)(3)).

IMPORTANT NOTICE
You may contact ***Quartz*** Customer Success before receiving services from an ***out-of-network provider*** to determine if a ***provider's charge*** will be within ***Quartz's usual, customary and reasonable charge*** range. A Benefits Determination Worksheet may be completed at ***QuartzBenefits.com***. If ***you*** call, ***you*** must provide ***Quartz*** with the following information:

- The ***provider's*** estimated ***charge***;
- The CPT code of the service(s) to be obtained;
- The ***provider's*** name and zip code; and,
- The anticipated date of service.

Benefit Payment for Physician and Professional Services

Professional and related services include medical, surgical and other services listed in this ***Certificate of Coverage***. Benefits are subject to any (1) any ***deductible***, ***co-payment***, ***co-insurance*** and other limitations shown on the ***Schedule of Benefits***, and (2) all other terms and conditions outlined in this ***certificate***. Specific services require ***prior authorization***.

Abortion

Subject to 215 ILCS 5/356z.4a, abortion services are covered without restriction or delay. Cost-sharing does not apply. This includes coverage for prescription medications used to terminate a pregnancy.

Acupuncture

Acupuncture services are covered only when:

- Provided for the treatment of nausea/vomiting when associated with pregnancy, chemotherapy, or for the treatment of chronic pain, including migraine or tension headaches, fibromyalgia, chronic neck and back pain, knee pain due to arthritis, or myofascial pain. Acupuncture is not covered for the treatment of any other conditions;
- Obtained from licensed acupuncture ***providers*** or licensed ***physicians***.

Coverage is limited to 12 visits per ***benefit period***.

Alzheimer's and Related Dementias

Per 215 ILCS 5/356z.80, coverage is provided for ***medically necessary*** diagnostic testing and FDA-approved treatments or medications prescribed to slow the progression of Alzheimer's disease or other related dementias in accordance with the FDA label as determined by a ***physician***.

Ambulance Services

Quartz covers ***Emergent/Urgent Transportation*** to the nearest ***hospital*** that can provide the required level of care.

As required under 215 ILCS 5/356z.31(b-10), if ***emergency*** or ***urgent ground ambulance services*** are received from an out-of-network ground ambulance service ***provider***, the ***member*** will incur no greater out-of-pocket costs than if such services were received from an in-network ground ambulance ***provider***.

- In-network cost-sharing will be applied;
- Except as otherwise provided in state or federal law, cost-sharing will be calculated based on the lesser of the ***co-payment*** or ***co-insurance*** for an emergency room visit or 10% of the recognized amount. The recognized amount will be calculated in accordance with 215 ILCS 5/356z.31(b-10)(3); and,
- Except as otherwise provided for in state or federal law, if the cost-sharing for the same item or service furnished by an in-network ground ambulance ***provider*** would have been a flat-dollar ***co-payment***, that amount will be the cost-sharing amount unless the out-of-network ground ambulance ***provider*** has billed a lesser total amount.

In non-emergent, non-urgent situations, transportation between ***hospitals*** requires ***prior authorization*** by ***Quartz***.

Anesthesia Services

Covered when connected with the medical and surgical benefits described in this ***certificate***.

For Dental Anesthesia Services, see the Oral Health section below.

Autism Spectrum Disorder Treatment

Autism Spectrum Disorder(s) means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism and pervasive developmental disorders not otherwise specified.

Your benefits for the diagnosis and treatment of ***Autism Spectrum Disorder(s)*** are the same as ***your*** benefits for any other condition. ***Prior authorization*** is not required. Treatment for ***Autism Spectrum Disorder(s)*** must be provided or ordered for an individual diagnosed with an ***Autism Spectrum Disorder*** by a:

- ***Physician*** or a psychologist who has determined that such care is ***medically necessary***; or,
- Certified, registered or licensed health care professional with expertise in treating ***Autism Spectrum Disorder(s)*** and when such care is determined to be ***medically necessary*** and ordered by a ***physician*** or a psychologist.

Treatment for ***Autism Spectrum Disorder(s)*** includes the following care when prescribed:

- Psychiatric care, including diagnostic services;
- Psychological assessments and treatments;
- ***Habilitative*** or ***rehabilitative*** treatments;
- Therapeutic care, including behavioral Speech, Occupational and Physical Therapies that provide treatment in self-care and feeding,

pragmatic, receptive and expressive language, cognitive functioning, applied behavior analysis (ABA), intervention and modification, motor planning, and sensory processing.

Quartz will not deny otherwise covered services based on the location that clinically-appropriate services are delivered.

Bariatric Surgery

Bariatric surgery is covered when Utilization Review Program criteria are met. ***Prior authorization*** is required.

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.

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***.

Behavioral Health and Substance Use Disorder Services

For assistance in accessing ***behavioral health and substance use disorder services***, contact Behavioral Health Care Management at (800) 683-2300.

We cover ***medically necessary*** treatment of serious mental illnesses, psychiatric and nervous disorders, alcoholism, ***substance use disorder***, and chemical dependencies, listed in the most current edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). Per 215 ILCS 5/370c.4, this includes all ***medically necessary behavioral health and substance use disorder services*** received by the same insured on the same

day for both outpatient and inpatient care. A range of digital care options may also be available through ***in-network providers*** or a ***Quartz***-sponsored ***care management*** program. ***Quartz*** provides benefits for ***medically necessary*** services delivered through the psychiatric Collaborative Care Model, as required under 215 ILCS 5/356z.39(b). ***We*** also reimburse for clinical trainees under the supervision of a licensed ***behavioral health provider*** when services are billed in the supervising clinician's name.

If ***you*** cannot find an ***in-network provider*** to provide ***medically necessary*** treatment for mental, emotional, nervous, or substance use disorders or conditions and ***Quartz*** grants a network exception, ***we*** will provide reasonable reimbursement for food, lodging and travel if ***you*** submit a claim for reimbursement within 60 days of the last date of service for which travel was undertaken, and the provider's office is located outside of state of Illinois or greater than 100 miles from ***your*** residence (215 ILCS 124/10(d-5)(3)).

Serious Mental Illnesses mean the following mental disorders as classified in the current DSM: (1) schizophrenia, (2) paranoid and other psychotic disorders, (3) bipolar disorders (hypomanic, manic, depressive and mixed), (4) major depressive disorders (single episode or recurrent), (5) schizoaffective disorders (bipolar or depressive), (6) pervasive developmental disorders, (7) obsessive-compulsive disorders, (8) depression in childhood and adolescence, (9) panic disorder, (10) post-traumatic stress disorders (acute, chronic, or delayed onset), and (11) anorexia nervosa and bulimia nervosa.

Substance Use Disorders mean the following mental disorders as defined in the most current edition of the DSM: (1) substance use disorders, (2) substance dependence disorders, and (3) substance-induced disorders.

Covered services include:

Inpatient Treatment
Inpatient room and board at the semi-private room rate, and other services and supplies related to ***your*** condition provided during ***your*** stay in a ***hospital***, psychiatric ***hospital***, or ***residential treatment facility***.

Outpatient Treatment
Outpatient treatment received while not confined as an inpatient in a ***hospital,*** psychiatric ***hospital*** or ***residential treatment facility***, including:

- Services provided in day treatment programs 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;
- Partial ***hospitalization*** treatment provided in a facility or program for mental health treatment provided under the direction of a ***physician*** and certified by the appropriate credentialing body in their state;
- Intensive outpatient program provided in a facility or program for treatment of substance use disorders provided under the direction of a ***physician*** and certified by the appropriate credentialing body in their state; and,
- Ambulatory detoxification which are outpatient services that monitor withdrawal from alcohol or other substance use disorders, including administration of medications.

Intensive Outpatient Program
Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a ***physician*** and certified by the appropriate credentialing body in their state.

Office Visits

Office visits to a ***physician*** or behavioral health ***provider*** such as a psychiatrist, psychologist, social worker, or licensed professional counselor, or clinical trainee under the supervision of one of these practitioners. This includes ***medically necessary*** individual psychotherapy sessions longer in duration than a standard 45-minute appointment (e.g., 60 minutes). Other outpatient mental health treatment such as:

- Electro-convulsive therapy (ECT); and,
- Mental health injectables.

Mental Health Prevention and Wellness Visits

Per 215 ILCS 5/356z.70, coverage for one annual mental health prevention and wellness visit for children and adults for up to 60 minutes. Includes:

- Any age-appropriate screening recommended by the USPSTF or by the American Academy of Pediatrics/ Bright Futures: Guidelines for Health Supervision of Infants, children, and Adolescents for purposes of identifying a mental health issue, condition, or disorder;
- Discussing mental health symptoms that might be present, including symptoms of a previously diagnoses mental health condition or disorder; performing an evaluation of adverse childhood experiences; and,
- Discussing mental health wellness.

The visit may be performed by a physician licensed to practice medicine in all of its branches, a clinical psychologist, a licensed clinical social worker, a licensed clinical professional counselor, a licensed marriage and family therapist, a licensed social worker, or a licensed professional counselor, or a clinical trainee under the supervision of one of these practitioners.

Cost-sharing does not apply. This benefit is provided in addition to an annual physical exam (i.e., well-child visit or general health or medical visit) covered under the policy.

Early Treatment Models for Serious Mental Illnesses

Per 215 ILCS 5/356z.36, coverage of the following:

- Coordinated specialty care for first episode psychosis treatment;
- Assertive Community Treatment (ACT), when coordinated by providers certified to provide ACT by the State of Illinois; and,
- Community Support Team (CST) treatment, when coordinated by providers certified to provide CST by the State of Illinois.

Skilled Behavioral Health Services provided in the Home

Covered health services also include skilled behavioral health services provided in the home, but only when all the following criteria are met:

- ***You*** are homebound;
- ***Your physician*** orders them;
- The services take the place of a stay in a ***hospital*** or a ***residential treatment facility***, or needing to receive the same services outside ***your*** home;
- The services are part of an active treatment plan of care;
- The skilled behavioral health care is appropriate for the active treatment of a condition, ***illness*** or disease to avoid placing ***you*** at risk for serious complications.

Emergency Behavioral Health Services

- **Emergency Behavioral Health Services.** 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;
- **Acute Treatment and Stabilization for Substance Use Disorders;**

- **Acute Treatment Services** means 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning;
- **Clinical Stabilization Services** means 24-hour treatment, usually following acute treatment services for substance use, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others, and aftercare planning for individuals beginning to engage in recovery from addiction.

  All ***medical necessity*** determinations for ***substance use disorders*** are made in accordance with the most current edition of the American Society of Addiction Medicine Patient Placement Criteria.

Per 215 ILCS 356z.39, psychiatric collaborative care services are covered (HCPCS 99492, 99493, 99494, and G0512).

Treatment during Pregnancy and Postpartum Period (215 ILCS 5/356z.40)

Medically necessary inpatient and outpatient services for treatment of a mental, emotional, nervous, or substance use disorder or condition related to pregnancy or postpartum complications are covered. ***Cost-sharing*** will be waived unless services are for inpatient or residential care, or for substance use disorder services at Level 3.1 (Clinically Managed Low-Intensity Residential) or above as established by the ASAM.

The first 48 hours of an inpatient admission, detoxification or withdrawal management program, or partial hospitalization admission for the treatment of a mental, emotional, nervous, or substance use disorder or condition related to pregnancy, miscarriage or stillbirth, or postpartum

complications, is covered without ***prior authorization*** or post claim review.

Outpatient or Partial Hospitalization Services for Mental Health Treatment (215 ILCS 5/370c(w))

Prior authorization is not required for outpatient or partial hospitalization services for mental health treatment rendered by certain ***providers***. ***You*** or ***your provider*** must, however, notify ***Quartz*** within two business days of starting outpatient treatment and within 48 hours of starting partial hospitalization treatment. ***We*** may not apply concurrent review until after the notice deadline and may not deny coverage during the notice period. If ***we*** deny coverage retrospectively, ***your*** out-of-pocket costs will be limited to standard cost-sharing applicable to the service, through the date the **adverse determination** is issued. If services are furnished by an ***in-network*** provider, ***Quartz*** may retrospectively deny coverage for services before the applicable notice deadline only if any of the following apply:

- ***We*** determine that inpatient mental health treatment was not provided;
- ***You*** were not a covered ***member*** under the ***policy*** at the time of treatment;
- A material misrepresentation was made by ***you*** or ***your provider***;
- The service provided is excluded under the ***policy***;
- The service was not ***medically necessary*** as defined in 215 ILCS 5/370c(h) through (n); and,
- ***You*** did not consent to treatment and treatment was not mandated by court order.

Inpatient Mental Health Treatment at In-Network Hospital (215 ILCS 5/370c(w))

If ***you*** are being admitted to an ***in-network hospital*** for treatment of a mental, emotional, or nervous disorder or condition, ***prior authorization*** is not required, and concurrent review will not apply for the first 72 hours as long as the ***provider*** (1) notifies ***us*** of ***your*** admission within 48 hrs.,

and (2) provides ***your*** initial treatment plan to ***us*** within 48 hours of admission.

We cannot retrospectively deny coverage during the first 72 hours of ***your*** stay unless one of the following applies:

- ***We*** determine that treatment was not provided;
- ***You*** were not a covered ***member*** under the ***policy*** at the time of treatment;
- The service provided was excluded under the ***policy***;
- A material misrepresentation was made by ***you*** or ***your provider***; or,
- You did not consent to treatment and treatment was not mandated by court order.

If upon retrospective review ***we*** conclude that inpatient treatment for a behavioral health condition was not ***medically necessary***, ***your*** out-of-pocket costs will be limited to standard cost-sharing applicable to your inpatient stay for the first 72 hours or through the date the **adverse determination** is issued, whichever is later.

Upon discharge, ***Quartz*** will provide coverage for the levels of care recommended by ***your provider***, if the levels comply with generally accepted standards of care, and ***your provider*** notifies ***us*** of ***your*** admission and provided ***your*** treatment plan within the 48-hours of ***your*** admission.

Substance Use Disorder Treatment (215 ILCS 5/370c (g)(3))

If ***you*** are starting a treatment program for a substance use disorder, ***your provider*** must notify ***Quartz*** within two business days of initiating treatment. Concurrent review will not be applied before the notice deadline. If ***we*** deny coverage retrospectively, ***your*** out-of-pocket costs will be limited to standard cost-sharing applicable to the service, through the date the **adverse determination** is issued. If services are

furnished at an ***in-network*** facility, Quartz may retrospectively deny coverage for services only under the following circumstances:

- ***We*** determine that benefits were not provided;
- ***You*** were not a covered ***member*** under the ***policy*** at the time of treatment;
- A material misrepresentation was made by ***you*** or ***your provider;***
- The service provided is excluded under the ***policy;***
- The service was not ***medically necessary*** as defined in 215 ILCS 5/370c(h) through (n); and,
- ***You*** did not consent to treatment and treatment was not mandated by court order.

If ***your*** ongoing inpatient or outpatient treatment for a substance use disorder or condition is no longer medically necessary, ***we*** will notify ***you***, ***your provider***, and ***your*** authorized representative (if any) of the ***adverse benefit determination*** and ***your*** rights to expedited ***external review*** under 215 ILCS 5/370c (g)(4). This notice will be provided within 24 hours of ***our*** decision. ***Co-payments***, ***co-insurance*** and ***deductibles*** may apply to ***behavioral health and substance use disorder services***. For benefits and limitations, refer to ***your Schedule of Benefits***.

Not Covered

Coverage is excluded for relationship counseling. Residential treatment as a substitute for legal actions or to provide respite for the family are not covered.

Biofeedback

Biofeedback is covered only for the treatment of:

- Headaches;
- Spastic Torticollis or Spasmodic Torticollis; and,
- Pediatric voiding dysfunction.

Biofeedback is not covered for muscle wasting, muscle spasm, muscle weakness, adult urinary or stress incontinence, or any other condition not listed as covered. ***Prior authorization*** is required.

Breast Milk (215 ILCS 5/356z.38)

Pasteurized donated human breast milk for infant consumption, including human milk fortifiers, when:

- Indicated as ***medically necessary*** by a prescribing licensed medical practitioner;
- The infant's mother is medically or physically unable to produce breast milk sufficient to the infant's needs; and,
- Obtained from a human milk bank that meets appropriate quality guidelines or is licensed by the Department of Public Health.

Breast Reconstruction

Covered services include:

- Mastectomy and reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses;
- Treatment for physical complications at all stages of the mastectomy, including lymphedema;
- Coverage for inpatient treatment following mastectomy for an amount of time to be determined by the ***attending physician***;
- Post-discharge physician office visit or in-home nurse visit within 48 hours of discharge; and,
- Breast reconstruction for ***congenital*** conditions, when ***medically necessary*** to correct a functional impairment.

Cardiopulmonary Monitors

Per 215 ILCS 5/356z.34, cardiopulmonary monitors are covered when ***medically necessary***. ***Prior authorization*** is required.

Chiropractic Services and Osteopathic Manipulation

Benefits are not available for care that is maintenance and supportive care or ***long-term therapy***. Chiropractic services and osteopathic manipulation are covered at the same benefit level specified for "Chiropractor Visits" on the ***Schedule of Benefits***.

Cleft Lip and Cleft Palate

Medically necessary care and treatment to address ***congenital*** anomalies associated with cleft lip or palate, or both, are covered subject to the same cost-sharing that is imposed for other surgical benefits under the ***policy***. ***Covered services*** include:

- Oral and facial surgery, including reconstructive services and procedures necessary to improve and restore and maintain vital functions;
- Prosthetic treatment such as obdurators, speech appliances, and feeding appliances;
- Orthodontic treatment and management; and
- Otolaryngology treatment and management.

Medically necessary care and treatment does not include cosmetic surgery performed to reshape normal structures of the lip, jaw, palate, or other facial structures to improve appearance.

Clinical Trials

Quartz covers ***routine patient care costs*** incurred during participation in a ***qualifying clinical trial*** for the treatment of a ***life-threatening condition***. Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a ***qualifying clinical trial***. Benefits are available only when the ***member*** is clinically eligible for participation in the trial, as defined by the researcher. Benefits are not available for preventive clinical trials.

Life-threatening Disease or Condition means any disease or condition from which the likelihood of death is probable, unless the course of the disease or condition is interrupted.

Qualifying Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or another ***life-threatening disease or condition***.

To be a qualifying clinical trial, a clinical trial must be approved or funded by one or more of the following:

- Federally funded trials
  - The National Institutes of Health;
  - The Centers for Disease Control and Prevention;
  - The Agency for Health Care Research and Quality;
  - The Centers for Medicare & Medicaid Services;
  - Cooperative group or center of any of the entities listed above;
  - The Department of Defense;
  - The Department of Veterans Affairs;
  - The Department of Energy;
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or,
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration;

- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.

The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a ***covered health service*** and is not otherwise excluded under the ***policy***.

Routine Patient Care Costs for ***qualifying clinical trials*** include:

- Healthcare that is covered under this ***Certificate of Coverage*** absent a clinical trial;
- Covered health services required solely for the provision of the ***investigational*** item or service, the clinically-appropriate monitoring of the effects of the item or service, or the prevention of complications; and,
- Covered health services needed for reasonable and necessary care arising from the provision of an ***investigational*** item or service.

Treatment, services, and devices that fall outside of ***routine patient care costs*** are not covered.

Routine patient care costs for clinical trials do not include:

- The ***experimental or investigational*** service or item. The only exceptions to this are:
  - Certain Category B devices as defined by Center for Medicare and Medicaid Services;
  - Certain promising interventions for patients with terminal ***illnesses***;

  - Other items and services that meet specified criteria in accordance with our medical ***policy*** guidelines;
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and,
- A service that is clearly inconsistent with widely-accepted and established standards of care for a particular diagnosis.

Quartz:

- May <u>not</u> deny the qualified individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition;
- May <u>not</u> deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and,
- May <u>not</u> discriminate against the individual on the basis of the individual's participation in the trial.

Contraceptive Coverage

In addition to ***preventive health services***, Quartz covers ***over-the-counter*** contraceptive drugs, devices, and products without a prescription, except male condoms require a prescription to be covered.

Diabetes Treatments

<u>Diabetic Self-Management Education</u>

A diabetic outpatient self-management education program or training is covered. Diabetic medical nutrition therapy is also covered. Coverage will be provided if these services are rendered by a ***physician***, or duly certified, registered or licensed healthcare professional with expertise in diabetes management. For benefit information, see "If ***you*** visit a health

care ***provider's*** office or clinic" on the ***Summary of Benefits and Coverage***.

Diabetes Management Services

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***.

Insulin and Prescription Drugs

Prescription drugs and insulin are covered subject to ***Quartz's drug formulary***. Per 215 ILCS 5/356z.41, cost-sharing on prescription insulin drugs will not exceed $35 for a 30-day supply, or a greater amount indexed by the Illinois Department of Insurance on an annual basis. "Prescription insulin drugs" includes drugs that contain insulin and are used to control blood glucose levels to treat diabetes but do not include insulin drugs administered to a patient intravenously.

Continuous Glucose Monitors

Medically necessary continuous glucose monitors (CGMs), related supplies, and training in the use of CGMs are covered for ***members*** who are diagnosed with any form of diabetes mellitus and require insulin for the management of their diabetes. Coverage is ***medically necessary*** when the following requirements 215 ILCS 5/356z.59(a) are met:

- The CGM has been prescribed by a ***physician***, certified nurse practitioner, or physician assistant, in accordance with the FDA's indications for use;
- The ***member*** or their caregiver has sufficient training in using the CGM;
- The ***member*** currently uses at least one injection or infusion of insulin per day, or has a reported history of problematic hypoglycemia; and,

- The prescribing provider had an in-person or telehealth visit with the ***member*** within the previous six months and determined that the above criteria are met.

Quartz covers the most appropriate device based on the **member's** circumstances and medical needs in consultation with their medical provider. No ***cost-sharing*** will be applied for coverage of a monthly supply of CGMs, including one transmitter, if necessary.

Some CGMs available from a pharmacy are covered subject to ***Quartz's drug formulary.*** You can view the most current ***formulary list*** by visiting our web site.

Durable Medical Equipment for Treatment of Diabetes

Durable diabetic equipment includes:

- Glucometers (includes ***medically necessary*** blood glucose monitors for the legally blind when prescribed by a ***physician*** per 215 ILCS 5/356w, even if obtained over-the-counter);
- Insulin infusion pumps and all supplies required for use with insulin infusion pumps; and,
- Original batteries.

Coverage for insulin infusion pumps is limited to one pump per ***benefit period*** and is subject to ***medical necessity***.

The terms and conditions applicable to ***durable medical equipment*** also apply to ***durable medical equipment*** for the treatment of diabetes. For example, requirements for repair and replacement also apply to ***DME*** for treatment of diabetes. See "Durable Medical Equipment" later in this section.

Diabetic Supplies for Treatment of Diabetes

Benefits are available for ***medically necessary*** items of diabetic supplies for which a health care ***provider*** has written an order.

Disposable diabetic supplies are covered and subject to ***Quartz's drug formulary***. Covered diabetes supplies include but are not limited to:

- Test strips specified for use with a corresponding blood glucose monitor;
- Glucose test solutions;
- Glucagon;
- Glucose tablets;
- Lancets and lancet devices;
- Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein;
- Insulin and insulin analog preparations;
- Injection aids, including devices used to assist with insulin injection and needleless systems;
- Lancets and lancing devices;
- Alcohol swabs;
- Insulin syringes and needles;
- Biohazard disposable containers;
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels; and,
- Glucagon emergency kits.

Per 215 ILCS 5/356w, cost-sharing for diabetic supplies is consistent with other pharmaceuticals or DME items covered for other conditions.

Diagnostic Services

Covered diagnostic services include:

- Standard allergy testing, which does not include sublingual allergy testing;
- Radiology, laboratory and other diagnostic tests, ordered as part of a physical examination;

- Whole body skin examinations for lesions suspicious of skin cancer, once annually. Per 215 ILCS 5/356z.37, cost-sharing will not be applied to the first examination of the ***benefit period***;
- Pap tests and pelvic examinations, as deemed appropriate by a ***provider***, including nurse practitioners and physician assistants;
- Vision and hearing screenings, when performed to determine the need for correction;
- Blood tests to detect lead exposure;
- Vitamin D testing, when vitamin D deficiency risk factors are present;
- Annual prostate cancer screening as recommended by ***your physician*** for asymptomatic individuals age 50 and older; African-American individuals age 40 and over; and, individuals age 40 and over with a family history of or genetic disposition to prostate cancer. Per 215 ILCS 5/356u cost-sharing will not be applied;
- Mammograms and other breast imaging per 215 ILCS 5/356g(a) as follows with no cost-sharing:
    - For individuals 35-39, one baseline mammogram, including digital mammography and breast tomosynthesis;
    - For individuals 40 years of age and older, an annual mammogram, including digital mammography and breast tomosynthesis;
    - For individuals under 40, with a family history of breast cancer or other risk factors, at the age and intervals considered ***medically necessary*** by a health care ***provider***;
    - Diagnostic mammograms, when ***medically necessary***, including digital mammography and breast tomosynthesis;
    - A comprehensive ultrasound screening and MRI of an entire breast or breasts if mammogram shows heterogeneous or dense breast tissue, when ***medically necessary*** as determined by ***your provider***;
    - Molecular breast imaging of an entire breast or breasts if mammogram shows heterogeneous or dense breast tissue, when ***medically necessary*** as determined by ***your provider***. ***Cost-sharing*** will not be applied (215 ILCS 5/356g(a)(4.5));

- ***Medically necessary*** colonoscopies. Per 215 ILCS 5/356z.48(b), ***cost-sharing*** will not be applied;
- A1C testing, when diabetes risk factors are present;
- Biomarker testing, up to and including whole genome sequencing, when supported by medical evidence for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a ***member's*** disease or condition;
- Other ***medically necessary*** comprehensive cancer testing, as defined at 215 ILCS 5/356z.50;
- Screening for pancreatic cancer, as ***medically necessary*** based on symptoms or family history;
- Preventive screening for colorectal cancer for ***members*** beginning at 45 years of age;
- Diagnostic services for colorectal cancer are covered when ***medically necessary***;
- Preventive liver disease screenings for ***members*** 35 years of age or older and under the age of 65 at high risk for liver disease, including liver ultrasounds and alpha-fetoprotein blood tests every six months. Cost-sharing will not be applied (215 ILCS 5/356z.61);
- ***Medically necessary home saliva cancer screening*** every 24 months if the ***member*** is asymptomatic and at high risk for the disease being tested for or demonstrates at a physical exam symptoms of the disease being tested for;
- At-home, urine-based pregnancy tests when prescribed, even if otherwise available over-the-counter, limited to two tests every 30 days;
- Genetic testing for an inherited gene mutation for individuals with a personal or family history of cancer, in accordance with 215 ILCS 5/356u.10. ***Your out-of-pocket*** cost for a clinical genetic test will not exceed $50. Evidence-based screenings following a positive genetic test are covered when recommended by a health care professional, subject to cost-sharing as stated on the ***Schedule of Benefits***;
- Karyotype test or related hormone testing to diagnose Klinefelter syndrome, in accordance with 215 ILCS 5/356z.80; and,

- ***Medically necessary*** peripheral artery disease screening test for any at-risk individual, as defined by the American College of Cardiology and the American Heart Association's Joint Committee on Clinical Practice Guidelines, per 215 ILCS 5/356z.80.

Drugs and Biologicals

Coverage for outpatient ***prescription drugs*** is described in the "Benefits for Outpatient Prescription Drugs" section. Outpatient ***prescription drugs*** benefits follow the Prescription Drug Tiers listed on ***your Summary of Benefits and Coverage (SBC)***. Outpatient ***prescription drugs*** are obtained at pharmacies. Some pharmacies may be attached or inside other facilities, like hospitals.

In contrast, certain drugs follow ***your*** medical benefits. For example, drugs received while confined in a ***hospital*** are subject to ***your*** medical benefits.

Per 215 ILCS 5/356z.60 (b), abortifacients administered by a health care professional to terminate a pregnancy are covered without restriction or delay, and at no cost-sharing. This includes follow-up services related to clinic-administered abortifacients. Similarly, hormone therapy for the treatment of ***gender dysphoria*** and human immunodeficiency virus pre-exposure prophylaxis and post-exposure prophylaxis drugs and follow-up services are also covered without restriction or delay, and at no cost-sharing. Follow-up services include but are not limited to management of side effects, medication self-management or adherence counseling, risk reduction strategies, and mental health counseling.

Anti-hemophilic factor products are available under the medical benefit and should be ***prior authorized***. Anti-hemophilic factor products should be obtained and administered consistent with an approved ***prior authorization***. ***Quartz*** contracts with specific providers for anti-hemophilic factor products. To obtain the list of contracted ***providers***, please visit our website or contact ***Quartz*** Customer Success. These products may also be obtained from an

out-of-network provider when ***prior authorized*** by ***Quartz***; ***out-of-network*** cost-sharing will apply.

Durable Medical Equipment (DME) and Medical Supplies

We base our coverage of expenses for ***durable medical equipment*** **(DME)** on ***medical necessity***, medical appropriateness, and cost-effectiveness criteria. In comparing equipment alternatives, we consider whether distinct medical advantages justify greater cost or more frequent replacement. As a result, we do not cover added costs for equipment that has no medical 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 a DME item. If a DME replacement is covered under an active manufacturer's warranty, ***Quartz*** will not cover the cost of replacement.

The purchase or repair of ***durable medical equipment*** and medical supplies may require ***prior authorization*** to be eligible for coverage (except for the purchase of hearing aids, which do not require ***prior authorization***, and repair of ***complex rehabilitation technology*** unless certain circumstances exist). Please review ***your*** Summary of Benefits and Coverage (SBC) for information on ***prior authorization*** requirements. If *you* have any questions regarding a specific item, please call ***Quartz*** Customer Success.

Covered Durable Medical Equipment

The following are covered ***durable medical equipment*** (standard models only):

- Initial acquisition of prosthetic devices including artificial limbs, face, eyes, ears and nose. **Prosthetic Device** means an artificial device to replace, in whole or in part, an arm or leg and includes accessories essential to the effective use of the device and the replacement or repair of the device based on the patient's physical condition as ***medically necessary***;

- Splints, trusses, crutches, orthopedic braces and appliances;
- Rental of mechanical equipment or the purchase of such equipment, at ***Quartz's*** option;
- Initial lens(es) following cataract surgery;
- IUDs, diaphragms and implantable contraceptives;
- Breast pumps and supplies;
- Customized Orthotic Device. **Customized orthotic device** means a supportive device for the body or a part of the body, the head, neck, or extremities, and includes the repair or replacement of the device based on the patient's physical condition as ***medically necessary***;
- Foot orthotics that are custom-molded to the ***member's*** foot;
- Compression sleeves that are ***medically necessary*** to prevent or mitigate lymphedema (215 ILCS 5/356z.64);
- Other medical equipment and supplies ***prior authorized*** by ***Quartz***.

Quartz also covers a non-standard model of a ***prosthetic device*** or a ***customized orthotic device*** if the ***member's provider*** determines the non-standard model to be the most appropriate model that is ***medically necessary*** for the ***member*** to perform physical activities, as applicable, such as running, biking, swimming, and lifting weights, and to maximize the ***member's*** whole body health and strengthen the lower and upper limb function (215 ILCS 5/356z.18).

Covered Medical Supplies

Covered medical supplies include enteral feedings and medical foods necessary to treat genetic disorders.

Repair and Replacement

The repair and replacement of ***durable medical equipment*** will be covered provided that:

- The ***DME*** item is no longer useful or has exceeded its reasonable lifetime under normal use and is still ***medically necessary***, or the

member's condition has significantly changed such that the original equipment is no longer appropriate; and,
- The item is not covered under an active warranty; and,
- The replacement is not a "deluxe" model or "more advanced technology" model than required.

Per 215 ILCS 5/356z.80, ***Quartz*** may not require ***prior authorization***, medical documentation, or proof of continued need to complete ***medically necessary*** repairs for member-owned ***complex rehabilitations technology*** unless:
- The repairs are covered under a manufacturer's warranty;
- The cumulative cost of the repairs exceeds 75% of the cost to replace the ***complex rehabilitation technology***; or,
- The ***complex rehabilitation technology*** in need of repair is subject to replacement because the age of the ***complex rehabilitation technology*** exceeds or is within one year of the expiration of the 5-year reasonable useful life of the ***complex rehabilitation technology***.

Coverage for rented ***complex rehabilitation technology*** is provided while the primary member-owned ***complex rehabilitation technology*** is under repair. Neither ***you*** nor ***Quartz*** will be responsible for costs to repair non-***medically necessary*** features of the ***complex rehabilitation technology*** which were not initially approved for coverage.

Prior authorization is required for replacement requests of all other DME items.

See Section 4: Exclusions and Limitations for a listing of items that are excluded from coverage. Additionally, supplies and equipment that are not primarily intended for medical use (e.g., air conditioners, exercise bicycles, filter vacuum cleaners) are not covered. However, certain blood pressure cuffs and connected scales may be covered when medically appropriate,

including services for remote monitoring of these devices. Disposable medical supplies and equipment are not covered unless provided in conjunction with a ***home health care services*** visit.

Except for ***preventive health services***, ***DME*** and Medical Supplies may be subject to ***co-payment***, ***co-insurance***, ***deductibles*** and maximum amount limitations. Refer to ***your Schedule of Benefits*** or contact ***Quartz*** Customer Success for details.

Emergency Services

Services for the treatment of accident, ***injury*** or sudden ***illness*** are covered when provided at the nearest emergency room. Benefits for ***emergency services*** are covered at the ***in-network benefit level***, regardless of whether you receive treatment for an ***emergency medical condition*** at an ***in-network*** or ***out-of-network provider***.

Review ***your Schedule of Benefits*** to determine if a ***co-payment*** or ***co-insurance*** applies. If ***you*** are admitted for an inpatient ***hospitalization*** directly from the emergency room, the ***co-payment*** will be waived.

Foreign claims for ***emergency services*** are subject to the maximum benefit limit if shown in ***your Schedule of Benefits***.

Services recommended as follow-up to emergency treatment are not covered as ***emergency services***. Follow-up services must be provided by an ***in-network provider*** in order to be paid at the ***in-network benefit level***.

This ***policy*** covers testing and examination for victims of criminal sexual assault, with no ***member*** cost-sharing.

If a ***member*** receives neonatal intensive care from an ***out-of-network provider*** and the ***out-of-network provider*** bills the neonatal care as

emergency services, the ***member*** will incur no greater out-of-pocket costs than if they had received the care from an ***in-network provider***.

Fibrocystic Breast Condition

Coverage for treatment of fibrocystic breast condition.

Gender-Affirming (Transgender) Services

Quartz covers services, procedures and surgery for the treatment of ***gender dysphoria***. See ***Quartz's*** website at ***QuartzBenefits.com/ILPAList*** for the list of services and items that require ***prior authorization***.

Habilitative Services

Medically necessary physical and occupational therapy, speech-language pathology, other services and habilitative devices for people with disabilities.

Habilitative coverage includes ***habilitative services*** for children under 19 years of age with a ***congenital***, genetic, or early acquired disorder so long as all the following conditions are met:

- A ***physician*** licensed to practice medicine in all its branches has diagnosed the ***child's congenital***, genetic, or early acquired disorder;
- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, licensed ***physician***, licensed nurse, licensed optometrist, licensed nutritionist, licensed social worker, or licensed psychologist as ordered by a ***physician*** licensed to practice medicine in all its branches;
- The initial or continued treatment must be ***medically necessary*** and therapeutic and not ***experimental or investigational***.

Quartz will not deny benefits solely based on the location where clinically appropriate services are provided. Vocational therapy and custodial services are not covered.

Hearing Exams, Services and Devices

Hearing Screenings and Exams

Hearing screenings are covered when performed to determine the need for correction.

Hearing Aids and Cochlear Implants

Hearing aids and cochlear implants, and the cost of treatment related to hearing aids and cochlear implants, including procedures for the implantation of cochlear devices, that are prescribed by a physician, or by a licensed audiologist licensed in accordance with accepted professional medical or audiological standards are covered subject to the following conditions and limitations:

- The ***member*** must be certified as deaf or hearing impaired by a physician or audiologist;
- Coverage for prescribed hearing aids is limited to the cost of one hearing aid per ear per ***member*** once every two years. No dollar limit applies;
- In addition to the prescribed hearing aid coverage, ***Quartz*** also covers the cost of over-the-counter hearing aids, limited to $2,500 per ear every two years;
- Costs of treatment related to hearing aids such as ear molds and fittings are covered.

Bone-Anchored Hearing Aids

Bone anchored hearing aids are covered when medically indicated.

Hippotherapy and Therapeutic Riding

Quartz covers ***medical necessary hippotherapy*** and therapeutic riding services that incorporate equine movement as part of a therapeutic intervention, per 215 ILCS 5/356z.80.

Home Health Care Services

Home health care services, for the duration of ***medically necessary*** care, are covered per 215 ILCS 5/356z.53. To qualify for coverage, services must meet all the following requirements:

1. The care must be a ***home health care service***;

   Home Health Care Services means care and treatment of a ***member*** under a plan of care. These services must consist of one or more of the following:
   - Part-time or intermittent home nursing care by, or supervised by, a registered nurse;
   - Part-time or intermittent home health aide services that are ***medically necessary*** as part of the home care plan. Services must be supervised by a registered nurse or medical social worker and consist of caring for the patient;
   - Physical, respiratory, occupational and speech therapy provided by a registered therapist. (see Therapy Services in this section);
   - Medical supplies, drugs and medications prescribed by a ***physician***, and laboratory services performed by or on behalf of a ***hospital***, if necessary under the home care plan. These supplies and services are covered to the extent that they would be covered if the ***member*** were hospitalized;
   - Nutrition counseling provided or supervised by a registered or certified dietitian. Such services must be ***medically necessary*** as part of the home care plan;

- Evaluation of the need for and development of the home care plan. Evaluation must be provided by a registered nurse, physician extender or medical social worker, and approved or requested by the ***attending physician***;

2. The care must follow ***your attending physician's*** home care plan;

   The home care plan must be established, approved in writing, and reviewed by the ***attending physician***. ***Home health care services*** will not be covered unless the ***attending physician*** submits a treatment plan to ***Quartz***. The treatment plan must certify all the following:
   - ***Hospitalization*** or ***confinement*** in a ***skilled nursing facility*** would otherwise be needed if ***home health care services*** were not provided;
   - Necessary care and treatment are not available from the ***member's immediate family*** or other persons living with the ***member*** without causing undue hardship; and,
   - The ***home health care services*** will be provided or coordinated by a state-licensed or ***Medicare***-certified home health agency or certified rehabilitation agency.

   If the ***member*** was hospitalized immediately before ***home health care services*** began, then the home care plan will initially be approved by the ***physician*** who was the primary ***provider*** of care while the ***member*** was hospitalized.

3. ***Home health care services*** must be ***prior authorized*** by ***Quartz***.

   Up to four consecutive hours in a 24-hour period of ***home health care services*** will be considered as one home health care visit.

Hospice Care

Quartz will provide ***hospice care*** if such care is determined to be ***medically necessary***. ***Prior authorization*** is required.

Room and board in a ***skilled nursing facility*** are not covered for ***hospice care***.

Immune Gamma Globulin Therapy

Immune gamma globulin therapy is covered for persons diagnosed with a primary immunodeficiency when prescribed as medically necessary. Per 215 ILCS 5/356z.24, ***Quartz*** may not allow for the delay, discontinuation, or interruption of this therapy, but nothing in this Section shall prevent an insurer from applying appropriate utilization review standards to the ongoing coverage of immune gamma globulin therapy. Initial authorizations and reauthorizations of treatment will be consistent with 215 ILCS 5/356z.24 (b).

Infertility

This ***certificate*** covers the diagnosis and treatment of ***infertility*** including but not limited to in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, surgical sperm extraction procedures, and low tubal ovum transfer. Transfer procedures are eligible for coverage when billed in the name of a covered individual, whether eggs/embryos are transferred to the covered individual or a surrogate. Coverage provided to a ***surrogate*** who is not our ***member*** will end when the ***surrogate*** is discharged to regular obstetric care.

Coverage is also provided for procedures necessary to screen or diagnose a fertilized egg before implantation including but not limited to preimplantation

genetic testing for aneuploidy, preimplantation genetic testing for chromosome structural rearrangements, and preimplantation genetic testing for monogenic or single gene disorders.

Infertility coverage is subject to the following conditions:

- Procedures for diagnosis and treatment of ***infertility*** are covered only if considered medically appropriate by the ***member's*** medical provider based on clinical guidelines or standards developed by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the Society for Assisted Reproductive Technology, and are performed at medical facilities or clinics that are members in good standing of the Society for Assisted Reproductive Technology;
- Coverage for procedures for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer are covered only if:
  - The ***member*** has been unable to attain a viable pregnancy, maintain a viable pregnancy, or sustain a successful pregnancy through reasonable, less costly medically appropriate ***infertility*** treatments for which coverage is available under this ***certificate***;
  - The ***member*** has not undergone four completed oocyte retrievals (except that if a live birth follows a completed oocyte retrieval, then two more completed oocyte retrievals will be covered); and,
  - The procedures are performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

Basic Infertility

Eligible health services include basic ***infertility*** care, including seeing a ***provider*** to diagnose the underlying medical cause of ***infertility*** and any surgery needed to treat the underlying medical cause of ***infertility***.

Comprehensive Infertility Services

You are eligible for comprehensive ***infertility*** services if:

- ***You*** are covered under this plan as an ***employee*** or as a covered ***dependent*** spouse or partner in a ***civil union*** (referred to as "your partner") or as a covered ***dependent*** age 18 or above;
- There exists a condition that meets the definition of ***infertility*** that has been identified by ***your physician*** or ***infertility specialist*** and documented in ***your*** medical records;
- ***You*** have not had a voluntary sterilization (tubal ligation, hysterectomy and vasectomy) without a surgical reversal or ***you*** had a successful surgical reversal of the voluntary sterilization;
- ***You*** are unable to conceive or sustain a successful pregnancy through reasonable, less costly ***infertility*** treatment for which coverage is available under this ***plan***.

Your provider must request ***prior authorization*** from ***us*** in advance for ***your infertility*** services. ***We*** will cover ***charges*** for the following ***infertility*** services:

- Ovulation induction with menotropins; and,
- Intrauterine insemination/artificial insemination.

Advanced Reproductive Technology (ART)

ART services are medical procedures or treatments performed to help a woman become pregnant. ***You*** are eligible for ART services if:

- ***You*** are covered under this ***plan*** as an ***employee*** or as a covered ***dependent*** spouse or partner in a ***civil union*** (referred to as "***your*** partner") or as a covered ***dependent*** age 18 or above. ***Dependent*** children under age 18 are covered under this ***plan*** for ART services only in the case of fertility preservation due to planned services that will render the individual infertile;
- ***Your*** condition meets the definition of ***infertility*** that has been identified by ***your physician*** or ***infertility specialist*** and documented in ***your*** medical records;
- ***You*** have not had a voluntary sterilization (tubal ligation, hysterectomy and vasectomy) without a surgical reversal or ***you*** had a successful surgical reversal of that voluntary sterilization;

- ***You*** are unable to conceive or sustain a successful pregnancy through reasonable, less costly ***infertility*** treatment for which coverage is available under this ***plan***; and,
- ***You*** have exhausted the ***comprehensive infertility services*** benefits or have clinical need to move on to ART procedures based on our medical criteria.

If the procedures are performed while not confined in a ***hospital*** or any other facility as an inpatient, ***we*** will cover ***charges*** made by an ART ***specialist*** for any combination of the following ART services:

- In vitro fertilization (IVF)*;
- Uterine embryo lavage;
- Low tubal ovum transfer (LTOT);
- Cryopreserved embryo transfers;
- Prescription drug therapy used during an oocyte retrieval cycle;
- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery;
- ***Charges*** associated with ***your*** care when ***you*** will receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into ***you***; or,
- Medical costs of oocytes or sperm donors for ART procedures used to retrieve occytes or sperm and includes the cost of the procedure used to transfer oocytes or sperm to the covered recipient. ***We*** will also cover associated donor medical expenses, established by ***us***, as a prerequisite to donation.

Fertility Preservation

Fertility preservation involves the creation of embryos or the retrieval of eggs and sperm that are frozen for future use. ***You*** are eligible for fertility preservation when ***medically necessary*** services are planned that are likely to render ***you*** infertile (either directly or indirectly), such as surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

You can find an ***in-network*** ART ***specialist*** and facility in by calling ***Quartz*** Customer Success.

Your provider will request ***prior authorization*** from ***us*** in advance for ***your*** ART services and fertility preservation services.

Quartz does not apply any pre-existing condition exclusion to ***infertility*** coverage and does not apply any lifetime dollar limits for completed oocyte retrievals.

Immunizations, Allergy Injections and Epinephrine Injectors

Appropriate and necessary immunizations and allergy shots (injections and allergy serum) are covered. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention or recommended in Illinois Department of Public Health guidance with respect to the individual involved, are not subject to ***deductibles***, ***co-insurance*** and ***co-payments***. See "Preventive Health Services" for details.

Epinephrine injectors for the treatment of allergic reactions are also covered and cost-sharing will not exceed $60 for a twin-pack of ***medically necessary*** epinephrine injectors, regardless of type (215 ILCS 5/356z.33).

Laser Hair Removal

Medically necessary laser hair removal is covered if the procedure is a prescribed medical treatment in accordance with generally accepted standards of medical care.

Maternity Services

Coverage is provided for pregnancy, postpartum, and newborn care. Services may be provided by a ***primary care provider*** or ***specialist*** in a traditional facility setting, or may be rendered by perinatal doulas or licensed certified professional midwives in a traditional facility setting or home setting, including home births, home visits, and support during labor, abortion, or miscarriage.

- Includes necessary equipment and medical supplies for a home birth;
- Home visits for perinatal doula care may have limits for each ***pregnancy event***, not counting visit(s) for a home birth. See ***your Schedule of Benefits*** for more information.

Coverage includes home visits by lactation consultants, behavioral counseling interventions to support breastfeeding, as well as the purchase of breast pumps, breast pump supplies, breastfeeding supplies, and feeding aids as recommended by the lactation consultant.

Postpartum services will not be covered beyond 12 months after the end of pregnancy. Except for services for home births, cost-sharing will not be applied to the above-listed services when rendered by perinatal doulas or certified professional midwives.

The ***member*** is entitled to inpatient ***hospital*** services for 48 hours following a vaginal delivery and 96 hours following a cesarean section. Shorter lengths of stay are determined by the ***attending physician***.

Prenatal care includes pre-natal HIV testing.

Menopause Health

An annual menopause health visit is covered for individuals 45 years of age and older. ***Cost-sharing*** will not be applied.

Quartz also covers ***medically necessary*** hormonal and non-hormonal therapy to treat menopausal symptoms if the therapy is recommended by a qualified health care **provider** who is licensed, accredited, or certified under Illinois law and the therapy has been proven safe and effective in peer-reviewed scientific studies. Coverage includes all FDA-approved modalities of hormonal and non-hormonal administration including, but not limited to, oral, transdermal topical, and vaginal rings.

Mobile Integrated Health Care Services

For an ***eligible recipient***, ***Quartz*** covers ***medically necessary*** health care services provided on-site by emergency medical services (EMS) personnel through a mobile integrated health care program. Mobile integrated health care services include assessment, chronic disease monitoring and education, medication compliance, immunizations and vaccinations, laboratory specimen collection, hospital discharge follow-up care, and minor medical procedures approved by the EMS Medical Director.

Eligible recipient means an individual who has received hospital emergency department services three or more times in a period of four consecutive months in the past 12 months or an individual identified by a health care provider as an individual for whom mobile integrated health care services would likely prevent admission or readmission to, or would allow discharge from a hospital, behavior health facility, acute care facility, or nursing facility.

Non-emergent ambulance transport is not covered under this provision.

Neonatal Intensive Care

If a ***member*** receives neonatal intensive care from an ***out-of-network provider***, the ***member*** will incur no greater out-of-pocket costs than if they

had received the care from an ***in-network provider***, as long as the ***out-of-network provider*** bills the neonatal care as **emergency services**.

Neuromuscular, Neurological, or Cognitive Impairment

Coverage for therapy, diagnostic testing, and equipment necessary to increase quality of life is provided for children who have been clinically or genetically diagnosed with any disease, syndrome, or disorder that includes low tone neuromuscular impairment, neurological impairment, or cognitive impairment.

Services not covered under this benefit are those outside the standards of care for these conditions, and those otherwise excluded under the ***policy***, such as ***experimental or investigational*** services.

Nurse Practitioner and Physician Assistant Services

Services performed by nurse practitioners and physician assistants are covered when performed under the supervision and guidance of ***your provider***.

Nutritional Counseling

Nutritional counseling is covered. However, weight loss medications and services related to non-covered surgical procedures are not covered.

Nutritional Supplements

Covered nutritional supplements are limited only to the following:

- Amino acid-based formula products ordered by a physician for the treatment of eosinophilic disorders or short bowel syndrome, regardless of the delivery method; and,
- Formula and ***low protein modified food products*** ordered by a ***physician*** for the treatment of phenylketonuria or an inherited disease of amino and organic acids.

For purposes of this coverage, **Low Protein Modified Food Product** means foods specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a ***physician*** for the dietary treatment of any inherited metabolic disease. ***Low protein modified food products*** do not include foods that are naturally low in protein.

Oral Health

This ***Certificate of Coverage*** does not provide coverage for routine dental services. **Routine Dental Services** include but are not limited to: preventive dental services, evaluations, fillings, and orthodontics performed at a dentist's office. Coverage under this ***certificate*** is limited to the specific services outlined in this sub-section.

Extraction and Replacement of Sound Natural Teeth Because of Accidental *Injury*

Benefits are for repair of Sound Natural Teeth, or extraction and replacement of non-restorable natural teeth, damaged due to trauma to the teeth or jaw, regardless of whether the individual was covered under the ***policy*** during the time of the accidental ***injury***. **Sound Natural Tooth** is defined as a tooth that would not have required restoration in the absence of trauma or ***injury***, or a tooth with restoration limited to composite or amalgam filling, but not a tooth with crowns or a tooth that has had root canal therapy.

Treatment must begin within 90 days after the accident and will be covered for a maximum of 12 months after treatment begins. Chewing accidents and dental implants are not covered by this provision.

Dental Care Provided in a *Hospital* or Ambulatory Surgical Treatment Center

Dental care provided in a ***hospital*** or Ambulatory Surgical Treatment Center is covered with ***prior authorization*** if any of the following applies:

- The ***member*** is a ***child*** age six or under;
- The ***member*** has a disability;
- The ***member*** is under age 26 and has been diagnosed with an ***Autism Spectrum Disorder***; or,
- The ***member*** has a medical condition that requires ***hospitalization*** or general anesthesia for dental care.

Dental Anesthesia

Anesthesia services for dental care are covered under certain circumstances subject to ***prior authorization*** requirements. These services are covered if any of the following applies:

- The ***member*** is a ***child*** age six or under;
- The ***member*** has a chronic disability;
- The ***member*** is under age 26 and has been diagnosed with an ***Autism Spectrum Disorder***; or,
- The ***member*** has a medical condition that requires ***hospitalization*** or general anesthesia for dental care.

For purposes of this provision only, the following definitions apply:

Autism Spectrum Disorders means a pervasive developmental disorder described by the American Psychiatric Association or the World Health Organization diagnostic manuals as an autistic disorder, atypical autism, Rett Syndrome, childhood disintegrative disorder, or pervasive developmental disorder not otherwise specified; or a special

education classification for autism or other disabilities related to autism.

Developmental Disability means a disability that is attributable to an intellectual disability or a related condition, if the related condition meets all the following conditions:

- It is attributable to cerebral palsy, epilepsy or any other condition, other than a mental ***illness***, found to be closely related to an intellectual disability because that condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability and requires treatment or services similar to those required for those individuals. For purposes of this definition, ***autism*** is considered a related condition;
- It is manifested before the age of 22;
- It is likely to continue indefinitely; and,
- It results in substantial functional limitations in three or more of the following areas of major life activity: self-care, language, learning, mobility, self-direction, and the capacity for independent living.

Facility ***charges*** for dental anesthesia are covered under the ***hospital*** benefit.

Oral Surgery Services

The following are covered oral surgery procedures:

- Surgical removal of bony or tissue-impacted teeth;
- Removal of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth;
- Removal of apex of tooth root (apicoectomy);
- Removal of exostoses of the jaw and hard palate;
- External and internal incision and drainage of cellulitis;
- Cutting of accessory sinuses, salivary glands or ducts;
- Frenectomy;

- Vestibuloplasty (surgical modification of the gingival-mucous membrane relationship in the vestibule of the mouth);
- Residual root removal and root amputation; and,
- ***Medically necessary*** care and treatment to address a major ***injury*** to the jaw either through an accident or disease including:
  - Oral and facial surgery, including reconstructive services and procedures necessary to improve, restore, or maintain vital functions;
  - Dental implants, crowns, or bridges;
  - Prosthetic treatment such as obturators, speech appliances, and feeding appliances;
  - Orthodontic treatment and management;
  - Prosthodontic treatment and management; and,
  - Otolaryngology treatment and management.

These services also include diagnostic radiology by a dentist or oral surgeon when ordered in conjunction with a covered surgery, and anesthesia services when ordered in conjunction with a covered surgery.

Orthognathic surgery may also be covered when medical necessity criteria are met for the correction of a severe and handicapping malocclusion of the mandible and/or maxillae.

There is no coverage for:

- Extraction of teeth by pulling;
- Root canal procedures;
- Filling, capping or recapping of teeth; or,
- Dental implants.

Dental X-Rays

Dental x-rays are covered only when performed in conjunction with covered dental procedures listed above. Diagnostic cost-sharing applies.

Preventive Dental for Young Children

See **Preventive Health Services** for information on Oral Health Risk Assessment, Dental Caries Prevention, and Fluoride Chemoprevention Supplements.

Osteoporosis/Bone Mass Measurement

Benefits are provided for ***medically necessary*** bone mass measurement and for the diagnosis and treatment of osteoporosis.

Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts;
- Irrigation sleeves, bags and ostomy irrigation catheters; and,
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Pain Management Services

Coverage is provided for pain management services, including nonopioid, nonnarcotic pain management services and non-medication pain management services that serve as alternatives to the prescribing of opioid or narcotic drugs, in accordance with 215 ILCS 5/370c.3. ***You*** can find ***Quartz's*** pain management plan filed with the Illinois Department of Insurance and on our website at ***Quartzbenefits.com***.

PANDAS/PANS

Benefits for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS) include:

- Diagnosis of the conditions;
- Medically necessary inpatient and outpatient treatment of PANDAS/PANS, including but not limited to the use of intravenous immunoglobulin therapy, plasma exchange, neuropsychiatric therapy, pharmacologic therapy, etc., unless the ***member*** is no longer benefiting from treatment.

Coverage adheres to treatment recommendations developed by a medical professional consortium convened for researching, identifying, and publishing best practice standards for diagnosis and treatment that are accessible for medical professionals and are based on evidence of positive patient outcomes.

Services not covered under this benefit are those outside the standards of care for PANDAS/PANS as noted above, and those otherwise excluded under the policy, such as ***experimental or investigational*** services.

Quartz may request treatment notes and anticipated duration of treatment and outcomes for ***our*** review.

Pediatric Palliative Care

Per 215 ILCS 5/356z.57, coverage is provided for community-based pediatric ***palliative care*** and ***hospice care***, for any qualifying child with a ***serious illness*** by a trained interdisciplinary team that allows a child to receive community-based pediatric ***palliative care*** and ***hospice care*** while continuing to pursue curative treatment and disease-directed therapies for the qualifying illness.

Palliative care means care focused on expert assessment and management of pain and other symptoms, assessment and support of caregiver needs, and coordination of care. Palliative care attends to the physical, functional, psychological, practical, and spiritual consequences of a serious illness. It is a person-centered and family-centered approach to care, providing people living with serious illness relief from the symptoms and stress of an illness. Through early integration into the care plan for the seriously ill, palliative care improves quality of life for the patient and the family. Palliative care can be offered in all care settings and at any stage in a serious illness through collaboration of many types of care providers.

Serious illness means a health condition identified in Section 25 that carries a high risk of mortality and negatively impacts a person's daily function or quality of life.

Port-Wine Stains (Nevus Flammeus)

Benefits for nevus flammeus, also known as port-wine stains, are intended to prevent functional impairment related to vision function, oral function, inflammation, bleeding, infection, and other medical complications. Covered services may include, subject to ***prior authorization***:

- Early intervention treatment, including topical, intralesional, or systemic medical therapy and surgery; and,
- ***Medically necessary*** laser treatments.

Services not covered under this benefit are those outside the standards of care for port-wine stains, pursuant to ***Quartz*** medical policy, and those otherwise excluded under the policy, such as non-urgent, non-emergent services obtained from out-of-network providers, cosmetic treatment, and ***experimental or investigational*** services.

Preventive Health Services

Definition

Preventive Health Services are defined as any of the following:

- Evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force (USPSTF);
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- Immunizations recommended in the Guidelines for Communicable Disease Prevention issued by the Illinois Director of Public Health;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and,
- Such additional preventive care and screenings not described in the paragraph above as provided for in comprehensive guidelines supported by the HRSA for purposes of this paragraph (i.e., Women's Preventive Services Guidelines).

Covered without Cost-Sharing

Preventive health services are covered and not subject to cost-sharing (including ***deductibles***, ***co-insurance*** and ***co-payments***) when received ***in-network***.

Updated Recommendations and Effect on Coverage

When the ***preventive health services*** recommendations and guidelines are updated, they will apply to this ***plan***. The updates will be effective at renewal, one year after the updated recommendation or guideline is published.

Diagnostic Testing is Not Covered under the Preventive Health Services Benefit.
Cost-sharing applies when services are intended to diagnose a condition.

If a covered ***preventive health service*** is provided during an office visit and is billed separately from the office visit, ***you*** may be responsible for ***co-insurance***, ***deductible*** and/or ***co-payment*** for the office visit only.

If an office visit and the ***preventive health service*** are billed together and not billed separately, and the primary purpose of the visit was not the **preventive health service**, ***you*** may be responsible for ***co-insurance***, ***deductible*** and/or ***co-payment*** for the office visit including the ***preventive health service***.

Gender-Specific Preventive Care Benefits
Preventive services recommendations are often published as specific to a certain gender. However, preventive care benefits include any covered health services described below as preventive, regardless of the sex ***you*** were assigned at birth, ***your*** gender identity, or ***your*** recorded gender, even if they are referred to as gender-specific.

If a recommendation or guidance for a particular ***preventive health service*** does not specify frequency, method, treatment or setting in which it must be provided, ***Quartz*** may use reasonable medical management techniques to determine coverage.

Routine Physical Exams

Preventive health services include office visits to ***your physician*** or other health professional for routine physical exams. A routine exam is a medical exam given by a ***physician*** for a reason other than to diagnose or treat a suspected or identified ***illness*** or ***injury***. A routine exam may include:

Abdominal aortic aneurysm screening	One-time screening for abdominal aortic aneurysm (AAA) with ultrasonography in men aged 65 to 75 years who have ever smoked and were assigned male at birth.
Alcohol and drug misuse screening and counseling	For adolescents and adults. ***Preventive health services*** include screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance: ▪ Preventive counseling visits; ▪ Risk factor reduction intervention; and, ▪ A structured assessment.
Anxiety screening	Once annually.
Blood pressure screening in a clinical setting	For adults age 18 and older.
Blood pressure screening outside a clinical setting	For adults age 40 and older.
Cholesterol screening	For adults of certain ages or at higher risk.
Cholesterol screening	For adults at higher risk.
Depression screening	For adolescents ages 12 to 18 and adults. Includes screening for perinatal depression in pregnant and postpartum individuals at increased risk.
Fall prevention	Exercise or physical therapy to prevent falls for adults 65 years and older who are at increased risk for falls.
Healthy diet and physical activity counseling	For adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors. Beginning at

	age 40, counseling will be covered for individuals with normal or greater weight without additional risk factors.
Hepatitis B screening	For adults and adolescents ages 11-17 at high risk. This includes: ▪ Individuals from countries with 2% or more Hepatitis B prevalence; and, ▪ U.S. born individuals not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.
Hepatitis C screening	For adults ages 18-79.
High Body Mass Index (BMI) behavioral interventions (≥95th percentile for age and sex)	For children and adolescents six years or older
Human Immune Deficiency Virus (HIV) screening	For everyone ages 15 to 65 and other ages at increased risk. For pregnant individuals, at least one per pregnancy.
Intimate partner violence screening	Individuals of reproductive age, including those who are pregnant and postpartum.
Obesity screening and counseling	For adults.
Screening for diabetes (type 2)	For adults with high blood pressure, adults aged 35 to 70 years who are overweight or obese, and non-pregnant individuals with a history of gestational diabetes.
Sexually Transmitted Diseases (STD) screening and counseling	For adolescents and adults at higher risk.

Sexually Transmitted Infection (STI) prevention counseling	For adolescents and adults at higher risk.
Skin cancer behavioral counseling	For children and adults from six months to 24 years of age.
Syphilis screening	For adults at higher risk, and early in pregnancy for pregnant individuals.
Tuberculosis screening	For adults at high risk.

Tobacco Cessation

Tobacco product means a substance containing tobacco or nicotine such as cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco, or candy-like products that contain tobacco.

Counseling visits to help ***you*** to stop the use of tobacco products	For tobacco users.
Tobacco cessation prescription and over-the-counter drugs	FDA-approved ***prescription drugs*** and over-the-counter (OTC) drugs to help stop the use of tobacco products.
Tobacco screening and preventive education	For all adults (including pregnant individuals).

HRSA-Recommended Preventive Visits and Services

Through the "Women's Preventive Services Guidelines," HRSA recommends at least one preventive care visit per year beginning in adolescence and continuing across the lifespan to ensure the provision of all recommended preventive services. A routine preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified ***illness*** or ***injury***. A "well woman preventive exam" may be an office visit with ***your physician***, obstetrician (OB), gynecologist (GYN) or OB/GYN.

Anemia screening	For pregnant individuals or individuals who may become pregnant.
Annual Pap smears, including surveillance tests for ovarian cancer; cervical cancer screening	For individuals at risk for ovarian cancer.
BRCA gene blood testing by a physician and lab	For individuals with positive BRCA screening results (215 ILCS 5/356u.5).
BRCA risk assessment or screening	
Breast cancer chemoprevention counseling	
Breast cancer genetic counseling (BRCA) provided by a genetic counselor to interpret the test results and evaluate treatment	For individuals with positive BRCA screening results.
Breast cancer screening and relevant patient navigation services	▪ For individuals 40 years of age and older, an annual mammogram including additional imaging to address findings and pathology evaluation when indicated; ▪ Comprehensive ultrasound screening of the entire breast when a mammogram shows it is needed; and, ▪ A screening MRI, as determined by ***your physician***.
Cervical cancer screening and relevant patient navigation services. Includes	▪ For individuals 21-29 years, pap test every three years;

additional testing to complete screening and follow-up on initial findings.	▪ For individuals 30-65 years, high risk human papillomavirus (HPV) testing every five years or pap test and HPV testing (co-testing) every five years. If HPV testing is not available, pap testing every three years.
Chlamydia screening	For sexually active individuals and other individuals at higher risk for infection.
Clinical breast exams	For individuals over 20 years of age but less than 40, at least every three years, and annually for individuals 40 years of age and older.
Folic acid supplements	For individuals who may become pregnant.
Gonorrhea screening	For all individuals at higher risk.
HIV screening and counseling	For sexually active individuals. For pregnant individuals, at least one per pregnancy.
Intimate partner and domestic violence screening and counseling	Annually and as needed for adolescents and adults
Osteoporosis screening	For individuals assigned female at birth and either (1) 65 or older; or (2) younger than 65 and at increased risk for fracture.
Preventive ovarian cancer genetic counseling	Counseling and evaluation services to help ***you*** assess whether or not ***you*** are at increased risk for breast and ovarian cancer.
Rh Incompatibility screening	For all pregnant individuals and follow-up testing for individuals at higher risk.

Screening for gestational diabetes	For individuals, including women 24-28 weeks pregnant and those at risk of developing gestational diabetes.
Screening for urinary incontinence	
Sexually Transmitted Infection (STI) counseling	Once annually for all sexually active individuals.
Syphilis screening	For pregnant individuals.

Prenatal Care	
Your routine prenatal, antenatal and postnatal physical exams are preventive care, which includes the initial and subsequent physical exam services such as:	
Anemia screening	For pregnant individuals.
Bacteriuria screening	
Chlamydia infection screening	
Fetal heart rate check	
Fundal height	
Hepatitis B screening	
Human Immune Deficiency Virus (HIV) screening	
Maternal weight, and behavioral counseling for health weight and weight gain in pregnancy	
Preeclampsia screening	
Rh incompatibility screening	
Lactation Support and Counseling Services	
Breast pump	Includes the purchase of: ▪ An electric breast pump (non-***hospital*** grade). ***Your plan*** will cover this cost once every three years; or, ▪ A manual breast pump. ***Your plan*** will cover this cost once per pregnancy.

	If an electric breast pump was purchased within the previous three-year period, the purchase of another electric breast pump will not be covered until a three-year period has elapsed since the last purchase or if the initial electric breast pump is broken and no longer covered under a warranty.
Breast pump supplies and accessories	Eligible health services include breast pump supplies and accessories, and milk storage supplies. These are limited to only one purchase per pregnancy in any year where a covered individual would not qualify for the purchase of a new pump. Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose. It also includes the accessories and supplies needed to operate the item. ***You*** are responsible for the entire cost of any additional pieces of the same or similar equipment ***you*** purchase or rent for personal convenience or mobility.
Referral for and provision of lactation support, training, and counseling (including behavioral counseling interventions)	During pregnancy or at any time following delivery for breastfeeding for ***you*** and ***your*** family members. when ***you*** get it from appropriately certified individuals.
Family Planning Services	
All FDA-approved contraceptive methods (including male condoms when a ***member*** obtains a prescription), sterilization procedures, follow-up services (including but not limited to management of side effects, counseling for	

continued adherence, and device insertion), and patient education. Frequency as prescribed. ***Quartz*** may manage contraceptives through formulary placement. However, exceptions will be made for contraceptive coverage at $0 cost-sharing if ***your provider*** indicates the prescribed contraceptive product or method is medically appropriate.	
Contraceptive counseling	Eligible health services include counseling services provided by a ***physician***, PCP, OB, GYN, or OB/GYN on contraceptive methods. These will be covered when ***you*** get them in either a group or individual setting.
Contraceptive devices	***Preventive health services*** include contraceptive devices (including any related services or supplies) when they are provided by, administered or removed by a ***physician*** during an office visit.
Voluntary sterilization	Voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.
Well Child & Well Baby Preventive Visits	
Covered ***preventive health services*** include routine:	
Autism screening	For children at 18 and 24 months.
Behavioral, social and emotional screening, including for anxiety	For children ages zero to 18.
Blood pressure screening	For children ages zero to 18.
Cardiac arrest risk identification	For children ages 11 to 21.
Cervical dysplasia screening	For sexually active adolescents.
Dental caries prevention	For infants and children up to five years

	old. Includes application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices.
Developmental screening	For children under age three.
Dyslipidemia screening	For children at higher risk of lipid disorders ages zero to 18.
Fluoride chemoprevention supplements	For children without fluoride in their water source.
Gonorrhea preventive medication	For the eyes of all newborns.
Hearing screening	As recommended periodically until age 21.
Height, weight and BMI measurements	For children ages zero to 18.
Hemoglobinopathies or sickle cell screening	For newborns.
Hemotocrit or hemoglobin screening	For all children.
Hepatitis B virus infection risk identification	For children ages zero to 21.
HIV screening	For adolescents and young adults at higher risk.
Hypothyroidism screening	For newborns.
Iron supplements	For children ages six to 12 months at risk for anemia.
Lead screening	For children at risk of exposure.
Medical history throughout development	For children ages zero to 18.

Oral health risk assessment	For young children ages zero to 10.
Phenylketonuria (PKU) screening	For newborns.
Suicide risk screening	For children ages 12 to 21.
Tobacco use counseling	To prevent initiation of tobacco use in children age six to 18.
Tuberculin testing	For children at higher risk of tuberculosis ages zero to 18.
Vision screening	For all children.
Cancer Screenings	
In addition to other cancer screenings noted above.	
Colonoscopies	Includes preventive screenings and the first colonoscopy following a positive stool or direct visualization screening. Includes removal of polyps performed during a screening procedure and a pathology exam on any removed polyp.
Colorectal cancer screening	For adults age 50 to 75.
Double contrast barium enemas (DCBE)	
Fecal occult blood tests	
Lung cancer screenings	Adults age 50 to 80 at high risk for lung cancer because they are heavy smokers or have quit smoking in the past 15 years.
Sigmoidoscopies	
Medications	
Covered health services include the following preventive care drugs and supplements (including over-the-counter drugs and supplements) when	

prescribed by a prescriber and the prescription is submitted to the pharmacist for processing:	
Aspirin	Available to pregnant individuals to prevent preeclampsia.
Breast cancer preventive medications	For individuals at: ▪ Increased risk for breast cancer; and, ▪ Low risk for adverse medication side effects. Examples include tamoxifen or raloxifene.
Folic acid supplements	Available to adults planning to become pregnant or capable of pregnancy.
HIV Preexposure Prophylaxis (PrEP) drugs, including support services recommended by the USPSTF	For everyone ages 15 to 65, and others at increased risk.
Iron supplements	Available to children ages six to 12 months without symptoms of iron deficiency but who are at an increased risk for iron deficiency anemia.
Metformin, when prescribed for diabetic and pre-diabetic interventions	For adults age 35 and older.
Oral fluoride supplements	Available to children whose primary water source is deficient in fluoride.
Statin preventive medication	For adults age 40 to 75 without a history of cardiovascular disease.
Immunizations	
Herpes Zoster	
Mumps	

Rubella	For use in various populations, as recommended by the Centers for Disease Control and Prevention (CDC) or Illinois Department of Public Health guidance
Shingles	
Diphtheria	
Hepatitis A	
Hepatitis B	
Human papillomavirus (HPV)	
Influenzae (flu shot)	
Measles	
Meningococcal	
Pertussis (whooping cough)	
Pneumococcal	
Tetanus, including Tdap and DTaP	
Varicella (Chickenpox)	
Haemophilius influenzae type b	
Inactive poliovirus	
Rotavirus	
COVID-19	
Mpox	
Respiratory syncytial virus (RSV)	

Primary Care Provider Services

Services provided by the ***primary care provider*** **(PCP)** for the treatment of ***illness*** or ***injury*** and preventive care.

Radiation Therapy and Chemotherapy

Generally accepted therapeutic methods, such as radiology, radium or radioactive isotopes, and ***medically necessary*** proton beam therapy when performed and billed by a ***provider*** are covered. ***Quartz*** will not apply a higher standard of clinical evidence for the coverage of proton beam therapy than it applies for coverage of any other form of radiation therapy treatment (215 ILCS 356z.66).

Reconstructive Services

Per 215 ILCS 356z.65, ***medically necessary reconstructive services*** performed on structures of the body damaged by trauma, that are intended to restore physical appearance.

Routine Foot Care

Members may obtain routine and preventive foot care from a ***primary care provider*** or ***specialist***.

Second Opinion

A second opinion from an ***in-network provider*** is covered at the ***in-network benefit level***. A second opinion from an ***out-of-network provider*** is covered at the ***out-of-network benefit level***.

Surgical Services

Recognized surgical procedures are covered, including, but not limited to, the following:

- Pre-operative and post-operative care and the services of assistants and consultants that are necessary for the treatment of ***illness*** and ***injury***, including a post-mastectomy in-home nurse visit per 215 ILCS 5/356t;
- Elective sterilization procedures, which are covered at no cost-sharing to the member;
- Medically-recognized procedures performed as an alternative to surgery;
- Mastectomy and reconstruction of the breast on which the mastectomy was performed and reconstruction of the other breast to produce a symmetrical appearance;
- ***Reconstructive surgery*** to correct a functional defect caused by ***congenital*** deformities (including the treatment of cleft lip and cleft palate), accidental injuries, scars, tumors or diseases, or to provide ***reconstructive services***;
- Removal of breast implants for an ***illness*** or ***injury***. This coverage does not apply to implant removals solely for cosmetic purposes;
- LINX procedure to treat gastroesophageal reflux disease (GERD).

Telehealth Visits

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.

Services covered under this benefit include telepsychiatry for the treatment of mental health and substance use disorders, and ***telehealth*** services for diabetes counseling, which ***members*** may access by telephone from their own homes.

Temporomandibular Joint Treatment (TMJ)

Diagnostic procedures and surgical and non-surgical treatment for the correction of temporomandibular joint disorders. The treatment must be ***medically necessary*** and all of the following criteria must apply:

- The condition is caused by ***congenital***, developmental or acquired deformity, disease or ***injury***;
- Under the accepted standards of the profession of the ***provider*** rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition; and,
- The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

For purposes of this section only, non-surgical treatment may include intra-oral splint and therapy devices and appliances. These items are covered as ***durable medical equipment***.

Covered services under this provision are subject to certain ***exclusions*** and limitations. Mandibular and/or maxillary osteotomy are excluded for the treatment of TMJ. Review Section 4: Exclusions and Limitations for additional information.

Therapy Services

The following therapy services are eligible for coverage:

Outpatient Physical, Occupational, Speech and Hearing Therapy
Refer to ***your Schedule of Benefits*** for visit limits and benefits available.

Outpatient Therapy for the Treatment of Mental Health and Substance Use Disorders
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.

Inpatient Therapy
Benefits are payable for inpatient medical rehabilitation. Refer to the ***Schedule of Benefits*** for specific levels of coverage.

Cardiac Rehabilitation Therapy
Cardiac rehabilitation therapy services are covered for eligible ***members*** with a recent history of heart attack (myocardial infarct), coronary artery bypass graft (CABG), onset of stable angina pectoris, onset of decubiti angina, heart valve surgery, PTCA and cardiac transplant.

Benefits are payable only for an eligible ***member*** for one of the seven covered conditions. Refer to the ***Schedule of Benefits*** for specific levels of coverage. Benefits are not payable for behavioral or vocational counseling and maintenance cardiac rehabilitation. Phase IV cardiac rehabilitation is not covered.

Post Cochlear Implant Aural Therapy

Preventive Physical Therapy for Members with Multiple Sclerosis
Preventive physical therapy is covered for ***members*** diagnosed with multiple sclerosis.

Preventive Physical Therapy means physical therapy that is prescribed by a licensed physician for the purpose of treating parts of the body affected by multiple sclerosis, but only where the physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals. ***Cost-sharing*** for this coverage is the same as outpatient therapy cost-sharing.

Breast Cancer Pain Therapy

Coverage for Breast Cancer Pain Medication and Therapy includes ***medically necessary*** pain medication and pain therapy related to the treatment of breast cancer under the same terms and conditions applicable to treatment of other medical conditions. Pain therapy is medically based with reasonably-defined goals including but not limited to stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals.

Long-term therapy, ***maintenance care or therapy***, ***and supportive care or therapy***, are not ***covered services***.

Transplant and Related Surgical Services

Your benefits for certain human organ transplants are the same as ***your*** benefits for any other condition. ***Your*** benefits for human organ transplants include the evaluation, preparation and delivery of the donor organ and the removal of the organ from the donor. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

- When a ***member*** is the recipient of the transplant, benefits under this ***policy*** will be provided for both the ***member*** and the donor;

- Donor charges are excluded when the recipient is not a ***member***.

In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants will be provided as follows:

- Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by ***your physician***, ***you*** must contact ***Quartz*** by telephone before ***your*** transplant surgery has been scheduled. ***Quartz*** will furnish ***you*** with the names of ***hospitals*** which have Human Organ Transplant Programs.
- ***Your*** benefits under this coverage will begin no earlier than five days prior to the transplant surgery and shall continue for a period of no longer than 365 days after the transplant surgery. Benefits will be provided for all in-patient and out-patient ***covered services*** related to the transplant surgery;
- Benefits will also be provided for the transportation of the donor organ to the location of the transplant surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the other ***exclusions*** of this ***certificate***, benefits will not be provided for the following:

- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a ***hospital*** for transplant surgery;
- Transportation by air ambulance for the donor or the recipient;
- Travel time and related expenses required by a ***provider***;
- Drugs which are ***experimental or investigational***;
- Drugs which do not have the approval of the Food and Drug Administration;
- Storage fees;
- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified provision; and,
- Meals.

Organ or Tissue Transplant Services

Organ or Tissue Transplant Services means the following as it relates to a covered transplant procedure:

- Organ and tissue procurement (consists of removing, preserving and transporting the donated part, as well as tissue-typing for related or unrelated donors);
- ***Hospital*** room and board and medical supplies; and,
- Diagnosis, treatment, surgery and follow-up care by a ***physician***, including dressings and supplies. Transplant services also include immunosuppressive drugs administered in a licensed hospital in connection with a human organ transplant.

All ***organ or tissue transplant services*** and donor services require ***prior authorization***. ***Organ or tissue transplant services*** are covered when all the following criteria are met:

- The ***charges*** must be incurred during a transplant benefit period that begins with the initial transplant evaluation while a ***member*** is insured under this ***plan***;
- The ***charges*** must be due to a covered ***injury*** or ***illness***;
- A transplant is only a **Covered Transplant Procedure** if it includes any of the following human-to-human organ or tissue transplants: cornea, heart, lung, heart with lung, liver, kidney, kidney with pancreas, and bone marrow (e.g., peripheral stem and cord blood).

Donor Services

Donor services are covered only if the ***recipient*** is a ***member***. **Recipient** means the person who receives an organ or tissue transplant.

Special Exclusions and Limitations for Transplant and Related Surgical Services

Benefits are not payable for the following:

- Services not ordered by a ***physician***;

- Services for which a ***member*** has no legal obligation to pay in the absence of insurance;
- Services for an ***injury*** or ***illness*** due to employment with an employer or self-employment that are otherwise covered by a Workers' Compensation or other occupational disease law;
- ***Custodial care***;
- Services for bone marrow transplants for the treatment of solid tumors in adults;
- All other transplants not indicated as ***covered transplant procedures***;
- Artificial organ implant procedures.

Urgent Care Services

Urgent care services for the treatment of an accident, ***injury*** or ***illness*** are covered. Refer to ***your Schedule of Benefits*** for details or contact ***Quartz*** Customer Success.

Vaccinations (215 ILCS 5/356z.71)

Quartz covers ***in-network*** vaccinations for COVID-19, influenza, and RSV, including the administration of the vaccine by a pharmacist or ***health care provider*** authorized to administer such a vaccine, without imposing a ***deductible***, ***co-insurance***, ***co-payment***, or any other cost-sharing requirement if the following conditions are met:

- The vaccine is authorized or licensed by the United States Food and Drug Administration (FDA); and,
- The vaccine is ordered and administered according to the Advisory Committee on Immunization Practices standard immunization schedule or according to the Guidelines for Communicable Disease Prevention issued by the Illinois Director of Public Health.

Quartz also covers these services without cost-sharing when administered by an ***out-of-network*** pharmacist or ***provider*** if these vaccinations are not otherwise available to be administered by an ***in-network provider*** or pharmacy.

Virtual Visits

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.

Vision Services and Eyewear

Coverage for Diabetic Members

Routine eye care provided by a vision care ***specialist*** (ophthalmologist or optometrist) is covered, with or without refraction.

Coverage for All Members

Contact lenses may be determined to be ***medically necessary*** and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be ***medically necessary*** and appropriate when the use of contact lenses, in place of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. 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. Also, the first pair of corrective lenses following cataract surgery are covered.

Adult Vision

For ***members*** age 19 and older:

Adult Eye Exam. Routine eye care provided by a vision care ***specialist*** (ophthalmologist or optometrist) is covered with or without refraction.

Adult Eyewear is not covered. **Fitting of Adult Eyewear** is not covered.

Pediatric Vision

For ***members*** under age 19:

- **Pediatric Eye Exam.** Routine eye care provided by a vision care ***specialist*** (ophthalmologist or optometrist) is covered with or without refraction.
- **Pediatric Eyewear**
  - One pair of lenses covered every ***benefit period***;
  - One set of frames are covered once every ***benefit period***. Designer frames are not covered;
  - One set of contact lenses may be covered in lieu of glasses every ***benefit period***;
- **Fitting of Pediatric Eyewear**

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

Wigs and Hair Prostheses

Coverage is provided for a wig or other scalp prosthesis worn for hair loss caused by alopecia, chemotherapy, or radiation treatment for cancer or other conditions, once per ***benefit period***.

Benefit Payment for Hospital Services

Inpatient and outpatient ***hospital*** services that are necessary for admission, diagnosis and treatment are covered.

Inpatient Care

Hospitals and Specialty Hospitals
Benefits are for semi-private room, ward or intensive care unit and necessary and reasonable ancillary ***hospital charges***. A private room is covered if ***medically necessary***.

Licensed Skilled Nursing Facility
The ***member*** must be admitted of discharge from a ***hospital*** for continued treatment of the same condition. Care must be ***skilled nursing care***. The daily rate payable under this benefit will be at least the daily minimum rate established for licensed ***skilled nursing care facilities***. Coverage under this benefit applies only to ***skilled nursing care*** that is certified as ***medically necessary*** by ***Quartz***.

Coverage is for the continued treatment of the same condition for which the ***member*** was treated in the ***hospital*** before entry into the ***skilled nursing facility***. There is no coverage for care that is:

- Essentially domiciliary or ***custodial care***;
- Available to the ***member*** without ***charge***; or,

- Paid for under a governmental health care program other than ***Medicaid***.

Nervous and Mental Disorders and Substance Use Disorder Confinements
See ***Behavioral Health and Substance Use Disorder Services*** in this section and the ***Schedule of Benefits*** for details.

Outpatient Care

Emergency Room
Emergency services are those services that are necessary to treat an ***emergency medical condition***. ***Emergency services*** include both professional and facility components. Follow-up care is not covered as an ***emergency service***.

Ambulatory Surgical Care
These are services provided in an outpatient setting. Unless specifically authorized in this ***certificate***, services may require ***prior authorization***.

Behavioral Health (Mental Health) Services
See ***Behavioral Health and Substance Use Disorder Services*** in this section and the ***Schedule of Benefits*** for benefit details.

Diagnostic Testing
Includes laboratory, radiology and other diagnostic tests.

Clinic Visits
Physician services and facility services associated with immunizations and well-child care.

Benefit Payment for Outpatient Prescription Drugs

You can visit our website at ***QuartzBenefits.com*** for a list of ***in-network pharmacies*** or call the Customer Success toll-free number on ***your identification card***. The pharmacies that are ***in-network*** may change. ***You*** should check with ***your*** pharmacy before obtaining drugs or supplies to make certain of its ***in-network*** status.

Definitions

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 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*** drugs and their ***biosimilars*** may be considered ***brand drugs***.

Compound Drugs
Those drugs or inert ingredients that have been measured and mixed with United States Food and Drug Administration (FDA)-approved pharmaceutical ingredients by a pharmacist to produce a unique formulation that is

medically necessary because commercial products either do not exist or do not exist in the correct dosage, size, or form.

Covered Drug

A ***formulary drug***:

1. Which is ***medically necessary*** and is ordered by a ***health care provider*** naming ***you*** as the recipient;
2. For which all ***formulary*** requirements, including any ***prior authorization*** requirements, have been met;
3. For which a written or verbal prescription order is provided by a ***health care provider***;
4. For which a separate charge is customarily made;
5. Which is not entirely consumed or administered at the time and place that the prescription order is written;
6. For which the FDA has given approval for at least one indication; and,
7. Which is dispensed by a pharmacy and is received by ***you*** while covered under this ***policy***, except when received from a ***provider's*** office, or during confinement while a patient in a ***hospital*** or other acute care institution or facility (refer to the Exclusions provision below).

Drugs that are eligible for coverage include:

1. Any ***prescription drug*** on ***Quartz's formulary list*** as a ***formulary drug***, including prescription contraceptives;
2. ***Over-the-counter*** contraceptives without a prescription, except male condoms are only covered with a prescription;
3. Injectable insulin, insulin syringes, glucose test strips, glucometers and continuous glucose monitors on ***Quartz's formulary list*** as ***formulary drugs*** or items;
4. 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;

5. 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***, unless state or federal laws prohibit ***Quartz*** from requiring a prescription; or,
6. 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.

Date of Service

Date of Service means the date the ***pharmacy*** submits the ***claim*** to ***Quartz***.

Formulary

Quartz's formulary contains a list of 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 drug formulary***.

Formulary List

A list of medications indicating formulary tier 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 also can 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***.

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*** or call the Customer Success toll-free number on ***your*** identification card.

Low-Cost Generic
A ***generic*** medication on ***Quartz's formulary*** that has been designated by ***Quartz*** as a ***low-cost generic drug***. Select ***brand*** medications may also be included in this ***formulary*** tier.

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.

Medically Necessary Prescription Drugs or Supplies

Prescription drugs or supplies which address the specific needs of an individual for purposes of screening, preventing, diagnosing, managing, treating, or minimizing the progression of an ***illness***, ***injury***, or condition or its symptoms and comorbidities, in a manner that is all of the following:

1. In accordance with generally accepted standards of care to treat that ***illness*** or ***injury***;
2. Not primarily for the economic benefit of ***Quartz*** or for the convenience of the ***member***, ***physician***, ***hospital*** or other health care ***provider***, caregiver, family member, or other interested party; and,
3. Clinically appropriate for the ***member*** in terms of type, frequency, extent, site, and duration.

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***. ***Quartz*** may also delegate criteria development and ***medical necessity*** reviews to other entities.

Non-Formulary Drug

A medication that (1) has not been designated by ***Quartz's*** Pharmacy and Therapeutics Committee as a ***formulary drug***, and (2) is not listed on the ***formulary list***. Medications new to the market are ***non-formulary drugs*** until a ***formulary*** determination has been made by ***Quartz***.

Non-Preferred Drug

A brand *or* generic medication that (1) is designated by ***Quartz's*** Pharmacy and Therapeutics Committee as a ***formulary drug***, and (2) 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***, and (2) 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. Orders written by a health care practitioner located outside the United States to be dispensed in the United States are not covered.

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 C.F.R. 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. ***Quartz*** will issue a ***prior authorization*** for this type of ***drug***.

Specialty Pharmaceutical or Specialty Drug

A ***drug*** that (1) is designated by the Pharmacy & Therapeutics Committee as being a ***specialty pharmaceutical***, and (2) is listed as specialty on ***Quartz's formulary list*** at ***QuartzBenefits.com***.

Tobacco Cessation Medication

A medication, including both prescription and ***over-the-counter drugs***, that is approved by the FDA for tobacco cessation.

About Your Benefits

1. **Formulary Drug List**
   The benefit levels of drugs listed on the ***formulary*** are selected by ***Quartz*** based upon the recommendations of a committee, which is made up of current and previously practicing physicians and pharmacists, some of whom are employed by or affiliated with ***Quartz***. The committee considers drugs regulated by the FDA for inclusion on the ***formulary***. As part of the process, the committee reviews data from clinical studies, published literature and opinions from experts who are not part of the committee. Some of the factors committee members evaluate include each drug's safety, effectiveness, cost and how it compares with drugs

currently on the ***formulary***. The committee considers drugs that are newly approved by the FDA, as well as those that have been on the market for some time. Entire drug classes are also regularly reviewed. Changes to the ***formulary*** can be made from time to time. Positive changes, such as adding drugs to the *formulary*, occur after review by the committee. ***Quartz*** will provide at least 60 days' advanced notice of changes to the ***formulary*** that affect medications ***you*** are receiving and could have an adverse financial impact to ***you*** (e.g., drug exclusion, drug moving to a higher payment tier, or drugs requiring ***prior authorization***). The notice will outline the changes and steps ***you*** or ***your*** prescriber can take to find alternative options or request continued coverage of the medication.

The ***formulary*** and any modifications will be made available to ***you***. ***Quartz*** may offer multiple formularies. By accessing the website at ***QuartzBenefits.com*** or calling the Customer Success toll-free number on ***your identification card***, ***you*** will be able to determine the ***formulary*** that applies to ***you*** and whether a particular drug is on the ***formulary***.

2. **Formulary Exception**
   Exceptions Process. There is an exceptions process to request consideration of coverage of clinically appropriate ***non-formulary drugs*** when the ***non-formulary drug*** is not otherwise specifically excluded.
   When Available. ***You***, ***your*** prescribing health care ***provider*** (***your*** "prescriber"), or ***your*** authorized representative, can ask for a ***formulary*** exception if ***your*** drug is not on (or is being removed from) the ***formulary***, and the alternative ***formulary prescription drug*** has been found to be (or is likely to be) not right for ***you*** or does not work as well in treating ***your*** condition.

   How to Request. To request this exception, ***you***, ***your*** prescriber, or ***your authorized representative***, can call the number on the back of ***your*** ID card to ask for a review. ***Quartz*** will let ***you***, ***your*** prescriber or authorized representative know the coverage decision within 72 hours after they receive ***your*** request.

When a Request Will Be Approved. A ***formulary*** exception request will not be denied if:

- The ***formulary prescription drug*** is contraindicated;
- The patient has tried the ***formulary prescription drug*** while under the patient's current or previous health insurance or ***health benefit plan*** and the prescribing ***provider*** submits evidence of failure or intolerance; or,
- The patient is stable on a ***prescription drug*** selected by their health care ***provider*** for the medical condition under consideration while on a current or previous health insurance or ***health benefit plan***.

Outcome of Exception Request. If the coverage request is denied, ***Quartz*** will let ***you***, ***your*** prescriber, or ***your*** authorized representative know why it was denied and offer ***you*** a covered alternative drug (if applicable). If ***your*** exception is denied, ***you*** may ***appeal*** the decision according to the appeals process ***you*** will receive with the denial determination. If ***your*** exception request is granted, it will be honored for 12 months following the date of the approval or until renewal of the plan, and ***co-pay*** or ***co-insurance*** will be at the ***non-preferred*** or ***Tier 4*** level, depending on the status of the medication.

When Expedited Review is Available. If ***you*** have a health condition that may jeopardize ***your*** life, health or keep ***you*** from regaining function, or ***your*** current drug therapy uses a non-covered drug ***you***, ***your*** prescriber or ***your*** authorized representative may be able to ask for an urgent review process. An **Expedited Request** is defined as a request for a situation when making routine or non-life-threatening determination could jeopardize ***your*** life, health, or safety or others, due to ***your*** psychological state, or in the opinion of ***your*** practitioner (as provided in documentation) could put ***you*** at risk for adverse health consequences without the medication being requested being available in an expedited manner. Without appropriate documentation justifying the urgency of the request, it may be treated as a standard request.

Coverage determination for an expedited request for a new medication therapy will be decided within 24 hours. If the request is denied, ***Quartz*** will let ***you***, ***your*** prescriber, or ***your*** authorized representative know why it was denied. If ***your*** exception is denied, ***you*** may ***appeal*** the decision according to the appeals process ***you*** will receive with the denial notification.

3. **Prior Authorization Requirements**
   When certain drugs, including ***restricted medications***, are prescribed, ***your provider*** will be required to obtain ***prior authorization*** from ***Quartz***. Failure to obtain the necessary ***prior authorization*** may result in a denial of coverage. If insurance coverage is denied at the pharmacy for failure to obtain ***prior authorization*** and ***you*** choose to purchase the ***prescription drug*** at ***your*** own cost, ***we*** will not reimburse ***you***. Medications included in this program are subject to change and other medications for other conditions may be added to the program.

   Although ***you*** may currently be on therapy, ***your claim*** may need to be reviewed to see if the criteria for coverage of further treatment has been met.

   To find out more about ***prior authorization*** requirements or to determine which drugs or drug classes require ***prior authorization***, please refer to the ***formulary*** and related pharmacy benefit content on our website at ***QuartzBenefits.com*** or call the Customer Success toll-free number on ***your identification card***. Per 215 ILCS 200, ***Quartz*** will provide advance notice of changing ***prior authorization*** requirements, and will not apply a change in coverage or approval criteria for a previously-authorized drug sooner than the end of the plan year.

4. **Persons with Autism Spectrum Disorder**
   We will not deny or refuse to provide medications for a person diagnosed with an ***Autism Spectrum Disorder*** on the basis that the individual declined an alternative medication when:

- The individual's health care ***provider*** has determined that such alternative medication may exacerbate clinical symptomatology and is medically contraindicated for the individual; and,
- The individual has requested and received a drug exception or ***prior authorization***.

5. **Coverage during shortage of generic drug or therapeutic equivalent shortage (215 ILCS 5/356z.75)**

   If you are prescribed a ***generic drug*** or a therapeutic equivalent that is listed as "Currently in Shortage" or as a "Discontinuation" in the FDA's Drug Shortages Database due to a supply issue and your dosage cannot be adjusted, a brand name FDA-approved drug that is not under patent will be covered until supply of the ***generic drug*** or therapeutic equivalent is available. This includes making an exception to the ***formulary*** if the ***brand drug*** is ***non-formulary***. Cost-sharing applicable to a ***non-preferred drug*** tier may apply.

Coverage and Benefits

1. **General Requirements**
   Prescription drug benefits are available for ***covered drugs*** prescribed by or at the direction of a ***provider***. The ***prescription drug*** must be ***medically necessary*** and must be ***prior authorized***, when required.

   The ***policy*** covers drugs appearing on ***Quartz's formulary list*** as a ***formulary drug,*** at the formulary tier in effect on the date ***you fill your prescription.*** The ***formulary list*** identifies the formulary tier under which the drug is covered, if applicable. ***Your Schedule of Benefits*** lists the formulary tiers that apply to ***your*** plan, the types of drugs that are covered under each tier, and the cost-sharing that applies to each tier.

Non-formulary drugs are not ***covered drugs***. ***In-network pharmacies*** automatically verify whether ***your prescription drug*** is covered under the ***formulary***.

Prescription drugs are subject to the requirements of ***Quartz's formulary***. A ***formulary list*** is available at ***QuartzBenefits.com*** or ***you*** may contact ***Quartz*** Customer Success.

2. **Cost-sharing**
   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 = one ***co-payment***, 31-60 day supply = two ***co-payments***, 61-90 day supply = three ***co-payments***). In cases where the pharmacy dispenses a claim for less than a 30-day supply of a maintenance medication 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.

   Per 215 ILCS 5/356z.41, cost-sharing on prescription insulin drugs will not exceed $35 for a 30-day supply, or a greater amount indexed by the Illinois Department of Insurance on an annual basis. "Prescription insulin drugs" includes drugs that contain insulin and are used to control blood glucose levels to treat diabetes but do not include insulin drugs administered to a patient intravenously.

3. **How Benefits are Paid**
   Benefits are payable for charges made by an ***in-network pharmacy*** for each separate prescription ***claim***.

Quartz will cover patient care fees to ***in-network pharmacies*** if reimbursement has been successfully negotiated and the service performed is within the scope of the pharmacist's licensure.

4. **Amounts from Manufacturer Offset Programs are Counted toward Cost-sharing**
   If the ***member*** used a pharmaceutical manufacturer program or other cost assistance to off-set ***out-of-pocket co-payment***, ***deductible***, or ***co-insurance*** for their prescription drug costs, those amounts will be applied to ***deductibles*** and ***out-of-pocket limits*** as indicated on the claim received by ***Quartz***.

5. **Restricted Medications**
   Restricted medications require ***prior authorization***.

6. **Preventive Medications**
   When prescribed by a ***physician*** or other health care ***provider***, ***formulary drugs*** listed on ***Quartz's formulary*** as ***preventive medications*** are covered without ***member*** cost-sharing when used in accordance with recommended preventive care guidelines.

   This includes coverage of ***tobacco cessation medications***, when prescribed by a healthcare ***provider***, for a 90-day treatment regimen, for at least two tobacco cessation attempts per calendar year.

7. **Cancer Medications**
   Orally-administered Chemotherapy Drugs. Benefits will be provided for self-administered oral cancer medications, intravenously administered cancer medications, or injected cancer medications that are dispensed by a community pharmacy and self-administered outside of a healthcare facility and used to kill or slow the growth of cancerous cells. Cost-sharing and treatment limitations applicable to orally-administered cancer medications are no more restrictive than cost-sharing and treatment limitations applied to intravenously administered or injected cancer

medications. There are no cost-sharing requirements or treatment limitations that are applicable only for prescribed orally-administered cancer medications.

Self-Administered Cancer Medications. Benefits will be provided for self-administered cancer medications, including pain medication.

Cancer Treatment and Treatment Indications. The specific indication for an FDA approved drug does not preclude benefits for the FDA approved drug when used for the treatment of other types of cancer, if documentation is provided in accordance with 215 ILCS 5/356z.7 and 215 ILCS 125/4-6.3.

8. **Injectable Drugs**
   Subject to the ***Quartz formulary***, benefits are available for ***medically necessary*** injectable drugs which are self–administered that require a written prescription by federal law, including epinephrine injectors (215 ILCS 5/356z.33). Benefits will not be provided for any self-administered drugs dispensed or administered by a ***physician***.

9. **Post-Transplant Immunosuppressant Drugs**
   Benefits are available for immunosuppressive drugs prescribed in connection with a human organ transplant. ***Quartz*** will provide at least 60-day advanced notice of any change to the ***formulary*** that affects prescription immunosuppressant drugs. When a prescribing ***provider*** has indicated on a prescription for post-transplant immunosuppressant drugs "may not substitute," ***Quartz*** will not require a pharmacist to substitute the drug without written consent from the prescribing ***provider*** and the patient. ***Quartz*** or its Pharmacy Benefit Manager may apply managed pharmacy care tools, including but not limited to formulary tiers, generic substitution, therapeutic interchange, or ***prior authorization***. An exception process is in place allowing the prescriber to petition for coverage of a ***non-formulary drug*** if sufficient clinical reasons justify an exception to the normal protocol.

10. **Immune Gamma Globulin Therapy**
    Immune gamma globulin therapy for persons diagnosed with a primary immunodeficiency is covered when prescribed by a ***physician*** and determined ***medically necessary***. Initial authorization will in no case be less than three months; reauthorization may occur every six months thereafter. For persons who have been in treatment for two years, reauthorization will be no less than every 12 months, unless more frequently indicated by ***your physician***.

11. **Opioid Antagonist**
    Benefits will be provided for at least one ***opioid antagonist*** drug, including the medication product, administration devices, and any pharmacy administration fees related to the dispensing of the ***opioid antagonist***. This includes refills for expired or utilized opioid antagonists. **Opioid Antagonist** means a drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors, including, but not limited to, naloxone hydrochloride or any other similarly acting drug approved by the U.S. Food and Drug Administration. Naloxone hydrochloride is covered with no ***co-payment***, per 215 ILCS 5/356z.23.

12. **Diabetic Supplies for Treatment of Diabetes**
    Subject to the ***Quartz formulary*** and 215 ILCS 5/356w (d), benefits are available for ***medically necessary*** items of diabetic supplies that a ***provider*** has written an order. Such diabetes supplies shall include, but are not limited to, the following:
    - Test strips specified for use with a corresponding blood glucose monitor;
    - Glucose test solutions;
    - Glucagon;
    - Glucose tablets;
    - Lancets and lancet devices;
    - Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein;
    - Insulin and insulin analog preparations;

- Insulin cartridges;
- Injection aids, including devices used to assist with insulin injection and needleless systems;
- Insulin syringes;
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels; and,
- Glucagon emergency kits.

13. **Fertility Drugs**
    Benefits are available for ***medically necessary*** fertility drugs, in connection with the diagnosis and treatment of ***infertility***, with a written prescription.

14. **Opioid Medically Assisted Treatment (MAT)**
    Benefits are available for formulary MAT drugs without restriction. This includes formulary intranasal opioid reversal agents when prescribed by ***your provider*** to accompany an initial opioid prescription with a dosage of 50 MME or higher.

15. **Topical Anti-Inflammatory Pain Medication**
    Quartz covers topical anti-inflammatory pain medications for acute and chronic pain without quantitative limits.

16. **Menopause Therapy**
    Quartz covers ***medically necessary*** hormonal and non-hormonal therapy to treat menopausal symptoms if the therapy is recommended by a qualified health care ***provider*** who is licensed, accredited, or certified under Illinois law and the therapy has been proven safe and effective in peer-reviewed scientific studies. Coverage includes all FDA-approved modalities of hormonal and non-hormonal administration including, but not limited to, oral, transdermal topical, and vaginal rings (215 ILCS 5/356z.56).

17. **Hormone Therapy to Treat Gender Dysphoria**
    Quartz covers hormone therapy medications to treat ***gender dysphoria*** per 215 ILCS 5/356z.60, without restriction or delay. The drugs and follow-up services do not apply cost-sharing.

18. **Vaginal Estrogen**
    Quartz covers at least one therapeutic equivalent version of vaginal estrogen. If a particular vaginal estrogen product or its FDA-approved therapeutic equivalent version is determined to be ***medically necessary***, cost-sharing will not exceed the cost-sharing requirement imposed on a prescription drug authorized for treatment of erectile dysfunction, covered by the ***policy*** (215 ILCS 5/356z.67).

19. **HIV Pre-exposure Prophylaxis and Post-exposure Prophylaxis Drugs**
    Quartz covers HIV pre-exposure prophylaxis and post-exposure prophylaxis drugs per 215 ILCS 5/356z.60, without restriction or delay. The drugs and follow-up services do not apply cost-sharing.

20. **Prenatal Vitamins**
    Per 215 ILCS 5/356z.58, prenatal vitamins are covered when prescribed by a ***physician*** licensed to practice medicine in all of its branches or an advanced practice registered nurse licensed under the Nurse Practice Act of Illinois.

21. **Direct Member Reimbursement for Out-of-Network Pharmacy**
    Benefits are payable for ***prescription drugs*** obtained from an ***out-of-network pharmacy*** at greater cost-sharing than those obtained from an ***in-network pharmacy***. ***Your out-of-pocket costs*** are only eligible for reimbursement when a completed Direct Member Reimbursement Form and an itemized paid prescription receipt are submitted to ***Quartz***. Amounts in excess of the ***usual, customary and reasonable charge*** are not covered benefits and are the responsibility of the ***member***.

22. **When Quartz Coverage is Secondary**

Members with a ***Quartz prescription drug*** benefit as secondary coverage must request ***prior authorization*** for secondary coverage of ***restricted medications***. In other words, even if ***your*** primary carrier is paying benefits for a ***restricted medication***, that does not by itself mean that ***Quartz*** will also pay benefits for a ***restricted medication***.

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.

23. **Brand Drugs with an Equivalent Generic Version**

Brand drugs for which there is an available equivalent ***generic drug*** may be ***non-formulary*** and require an approved ***formulary exception*** for coverage. ***Quartz*** will provide at least 60 days' advanced notice of changes to the ***formulary*** that affect medications ***you*** are receiving and could have an adverse financial impact to ***you***. As a cost-saving measure, ***Quartz*** may opt to cover a ***brand drug*** as the preferred option instead of the equivalent ***generic drug***.

Similarly, ***biologic reference*** products for which there is an approved ***biosimilar*** may be ***non-formulary*** and require an approved formulary exception for coverage. ***Quartz*** will provide at least 60 days' advanced notice of changes to the ***formulary*** that affect medications ***you*** are receiving and could have an adverse financial impact to ***you***. As a cost-saving measure, ***Quartz*** may opt to cover the ***biologic reference*** as the preferred option instead of the ***biosimilar***.

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.

24. **Synchronization**

Synchronization means the coordination of medication refills for a patient taking two or more medications for a chronic condition such that the patient's medications are refilled on the same schedule for a given time period. At least once per insured per ***benefit period***, synchronization will occur for covered maintenance medications. The following medications are not subject to synchronization:

- Schedule II, III, or IV controlled substances;
- ***Prescription drugs*** that have special handling or sourcing needs that require a single, designated pharmacy to fill or refill the prescription;
- ***Prescription drugs*** are of a formulation that cannot safely be split into short-fill periods to achieve synchronization.

Prorated daily cost-sharing rates are offered to permit synchronization, when necessary.

Prescription drugs subject to synchronization must meet this ***policy's*** clinical coverage criteria and all utilization management criteria specific to the ***prescription drugs*** at the time of synchronization.

Limitations

1. **Day Supply Limits**

Coverage for outpatient medications is limited to the quantity prescribed by the ***physician*** and one fill or refill cannot exceed:

- A 90-day supply; or
- A supply of more than 90 days if dispensing a single commercially prepared unit of an unbreakable of an unbreakable quantity.

Per 215 ILCS 5/356z.4, ***Quartz*** also provides coverage for the dispensing of 12 months' worth of contraception at one time.

In order to be eligible for coverage under this ***policy***, the prescribed day supply must be ***medically necessary*** and must not exceed the maximum day supply limitation described in this ***policy***. Payment for benefits covered under this Benefit Section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation.

However, early prescription refills of topical eye medication used to treat a chronic condition of the eye will be eligible for coverage after at least 75% of the predicted days of use and the early refills requested do not exceed the total number of refills prescribed by the prescribing ***physician*** or Optometrist.

Prescription Inhalers. ***Quartz*** will not deny or limit coverage for a prescription inhalers based on the number of days before an inhaler refill may be obtained if:

- The inhalant enables breathing when a person suffers from asthma or other life-threatening bronchial ailments;
- The inhalant has been ordered or prescribed by the ***attending physician***;
- The inhalant is ***medically necessary***.

Your cost for a 30-day supply of a prescription inhaler will not exceed $25. The ***deductible*** does not apply.

Exclusions

Drug benefits are **not** covered for the following:

1. Any ***non-formulary drug***, unless a formulary exception request has been approved by ***Quartz***;

2. Any ***formulary drug*** when the formulary requirements for coverage have not been met. For example, ***prior authorization*** not approved, etc. See ***Quartz's formulary list*** on our website for the requirements applicable to our ***formulary drugs***;
3. Medical devices and non-medical substances unless listed on the ***formulary***;
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) unless listed on the ***formulary***;
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 a long-term antibiotic therapy which has been approved by the FDA and prescribed for the treatment of tick-borne illnesses, as defined under 215 ILCS 5/356z.35; or,
    - Is prescribed for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection;
    - 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 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 more than one year after the initial prescription order was written;
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. Any ***prescription drug*** for a procedure not covered by ***your*** medical health insurance ***Certificate of Coverage***;
12. Any ***prescription drug*** for an ***illness*** or ***injury*** not covered by ***your*** medical health insurance ***Certificate of Coverage***;
13. ***Over-the-counter medications***, with or without a prescription order, unless the medication has been approved by ***Quartz***. Approved ***over-the-counter medications*** are listed on ***Quartz's formulary list*** as ***formulary drugs***;
14. ***Prescription drugs*** that are covered, or the ***member*** is entitled to receive, from any Workers' Compensation law or any municipal state or federal program;
15. ***Prescription drugs*** the ***member*** is entitled to receive without charge;
16. Nutritional products and special food or feedings, unless specifically listed on the ***Quartz formulary***;
17. ***Medical foods*** not listed on ***Quartz's formulary list*** as ***formulary drugs***, regardless of whether they are prescribed to ***you***;
18. Any outpatient ***drug claim*** with a date of service prior to the ***member's*** effective date of coverage under the ***plan*** or after the ***member's*** termination date;
19. ***Prescription drugs*** used for cosmetic treatment, including but not limited to Tretinoic Acid (Retin A);
20. Irrigation solutions and supplies;
21. Early refills;

22. Homeopathic medications;
23. Medications used to facilitate, obtain, maintain, enhance or prevent pain with sexual performance;
24. Vaccines, unless the vaccine has been approved by ***Quartz***. Preventive immunizations are covered as specifically stated in ***your Certificate of Coverage***;
25. Medications purchased from a pharmacy or other establishment located outside the United States for consumption inside the United States;
26. Medications used to treat growth retardation, including growth hormones, except if clinical criteria are met. Coverage is not extended for short stature syndrome or other related growth abnormalities;
27. 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;
28. 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; and,
29. ***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.

Out-of-Network Services Requiring Prior Authorization

Prior authorization is required to receive coverage for certain services. Visit ***QuartzBenefits.com/PPOPAList*** or contact ***Quartz*** Customer Success for services requiring ***prior authorization***. If a ***prior authorization*** is not obtained when one is required, the service will not be considered a ***covered service*** and ***you*** will be responsible for payment. ***Providers*** may not be familiar with ***Quartz's prior authorization*** requirements. Therefore, when ***you*** seek services, it is ultimately ***your*** responsibility to arrange for ***prior authorization***.

Note: For inpatient hospital treatment, ***you*** will not incur a penalty solely for failing to obtain ***prior authorization***.

At least three business days before ***you*** plan to receive the service, ***you*** or ***your provider*** should contact ***Quartz*** Customer Success to obtain ***prior authorization***. ***You*** will need the following information:

- ***Your member*** number;
- The name of ***your primary care physician***;
- The name of the ***provider*** who will provide the service;
- Telephone number of the ***provider***,
- Procedure to be performed,
- Date of the procedure;
- Name of the facility at which the procedure will be performed; and,
- Telephone number of the facility.

Customer Success will explain ***your*** benefits and transfer ***you*** to the appropriate representative to obtain ***prior authorization***.

You will receive written authorization or denial from ***Quartz*** regarding coverage of the requested service. An authorization will indicate all services approved for coverage and the location where services are to be received. ***Quartz*** will mail the authorization to ***you***. If there is not sufficient time to mail the authorization or denial, Medical Management will call ***you*** with the

information. If a denial is issued, a reason for the denial will be given along with information about ***Quartz's grievance*** process.

Section 4: Exclusions and Limitations

Exclusions

Your plan does not provide coverage for any of the following:

Surgical Services

1. Procedures to correct obesity or treat the complications or co-morbidities of obesity. Treatment of complications arising from such procedures are also excluded. This exclusion does not apply to bariatric surgery services, if specifically covered in Section 3: Covered Services and Specific Exclusions;
2. Removal of excess skin resulting from weight loss, other than panniculectomy;
3. Plastic or cosmetic surgery, including chemical peel, undertaken solely to improve the ***member's*** appearance. Surgeries to correct a functional defect caused by ***congenital*** deformities (including the treatment of cleft lip and cleft palate), accidental injuries, scars, tumors or diseases are not considered cosmetic services subject to this ***exclusion***;
4. Treatment, services and supplies for cosmetic or beautifying purposes, including removal of keloids;
5. ***Reconstructive surgery***, unless the purpose is to correct a functional defect or provide ***medically necessary reconstructive services*** performed on structures of the body damaged by trauma, that are intended to restore physical appearance;
6. Breast augmentation and any treatment for complications resulting from these procedures. This ***exclusion*** does not apply to ***medically necessary*** breast reduction surgery (215 ILCS 5/356z.54), the reconstruction of affected tissue incident to a mastectomy or for complications of mastectomy, including lymphedema;
7. Refractive eye surgery for vision correction;
8. Removal of skin tags;
9. Penile implants and other erection devices; and,

10. Robotic-assisted surgeries.

Medical Services

1. Examinations and assessments required for employment, participation in sports, licensing, education or insurance; or any ***third-party*** request, including court-ordered treatment that does not otherwise qualify for coverage;
2. Immunizations covered or requested by an employer, educational institution or other ***third party***;
3. Expenses for the preparation and presentation of medical reports and records;
4. Weight control programs. This exclusion does not apply to services provided through ***care management*** to members who are eligible for and enrolled in a ***Quartz***-sponsored clinical or disease management program;
5. ***Custodial care*** and ***maintenance and supportive care*** and/or ***therapy*** and ***long-term therapy***;
6. Sublingual (under the tongue) allergy testing and/or 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,
7. Any health care service, item or investigational drug that is the subject of a clinical trial; any health care service, item or drug provided solely to satisfy data collection and analysis needs that is not used in the direct clinical management of the patient; an investigational drug or device that has not been approved for marketing by the United States Food and Drug Administration (FDA); any service, item or drug provided by the clinical trial sponsor free of ***charge*** for any patient; or any service, item or drug that is eligible for reimbursement by an entity other than ***Quartz***, including the sponsor of the clinical trial.

Ambulance Services

Travel and transportation for a consultation or to receive non-emergent treatment, unless ***Quartz prior authorizes*** the ambulance service.

Therapies

1. ***Long-term therapy*** and ***maintenance and supportive care*** and/or ***therapy*** for chronic conditions, unless otherwise specified as covered in this ***certificate***. Therapies of this type include but are not limited to general exercise programs, maintenance exercise programs, physical conditioning programs, massage therapy, assistance with ***activities of daily living***, and any therapy services that are not ***medically necessary***;
2. Physical therapy services for athletic performance enhancement purposes;
3. Relationship counseling;
4. Vocational rehabilitation, including work-hardening programs;
5. Massage therapy;
6. Group homes and halfway houses for supportive and maintenance care;
7. Recreational or non-skilled services or activities conducted through wilderness and camp programs, therapeutic boarding schools and academy-vocational programs;
8. Prolotherapy that is not ***medically necessary*** and has not been ***prior authorized***; and,
9. Platelet-rich plasma therapy.

Oral Surgery and Dental Services

All dental procedures, including but not limited to examination, care, treatment, filling, removal, restoration or replacement of teeth, dental implants, and any oral surgical procedure not listed as a benefit under Section 3: Covered Services and Specific Exclusions. This ***exclusion*** does not apply to covered oral surgery procedures or covered dental services required because of accidental ***injury***.

Transplants

1. Transplants not listed as a covered benefit under Section 3: Covered Services and Specific Exclusions;
2. Follow-up care related to non-covered transplant procedures;
3. Medical or other costs related to the donation of organ(s) intended for a person who is not a ***Quartz member***; and,
4. Anti-rejection and immuno-suppressive drugs for non-covered transplant procedures.

Reproductive Services

1. Reversal of voluntary sterilization procedures and related procedures;
2. ***Charges*** for services rendered to a ***surrogate*** who is not a ***member***, after the ***surrogate*** is discharged to regular obstetric care, and any other services rendered to the ***surrogate*** that are not directly related to the covered ***member's infertility***;
3. Professional services for home delivery for childbirth. This exclusion does not include services rendered by a licensed midwife or perinatal doula; and,
4. Male condoms except when prescribed by a ***provider***.

Hospital Inpatient Services

1. Personal comfort or convenience items, including but not limited to, television, telephone, housekeeping and homemaker services. ***Charges*** for a private room will not be covered unless ***medically necessary***; and,
2. ***Hospital charges*** for services not covered under Section 3 of this ***policy***.

Outpatient Prescription Drugs

1. ***Prescription drugs*** prescribed for cosmetic purposes or for conditions or treatments that are not covered benefits under this ***policy*** (for example, ***prescription drugs*** related to the treatment of obesity);
2. 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;

3. ***Prescription drugs*** not approved by the FDA and those 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 is a long-term antibiotic therapy which has been approved by the FDA and prescribed for the treatment of tick-borne illnesses, as defined under 215 ILCS 5/356z.35.

Durable Medical Equipment (DME) and Disposable Medical Supplies

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. The repair or the replacement of ***durable medical equipment*** **(DME)**, other than those items that are covered specifically in Section 3: Covered Services and Specific Exclusions. Also excluded are the repair and replacement of DME that is covered by a warranty, homeowner's insurance policy, or other similar policy;
4. Eyeglasses and contact lenses and fittings for contact lenses, except as described under the Vision Services section in Article III: Covered Services;
5. Specialty intraocular lenses (over the cost of a standard monofocal 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;

6. Orthopedic shoes, unless they are part of a brace. Orthopedic shoes may be covered for ***members*** with diabetes if ***prior authorized*** by ***Quartz***;
7. Back-up supplies, back-up equipment or back-up prostheses;
8. Repair or replacement of supplies, equipment or prostheses if lost or stolen;
9. Repair or replacement of supplies, equipment or prostheses if unusable or non-functioning, because of misuse, abuse or neglect;
10. Optional accessories or devices primarily for the ***member's*** comfort or convenience; footwear; and orthodontic devices;
11. Elastic support stockings that are not ***medically necessary***; foot pads; bunion covers; batteries; antiseptics; tape; over-the-counter shoe inserts; supports; and elastic bandages;
12. Customization of vehicles and/or lifts for wheelchairs and/or scooters.
13. Any and all types of modifications to the ***member's*** home and items associated with such modifications (e.g., ramps, grab bars, stair lifts and chair lifts);
14. Items that are generally considered to be comfort or convenience items (e.g., personal sound amplification products (PSAPs)). 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***; and
15. Alternative communication devices (e.g., electronic keyboard for a hearing impairment, computers, hand-held phones or devices).

General

1. Any service that is not ***medically necessary***. Any service that is not required in accordance with accepted standards of medical, surgical or psychiatric practice. ***Hospital*** stays extended for reasons other than ***medical necessity*** are not covered and become the ***member's*** responsibility for payment. For example, inclement weather, lack of

transportation, lack of a caregiver at home and other social reasons do not justify coverage for an extended ***hospital*** stay;

2. Services obtained that require ***prior authorization*** and that the ***member*** did not receive ***prior authorization*** for are not covered. Treatments, services, or supplies in excess of what was ***prior authorized*** by ***Quartz*** will not be covered;
3. Treatment, services and supplies that exceed any maximum benefit limit specified in this ***policy***;
4. Any service for which the ***member*** refuses to authorize or provide for the release of medical information, including the names of all ***physicians*** and ***providers you*** received medical attention from, and information regarding the circumstances of ***your injury***;
5. ***Experimental or investigational*** treatment, services, devices and supplies;
6. Nutritional supplements, special feedings, and meal services that are part of a Home Health Care Program. This ***exclusion*** does not apply to items covered under "Nutritional Supplements" in Section 3: Covered Services and Specific Exclusions;
7. Services rendered by a masseuse or massage therapist;
8. Hypnotherapy;
9. Orthoptics (eye exercise-training programs);
10. Private duty nursing;
11. Custodial, domiciliary or convalescent care that does not require ***skilled care***;
12. Coma stimulation programs;
13. Hypnotherapy, acupuncture and laser treatment for smoking cessation;
14. Services that ***Quartz*** has no legal obligation to cover, such as services provided by free clinics and government programs;
15. ***Charges*** for services or items that the ***member*** has no legal obligation to pay;
16. Amounts paid for by or services provided under a federal, state, county, municipal or other governmental agency or law now existing, or subsequently enacted or amended, such as ***Medicare*** and

Veterans Administration programs covering service-connected disabilities or conditions; services covered under "No-Fault" automobile insurance; services related to any ***illness*** or ***injury*** covered by a Worker's Compensation Act or employer liability law;

17. Health and benefit expenses incurred before coverage under this ***policy*** begins and after coverage or eligibility terminates;
18. Any federal, state or local taxes due on benefits, goods or services; shipping and handling charges;
19. Services required while incarcerated in a federal, state or local penal institution, or services required while in custody of federal, state or local law enforcement authorities. This ***exclusion*** includes criminal competency evaluations. However, ***Quartz*** will pay for ***medically necessary*** mental health and substance use disorder services if required under 215 ILCS 370c;
20. **Illegal Occupation**: Any condition, disability or ***charge*** resulting from or sustained as a result of being engaged in an illegal occupation or the commission or attempted commission of an assault or a criminal act. Per 215 ILCS 5/357.24, the company shall not be liable for 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;
21. Services provided to or received by a ***member*** as a collateral medical procedure in connection with the treatment of any person who is not a ***member***;
22. Services, care or treatment for medical complications resulting from or associated with ***non-covered services***, including items or services to prepare for ***non-covered procedures***;
23. Any treatment or service rendered by a person residing in ***your*** home or rendered by a ***member*** of ***your immediate family*** or any other person related to ***you*** or a ***dependent*** in a similar fashion. 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;

24. Treatment, services and supplies not specifically identified by ***Quartz*** as being covered;
25. Expenses related to repatriation and medical evacuation;
26. Travel expenses including but not limited to rental car services, tolls, mileage reimbursement, gas, lodging, food, and airfare;
27. ***Foreign claims*** (except for emergency care). See the "Emergency Services" section. ***Members*** should always bring their ***Quartz*** ID Card when traveling inside or outside the United States;
28. Hair removal, unless authorized by ***Quartz*** as part of covered gender-affirming care;
29. Hair transplantation;
30. Wart removal except when ***medically necessary***, including:
    - physical pain/discomfort;
    - bleeding, inflammation, or infection;
    - risk of cancer; or,
    - functional impairment (e.g., restrict eye function, blocking an orifice);
31. The clinically-administered medications eteplirsen (Exondys 51), golodirsen (Vyvondys 53), casimersen (Amondys 45), and vitolarsen (Viltepso);
32. Cellular and gene therapies (except CAR-T) are excluded from coverage unless reviewed and approved for coverage, for a particular indication, by ***Quartz***. Review by ***Quartz*** will occur within required state and federal timelines. The coverage status of cellular and gene therapies (except CAR-T) is listed on ***Quartz's*** Restricted Medical Benefit Drug list posted on ***Quartz's*** website;
33. This ***policy*** does not pay or reimburse ***you*** for services ***you*** administer to ***yourself***, even if ***you*** are a ***provider***;
34. Any items offered over-the-counter that are not listed as covered in ***your policy*** documents;
35. Amounts charged to a ***member*** for services that were not rendered; and
36. Fitness or health tracking devices and related memberships, unless provided as part of a ***Quartz***-sponsored clinical, ***care management***

or disease management program, or when items are provided through ***care management***.

Limitations

Major Disaster or Epidemic

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

Circumstances Beyond the Control of Quartz

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

Treatment of Growth Retardation

Treatment of growth retardation is covered only when clinical criteria are met. Coverage is not extended for short stature syndrome or other related growth abnormalities.

Proof of Claim

You must submit proof of claim within 90 days of the date of service. Circumstances beyond ***your*** control might make this time limit unreasonable. If so, ***you*** must file the claim as soon as possible, and ***we*** will still process ***your*** claim if ***you*** submit it within one year after the time required under this provision.

If ***you*** are submitting ***claims*** for which ***you*** have already paid, and ***you*** are seeking ***Quartz's*** reimbursement, ***you*** must provide proof of payment. The bill or receipt from ***your provider*** must match the service that ***you*** are seeking ***Quartz's*** reimbursement for.

Specialty Providers

All specialty services must be ***medically necessary*** and a ***covered service*** under the ***plan***.

Out-of-Pocket Costs

Your Schedule of Benefits includes details relating to ***co-payments***, ***co-insurance*** and ***deductibles*** which may apply to office visits, specialty visits, inpatient ***hospital*** stays, emergency room visits and urgent care facility visits. ***Your Schedule of Benefits*** identifies the amount of ***co-payment***, ***co-insurance*** and/or ***deductible*** applicable to ***your plan***.

Other Limitations

In addition to the limitations listed in this ***Certificate of Coverage***, see the limitations in ***your Schedule of Benefits***.

Section 5: Coordination of Benefits

If ***you*** have health care coverage through another group program, individual ***policy***, or pharmacy benefit manager, ***Quartz*** will coordinate the payment of benefits in accordance with applicable law and as set forth in this ***Coordination of Benefits*** **(COB)** provision. The purpose of this provision is to ensure that ***you*** receive the benefits to which ***you*** are entitled without providing more benefits than the total cost of care received.

No policy shall reduce benefits solely on account of the existence of similar benefits provided under other policies where such reduction would reduce total benefits payable below an amount equal to 100% of total allowable expenses provided under the policies.

Definitions

Plan for the purposes of this Coordination of Benefits Section means any of the following that provides benefits or services for, or because of, medical or dental care:

- Individual or group insurance or group-type coverage, whether insured or uninsured (self-insured). This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage; or,
- Coverage under a governmental plan, or coverage 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 (42 USC 301 et seq.), as amended from time to time). It also does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.

Each contract or other arrangement for coverage described above is a separate ***plan***. Also, if an arrangement has two parts and Coordination of Benefits rules apply only to one of the two, each of the parts is a separate ***plan***.

Plan does not include:

- Hospital indemnity coverage benefits or other fixed indemnity coverage;
- Accident-only coverage;
- Specified disease or specified accident coverage;
- Limited benefit health coverage;
- School accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis;
- Benefits provided in long-term care insurance policies for nonmedical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care, or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
- Medicare Advantage policies;
- Medicare supplement policies;
- A state plan under Medicaid;
- A governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan; or,
- Disability income protection coverage.

This Plan or **This Quartz Plan** means the ***group health plan*** offered by ***Quartz*** and described in this ***Certificate of Coverage***.

Primary Plan means the ***plan*** that pays for health care expenses first. When ***this Quartz plan*** is a ***primary plan***, its benefits are determined before those of the other plan and without considering the other plan's benefits.

Secondary Plan means the ***plan*** that pays for health care expenses after the ***primary plan*** pays. When ***this Quartz plan*** is a ***secondary plan***, its benefits are determined after those of the other plan and may be reduced because of the other ***plan's*** benefits.

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

Allowable Expense means a necessary, reasonable and customary item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the ***claim*** is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an ***allowable expense*** under this definition unless the patient's stay in a private hospital room is ***medically necessary*** either in terms of generally accepted medical practice or as specifically defined in the ***plan***. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an ***allowable expense*** and a benefit paid.

Claim Determination Period means the ***benefit period***. However, it does not include any part of a year during which a person has no coverage under ***this Quartz plan***, or any part of a year before the date this Coordination of Benefits provision or a similar provision takes effect.

Effect of Benefits

Quartz will apply these provisions when ***you*** incur ***allowable expenses***, during a ***benefit 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 ***benefit 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; and,
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 a ***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.

Order of Benefit Determination

This ***plan*** determines the order of benefits using the first of the following rules that applies:

1. **Non-Dependent before Dependent**

   The benefits of the ***plan*** that covers the person as an ***employee*** or ***subscriber*** (that is, other than a ***dependent***) are determined before those of the ***plan*** that covers the person as ***dependent***.

2. **Dependent Child - Parents Not Separated or Divorced**

   When this ***plan*** and another ***plan*** cover the same ***child*** as a ***dependent*** of different ***subscribers***:

- The ***plan*** benefits of the parent whose birthday (month and day) falls earlier in a calendar year are determined before those of the ***plan*** of the parent whose birthday falls later in the year; and,
- If both parents have the same birthday, whichever parent's plan has been in effect longer is primary.

Birthday means the month and day (e.g., January 20th) the parent was born. The year of birth is not considered when determining which parent's birthday comes first. Determining the order of plans by looking to whose birthday falls earlier in the year is referred to as the **Birthday Rule**.

3. **Dependent Child - Separated or Divorced Parents**

If two or more ***plans*** cover a person as a ***dependent child*** of divorced or separated parents, benefits for the ***child*** are determined in this order:

- When parents are separated or divorced and the parent with custody of the ***child*** has not remarried, the benefits of a ***plan*** that covers the ***child*** as a ***dependent*** of the parent with custody of the ***child*** will be determined before the benefits of a ***plan*** that covers the ***child*** as a ***dependent*** of the parent without custody;
- If two or more ***plans*** cover a person as a ***dependent child*** of divorced or separated parents and the parent with custody of the ***child*** has remarried, benefits for the ***child*** are determined in the following order:
  - First, the ***plan*** of the parent with custody of the ***child***;
  - Then, the ***plan*** of the spouse of the parent with custody of the ***child***; and,
  - Finally, the ***plan*** of the parent not having custody of the ***child***;
- However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the ***child***, and the entity obligated to pay or provide the benefits of the ***plan*** of that parent has actual knowledge of those terms, the benefits of that ***plan*** are determined first. This paragraph does

not apply with respect to any ***benefit period*** during which any benefits are actually paid or provided before the entity has that actual knowledge. It is the obligation of the person claiming benefits to notify ***Quartz*** and, upon ***Quartz's*** request, to provide a copy of the court decree.

4. **Dependent Child - if Parents Share Joint Custody**

   If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the ***child***, the ***plans*** covering the ***child*** will follow the ***Birthday Rule*** described in #2.

5. **Young Adult Dependent**

   For an adult ***dependent child*** who has coverage under either or both parents' ***plans*** and also has his or her own coverage as a ***dependent*** under a spouse's plan, the ***longer/shorter*** rule described in #8 applies.

   In the event the ***dependent child's*** coverage under the spouse's plan began on the same date as the ***dependent child's*** coverage under either or both parents' plans, the order of benefits will be determined by applying the ***Birthday Rule*** described in #2 to the ***dependent child's*** parent or parents and the ***dependent's*** spouse.

6. **Active Employee before Inactive Employee**

   The benefits of a ***plan*** that covers a person as a laid-off or retired ***employee*** or as the ***dependent*** of laid-off or retired ***employee*** are determined after the benefits of a ***plan*** that covers such person through present employment.

7. **Continuation Coverage is Secondary**

   If a person has continuation coverage under Federal or State law and is also covered under another ***plan***, the ***plan*** covering the person as an ***employee***, ***member*** or ***subscriber*** or as a ***dependent*** of an ***employee***, ***member*** or ***subscriber*** is the ***primary plan*** and the continuation coverage is the ***secondary plan***.

8. **Longer Length of Coverage before Shorter Length of Coverage**

   The benefits of a ***plan*** that has covered the ***member*** for the longer length of time are determined before the benefits of a ***plan*** that has covered such person for the shorter length of time. This rule is referred to as the "**Longer/Shorter Rule**."

Whenever one ***plan*** does not contain a COB provision, that ***plan*** must pay its benefits before any other ***plan*** pays.

When these provisions reduce the total amount of benefits otherwise payable to ***you*** under this ***plan*** during any ***benefit period***, each benefit that would be payable in the absence of this provision is reduced proportionately and such reduced amounts are charged against any applicable benefit limit under this ***plan***.

Right to Receive and Release Necessary Information

Quartz may require certain information to coordinate these provisions with other ***plans***. To get the needed information, ***Quartz*** may, without ***your*** consent, release or obtain from any insurance company, organization, or person information needed to implement this provision. ***You*** agree to notify ***Quartz*** of the existence of any other group coverage that ***you*** have and to furnish any information ***Quartz*** needs to apply these provisions.

Coordination of Benefits with Medicare

This section explains how the benefits under this ***plan*** work with benefits available under ***Medicare***.

When ***we*** say ***Medicare***, ***we*** mean the health insurance provided by Title XVIII of the Social Security Act, as amended. It also includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of ***Medicare***.

You are eligible for ***Medicare*** when ***you*** meet the criteria for coverage because of:

- ***Your*** age;
- A disability; or,
- End-stage renal disease (ESRD).

You are also eligible for ***Medicare*** even if ***you*** are not enrolled because ***you***:

- Refused it;
- Dropped it; or,
- Did not make a proper request for it.

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

Sometimes, ***this plan*** is the ***primary plan***, which means that the ***plan*** pays benefits before ***Medicare*** pays benefits. Sometimes, ***this plan*** is the ***secondary plan***, and pays benefits after ***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***.

Per 215 ILCS 370c, this provision of the certificate will not be enforced for ***medically necessary*** mental health and substance use disorder services.

Coordination of Benefits with ***Medicare*** depends on how the ***member*** qualifies for ***Medicare***, the type of coverage the ***member*** has, and how large the ***member's*** employer is. Below is a brief summary of the situations when ***Medicare*** pays primary.

Coordination of Benefits with Medicare			
Circumstances	**Additional Conditions**	**Primary Payer**	**Secondary Payer**
Age-based Medicare entitlement + coverage due to current employment status	Employer has 20 or more employees	Group health plan	Medicare
Age-based Medicare entitlement + coverage due to current employment status	Employer has fewer than 20 employees	Medicare	Group health plan
Age-based Medicare entitlement + retiree health coverage or COBRA	N/A	Medicare	Group health plan
Disability-based Medicare entitlement + coverage due to current employment status	Employer has 100 or more employees	Group health plan	Medicare
Disability-based Medicare entitlement + coverage due to current employment status	Employer has fewer than 100 employees	Medicare	Group health plan
Disability-based Medicare entitlement + retiree health coverage or COBRA	N/A	Medicare	Group health plan

ESRD-based Medicare eligibility or entitlement + group health coverage (including coverage due to current employment status, retiree health coverage, or COBRA)	First 30 months of Medicare eligibility or entitlement	Group health plan	Medicare
ESRD-based Medicare eligibility or entitlement + group health coverage (including coverage due to current employment status, retiree health coverage, or COBRA)	After 30 months of Medicare eligibility or entitlement	Medicare	Group health plan

Facility of Payment

A payment made under another ***plan*** may include an amount that should have been paid under this ***plan***. If this occurs, ***Quartz*** may pay that amount to the organization that made that payment. That amount will then be treated as if it were a benefit paid under this ***plan***. ***Quartz*** will be fully discharged from liability under this ***plan*** to the extent of any payment so made. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right to Recovery

We are assigned the right to recover from the negligent ***third party***, or his or her insurer, to the extent of the benefits we paid for that sickness or injury. ***You*** are required to furnish any information or assistance, or provide any documents that *we* may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the ***third party*** admits liability.

Quartz reserves 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:

- Any person(s) to, for or with respect to whom, such payments were made; or,
- 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.

Reimbursement Provision

If ***you*** or one of ***your*** covered ***dependents*** (if ***you*** have family coverage) incur expenses for sickness or ***injury*** that occurred due to the negligence of a ***third party*** and benefits are provided for ***covered services*** described in this ***policy***, ***you*** agree:

- ***Quartz*** has the right to reimbursement for all benefits ***Quartz*** provided from any and all damages collected from the ***third party*** for those same expenses whether by action at law, settlement, or compromise, by ***you*** or ***your*** legal representative as a result of that sickness or ***injury***, in the amount of the total eligible ***charge*** or ***provider's claim***

charge for ***covered services*** for which ***Quartz*** has provided benefits to ***you***, reduced by any Average Discount Percentage ("ADP") applicable to ***your claim*** or ***claims***;

- ***Quartz*** is assigned the right to recover from the ***third party***, or his or her insurer, to the extent of the benefits ***Quartz*** provided for that sickness or ***injury***.

Quartz shall have the right to first reimbursement out of all funds ***you***, ***your*** covered ***dependents***, or ***your*** legal representative, are or were able to obtain from the same expenses for which ***Quartz*** has provided benefits as a result of that sickness or ***injury***.

You are required to furnish any information or assistance or provide any documents that ***Quartz*** may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the ***third party*** admits liability.

Premium rates are based upon the amount of taxes, fees, surcharges or other amounts currently in effect by various governmental agencies. If the amount of taxes, fees, surcharges or other amounts which ***Quartz*** is required to pay or remit are increased during the ***benefit year***, ***Quartz*** reserves the right, at its option, to ***charge*** policyholder for such amounts or adjust the ***premium*** rates to reflect such increase, on the ***effective date*** of such increase. Upon request, policyholder shall furnish to ***Quartz*** in a timely manner all information necessary for the calculation or administration of any such taxes, fees, surcharges or amounts.

The Affordable Care Act (ACA) requires that covered entities providing health insurance ("health insurer") pay an annual fee to the federal government (the "Health Insurer Fee"). The amount of this fee for a calendar year will be determined by the federal government and currently involves a formula based in part on a health insurer's net ***premiums*** from the preceding calendar year. In addition, ACA and/or other applicable laws may provide for the establishment of temporary transitional reinsurance program(s) that may

be funded by reinsurance contributions or other amounts (collectively, the "Reinsurance Fees or Amounts") from health insurance issuers and/or self-funded group ***health plans***. Federal and/or state governments may provide information as to how the Reinsurance Fees or Amounts are calculated. ***Your premium*** will include the Health Insurer Fees and the Reinsurance Fees or Amounts, if any.

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 not a Beneficiary of the Group's Workers' Compensation Policy.**
   Quartz will not deny claims solely based on the existence of the Group Policyholder's Workers' Compensation policy when all 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 not a beneficiary under the Workers' Compensation policy.

3. **When the Group Policyholder is under no obligation to Carry Workers' Compensation Coverage.**
   Quartz will not 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 not 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 Workers' Compensation coverage required by law, ***Quartz*** will not 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:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
2. No final determination is made that the ***injury*** or ***illness*** was sustained in the course of or resulted from ***your*** employment;
3. The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by ***you*** or the Workers' Compensation carrier;
4. 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: Obtaining Services 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 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 6: Eligibility and Effective Date of Coverage

Employee Enrollment

Employee Eligibility

See the PPO Employee Plan Eligibility Map at http://quartzbenefits.com/PPOEligibilityMap for the current information on where an ***employee*** may live and be eligible for a PPO plan. ***Quartz*** considers an ***employee's*** "residence" to be the location in which they spends at least nine months out of a 12-month period. The ***employee's*** county of residence is based on the United States Postal Service (USPS) record.

Eligibility for coverage begins on the date an ***employee*** meets all eligibility criteria specified on the ***Group Application*** and ***Group Master Policy Agreement***. Note: An individual may not be enrolled as both an eligible ***employee*** subscriber and as a ***child dependent***, ***dependent*** parent or stepparent, or ***dependent*** spouse/partner in ***civil union*** under the same employer group ***policy***.

Employee Enrollment and Effective Date

An ***employee*** may apply for enrollment in the ***plan*** by submitting a completed Enrollment Form and, if necessary, an employer's certification of group ***health plan*** coverage, or other acceptable documentation as indicated by federal law. Application must be made (1) within 31 days of becoming eligible, (2) during an annual ***open enrollment period*** (if offered by ***your*** employer), or (3) following the application requirements for ***special enrollment***. The Enrollment Form may be obtained from the group's benefit administrator. An enrolled ***employee*** may also change plans during the ***special enrollment period*** when gaining a ***dependent*** through marriage, birth, legal guardianship, adoption or placement for adoption, or when enrolling a ***dependent*** due to involuntary loss of other coverage.

Quartz, at its discretion, and with the mutual agreement of the employer, may allow for an ***open enrollment period*** or a Dual Choice Enrollment Period.

New Entrant

A new entrant may enroll within 31 days from the date he or she is eligible to enroll and will be covered on the date ***Quartz*** specifies. A new entrant is an ***employee*** who becomes part of the group after the first enrollment period.

Dependent Enrollment

Eligibility & Effective Date of Coverage

Each ***dependent*** must be enrolled on an ***Enrollment Application Form*** or electronically through ***QuartzBenefits.com***.

Except for continuation, an ***employee*** may cover ***dependents*** only if the ***employee*** is covered.

Except for full-time students, ***Quartz*** considers a ***dependent's*** "residence" to be the location in which he or she spends at least nine months out of a 12-month period.

A ***dependent's effective date*** may never be prior to the ***employee's effective date***.

Dependent Type	**Eligibility for Coverage Begins**	**Effective Date of Coverage**
New Subscriber's Dependents	The date the ***employee*** is eligible for coverage, if the ***employee*** has ***dependents***	A new entrant may enroll within 31 days from the date he or she is notified of the

	who may be covered on that date.	opportunity to enroll and will be covered on the date ***Quartz*** specifies. A ***dependent*** is a new entrant: ▪ When an ***employee*** becomes part of the group after the first enrollment period; or, ▪ If a court orders the ***dependent*** to be covered under the ***policy*** and the ***dependent*** requests coverage after issuance of the court order; or, ▪ The ***dependent*** did not enroll during an enrollment period and, at that time, was covered by a health insurance ***benefit plan***, involuntarily loses that coverage, and requests coverage under this ***plan*** within 31 days after the termination of the health insurance ***benefit plan*** coverage.
Spouse, Partner, or Children Acquired though	Depends on ***your*** employer's ***Group Master Policy Agreement***. Eligibility begins either:	If the Enrollment Form is received by ***Quartz*** before the ***dependent's*** eligibility date, the ***dependent*** is covered on the date he or she is eligible.

Marriage or Civil Union	▪ The date of the ***employee's*** marriage or ***civil union***; or, ▪ The first day of the month following the date of the marriage for any ***dependent*** acquired through the marriage or civil union.	If the Enrollment Form is received after the ***dependent's*** eligibility date, but within 31 days from the eligibility date, the ***dependent*** is covered on the date the enrollment is approved by ***Quartz***.
Newborn	The date of birth of the **employee's *child***. Newborns are covered from the moment of birth.	The ***employee*** has 60 days from the date of birth of a ***child*** to apply for ***dependent*** coverage effective on the newborn's birth date. This ***certificate*** covers the ***hospital*** or medical expenses of newborn infants from the moment of birth. ***You*** must notify ***us*** of a newly-born ***child*** within 60 days after the date of birth in order to have the coverage continue. ***You*** must also pay the required ***premium***. 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 due ***premium***.

Adopted Child, Foster Child or Placed Child	Whichever occurs first: ▪ The date a minor ***child*** is placed in the ***employee's*** home for adoption or foster care; ▪ The date that a court issues an interim court order of adoption; ▪ The date that a court issues a final order granting adoption of the minor ***child***; or, ▪ The date legal guardianship of the minor ***child*** is awarded to the ***employee***.	The ***employee*** has 60 days from the date a minor ***child*** is placed in the custody of the ***employee*** or from the eligibility date to apply for ***dependent*** coverage effective on the date of eligibility.
Disabled Dependent	The first of the month after the ***dependent*** attains the limiting age (26th birthday for most **dependents**).	Written proof of incapacity and dependency must be provided to ***Quartz*** within 31 days after the ***dependent*** has attained the limiting age. See the definition of ***dependent*** for additional requirements.
Military Veteran Dependents	Military veteran ***dependents*** under the age of 30 may apply for coverage if the veteran: ▪ Is an Illinois resident; ▪ Is not married; ▪ Has served in the active or reserve components of the U.S. Armed Forces	***Effective date*** is first of the month after ***Quartz*** receives the completed Enrollment Form. However, if ***Quartz*** receives the Enrollment Form between the 16th and the 31st of the month, the ***effective date*** will be the 1st of the month following.

	(including the National Guard); and, ▪ Has received a release or discharge other than dishonorable.	

Domestic Partners

Definitions

Domestic Partners

Domestic Partners are two individuals who, together, meet all of the following criteria:

1. Are 18 years of age or older;
2. Are competent to enter into a contract;
3. Are not legally married to, nor the domestic partner of, any other person;
4. Are not related by marriage;
5. Are not related by blood closer than permitted under the marriage laws of the State of Illinois;
6. Have entered into the domestic partner relationship voluntarily, willingly and without reservation;
7. Have entered into a relationship which is the functional equivalent of a marriage, and which includes all of the following:
   - Living together as a couple;
   - Mutual support of each other;
   - Mutual caring and commitment to one another;
   - Mutual fidelity;
   - Mutual responsibility for each other's welfare; and,
   - Joint responsibility for the necessities of life;
8. Have been living together as a couple for at least six months prior to applying for domestic partner coverage under this ***policy***; and,

9. Intend to continue the domestic partner relationship indefinitely, with the understanding that the relationship is terminable at the will of either partner.

Eligibility Criteria

Domestic Partners

To be eligible to enroll as ***Domestic Partners***, the ***subscriber*** and their ***Domestic Partner*** must satisfy all of the following:

1. Meet the definition of ***"Domestic Partners"*** as specified in the "Definitions" section.
2. The ***subscriber*** and their ***Domestic Partner*** have declared that they:
   - Are in a committed, and a mutually exclusive relationship; and,
   - Neither party has given the other party written notice rescinding that declaration;
3. Neither the ***subscriber*** nor the ***Domestic Partner*** is:
   - Currently married or legally separated to or from any other person; and,
   - If either individual has been a party to an action or proceeding for divorce or annulment, then at least six months shall have elapsed since the date of the judgment terminating that marriage;
4. Neither the ***subscriber*** nor their ***Domestic Partner*** is currently engaged in a domestic partnership nor are they registered with a municipality, county, or state in a domestic partnership with a different partner. If either party has previously registered with a different partner, then at least six months shall have elapsed since the registration was terminated;
5. The ***subscriber*** and their ***Domestic Partner*** currently reside at, and intend to continue to reside in, the same principal residence;
6. The ***subscriber*** and their ***Domestic Partner*** must be jointly prepared to demonstrate at least two or more of the following:
   - Evidence of the joint purchase and ownership of a home. Purchase of a residence with a business account is not sufficient

evidence, unless the business is a family farm business co-owned by the ***Domestic Partners***;

- A copy of a lease for a residence which identifies both the ***subscriber*** and their ***Domestic Partner*** as responsible for payment of rent under the lease;
- Evidence of a joint personal checking account which has been in effect and valid for at least 6 months;
- Evidence of a joint personal savings account which has been in effect and valid for at least six months;
- Documentation demonstrating joint ownership of a car (title, registration, or confirmation of ownership from the Department of Motor Vehicles);
- Evidence of joint use and liability for credit cards;
- A copy of a policy declaration page specifying that the ***Domestic Partner*** is the beneficiary under a policy of life insurance issued to the ***subscriber***, or vice versa;
- Evidence that the ***Domestic Partner*** is the beneficiary of the ***subscriber's*** deferred compensation or other retirement plan, or vice versa;
- Evidence of durable powers of attorney:
    - For property which satisfies Illinois statutory requirements; or,
    - For health which satisfies Illinois statutory requirements;
- The ***subscriber's*** last will and testament which specifies that their ***Domestic Partner*** is the major recipient of the ***subscriber's*** financial and real property assets; or,
- Other forms of documentary evidence which depicts significant joint personal financial interdependency between the ***subscriber*** and their ***Domestic Partner***.

The criteria above cannot be met with a shared business account, jointly shared business credit card, jointly shared business automobile or any other co-ownership created by a shared business endeavor. The evidence must demonstrate joint, personal financial interdependency. However, ***Quartz*** will

accept evidence of financial interdependency related to a family farm business co-owned by the ***Domestic Partners***.

Children of Domestic Partners

To be eligible to enroll as a ***dependent child*** of the ***subscriber's Domestic Partner***, the ***dependent child*** must satisfy all the following requirements:

1. The ***child*** is under age 26; and,
2. The ***child*** is a ***dependent*** of the ***subscriber*** or ***Domestic Partner*** for full or partial support.

Enrollment Criteria

A Domestic Partnership Affidavit must be fully completed within 31 days of the ***subscriber's*** initial eligibility.

Special Enrollment Period

Establishment of Domestic Partner Relationship. If an individual becomes a ***Domestic Partner*** of a ***subscriber*** after the ***subscriber's*** initial date of eligibility, and wishes to enroll as a ***dependent*** of the ***subscriber***, then the ***Domestic Partner*** may enroll within 31 days of both:

- The establishment of a ***Domestic Partner*** relationship; and,
- The execution of a fully completed "Affidavit of Domestic Partnership," certifying the date that the domestic partnership began and compliance with eligibility guidelines.

Termination of Domestic Partner Coverage

Coverage for the ***Domestic Partner*** will terminate when there is a change in one or more of the qualifying conditions as noted in the "Eligibility for Domestic Partners" section.

Coverage for the ***dependent child*** of a ***Domestic Partner*** will terminate:

- When there is a change in one or more of the qualifying conditions above in the "Eligibility for Domestic Partners" section;

- When there is a change in one or more of the qualifying conditions above in the "Eligibility for Children of Domestic Partners" section.

Right to Continuation Coverage

The Domestic Partner ***dependent*** will be entitled to continuation coverage in the same manner as a spousal ***dependent*** after a divorce or annulment of a marriage, as specified in the ***Group Master Policy Agreement*** and ***Certificate of Coverage***.

Changes to Your Enrollment Form

Changes to the original ***Enrollment Form***, other than ***physician*** changes, must be made by completing a new ***Enrollment Form*** or by submitting the change electronically by logging onto ***QuartzBenefits.com***.

When Coverage Ends

Employers and employees should provide notification of an event triggering termination promptly but no later than 60 days following the event terminating coverage. If ***Quartz*** receives late notification of the event terminating coverage, ***Quartz*** will not refund premium at the group's request more than 90 days from the date ***Quartz*** was notified.

Coverage terminates for ***employees*** and covered ***dependents*** when any of the following occurs:

Event Terminating Coverage	**Date Coverage Ends**
Group *Policy* Ends	The date ***your*** employer's ***Group Master Policy Agreement*** ends.

Discontinuing Product ***Quartz*** discontinues ***policy***.	We will only discontinue a particular type of health insurance coverage upon the renewal date of the coverage, with 90 days' notice to insureds. In the event of termination, ***you*** may purchase any other products ***we*** offer in ***your*** market.
Employment Ends The ***employee's*** employment ends.	End of the month in which the ***employee's*** employment with the group ***policyholder*** ends or the ***employee*** no longer meets the definition of an "active" employee. * However, see "Continuation Coverage" for circumstances when coverage will continue.
Retirement The ***employee*** retires.	End of the month in which the ***employee*** retires. However, if ***your*** employer maintains retiree coverage, ***you*** may complete the Retiree ***Group Application Form***.
Loss of Eligibility - Employee The ***employee*** ceases to meet eligibility requirements or is no longer in a class of ***employees*** that is eligible for coverage under the ***policy***.	End of the month in which the ***employee*** no longer meets the eligibility requirements.
Loss of Eligibility - Dependent For example, when the ***dependent*** reaches limiting age for coverage or the marriage or ***civil union*** ends.	End of the month in which the ***dependent*** no longer meets the eligibility requirements. For a parent/stepparent insured as a qualifying relative of a

	member, the date coverage terminates for that ***member***. A ***dependent*** (except for a ***dependent child*** under age 26), ceases to be eligible for coverage as a ***dependent*** on the date he or she is: ▪ Insured as a ***subscriber*** in or through any other ***health plan***; or, ▪ On active duty with the military service, including National Guard or reserves, other than for duty of less than 30 days.
Voluntary Disenrollment The ***member*** requests voluntary ***disenrollment***.	End of the month in which the ***employee*** requests voluntary ***disenrollment***.
Failure to Pay Required Premium or Contributions	**Grace Period**. A grace period of 10 days will be granted for the payment of each ***premium*** falling due after the first ***premium***, during which grace period the ***policy*** shall continue in force. If payment is not made before the end of the ***grace period***, coverage terminates on the last day of the last month when full ***premium*** was received.
Disenrollment ***Quartz*** ends ***your*** coverage.	We will give ***you*** 30 days' advance written notice if we end ***your*** coverage because ***you*** do not cooperate or give facts that we need to administer the ***Coordination of Benefits (COB)*** provisions.

	We may <u>immediately</u> end ***your*** coverage if: ▪ ***You*** commit fraud or intentionally misrepresent ***yourself*** when ***you*** applied for or obtained coverage. Any statement made is considered a representation and not a warranty. We will only use a statement during a dispute if it is shared with ***you*** and ***your*** beneficiary, or the person making the ***claim***; ▪ ***You*** allow a non-***member*** to use ***your identification card*** to obtain ***covered services***; or, ▪ ***You*** act in such a disruptive way as to prevent or adversely affect our operations or those of a network ***provider***. On the date ***your*** coverage ends, we will refund to ***your*** employer any prepayments for periods after the date ***your*** coverage ended. As an Illinois resident, if ***your*** coverage lapses due to military service and ***you*** were honorably discharged, ***you*** and ***your dependents*** who may have been eligible for a federal government sponsored health insurance program may be reinstated in this plan. Reinstatement is subject to payment of the current required contribution.

*Per HIPAA Final Rules – Nondiscrimination in Health Coverage in the Group Market at 45 C.F.R. §146.121, an ***employee*** is considered to be in "active" status if they are actively working or if they are absent from work due to any health factor such as being absent from work on sick leave. If not actively working, an ***employee*** must, also meet all of the following conditions to be considered in "active" status and eligible for coverage under the ***policy***:

- The ***employee*** retains employment rights in the industry;
- The ***employee*** has not had their employment terminated by the employer, if the employer provides the coverage, or has not had their membership in an employee organization (such as an association or union) terminated, if the employee organization provides the coverage;
- The ***employee*** is not receiving disability payments from an employer for more than six months;
- The ***employee*** is not receiving Social Security disability benefits; and,
- The ***employee*** has employment-based group health plan coverage that is not COBRA continuation coverage.

Cancellation

The company may cancel this ***policy*** at any time by written notice delivered to the insured, or mailed to his last address as shown by the records of the company, stating when, not less than 30 days thereafter, such cancellation shall be effective; and after the ***policy*** has been continued beyond its original term the insured may cancel this ***policy*** at any time by written notice delivered or mailed to the company, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the company will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the company cancels, the earned premium shall be computed pro-rata.

Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

Reinstatement

If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the company or by any agent duly authorized by the company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the ***policy***; provided, however, that if the company or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the ***policy*** will be reinstated upon approval of such application by the company or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the company has previously notified the insured in writing of its disapproval of such application. The reinstated ***policy*** shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and company shall have the same rights thereunder as they had under the ***policy*** immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Continuation Coverage

Illinois State Continuation

The ***member*** may have the right to continue coverage under the ***plan*** if the ***member*** ceases to meet eligibility requirements. A ***member*** may elect this option if:

1. **Eligibility Ends.** The ***subscriber*** is an ***employee*** whose eligibility for group coverage terminates (the option is not available if the ***employee*** was fired for misconduct on the job); or,

2. **Former Spouse or Former Partner in a *Civil Union*.**
   - The ***dependent*** is the former spouse of an ***employee***, and the marriage ends due to divorce or annulment while ***dependent*** coverage is in effect; or,
   - The ***dependent*** is the former partner in a ***civil union*** with the ***employee*** and the ***civil union*** is dissolved while ***dependent*** coverage is in effect; or,

3. **Surviving Dependent.** An Employee dies while ***dependent*** coverage is in effect and the ***dependent*** is a surviving ***dependent*** spouse, partner in a ***civil union***, or ***child*** of the ***employee***. Per 215 ILCS 5/367(5), this coverage may continue at least 90 days, subject to termination provisions generally applicable to dependents under the ***policy***.

In order to qualify for Illinois state continuation coverage, the ***employee*** must have been continuously covered under the ***Group Master Policy Agreement*** during the entire three-month period preceding termination from ***this health plan***. Illinois state continuation will not be available for any ***member*** who is covered by Medicare Part A and/or Part B. Illinois state continuation will not be available for any ***member*** who is subsequently covered by any other insured or uninsured plan that provides hospital, surgical, or medical coverage for individuals in a group.

Within 10 days of the ***employee*** or ***member's*** termination, the Employer will mail a written notice stating that Illinois state continuation is available to the ***employee*** and his or her covered ***dependents***. Following termination from the ***policy***, the ***employee*** will have 60 days to request Illinois state continuation.

Illinois state continuation coverage ends as soon as any one of the following events occurs:

- Twelve months elapse following the ***employee*** or covered ***dependent's*** termination from this group ***health plan*** , or when twenty-four months elapse, if eligible for Illinois spousal continuation under 215 ILCS 5/367.2 or dependent child continuation under 215 ILCS 5/367.2-5;
- A former spouse of the ***employee*** remarries;
- If the ***employee*** or ***member*** fails to make timely payment of a required contribution, the end of the period for which contributions were made;
- The date the ***policyholder*** terminates the ***Group Master Policy Agreement***;
- Illinois state continuation will also end whenever any person on continuation becomes eligible for Medicare; or,
- Following termination in this group ***health plan***, the ***employee*** or covered ***dependent*** becomes covered by any other insured or uninsured ***plan*** that provides hospital, surgical, or medical coverage for individual in a group.

However, in the event that the ***employee's*** spouse is 55 years old or older at the time coverage is lost due to the retirement or death of the ***employee***, or due to divorce, the spouse of the retired ***employee***/former spouse and any otherwise eligible ***dependents*** may be able to continue on the plan until the spouse/former spouse is eligible for Medicare. Additional premium may be collected by ***Quartz*** if the continuation coverage extends longer than twenty-four months, up to 20% more than the rate that would be assessed the ***member*** under active ***employee*** coverage.

Federally-Required Continuation Coverage (COBRA)

COBRA gives some people the right to keep their health coverage for 18, 29 or 36 months after a "qualifying event." COBRA usually applies to employers with 20 or more employees.

How do you enroll in COBRA?
You enroll by sending in an application and paying the ***premium***. ***Your*** employer has 30 days to send ***you*** a COBRA election notice. It will tell ***you*** how to enroll and how much it will cost. ***You*** can take 60 days from the qualifying event to decide if ***you*** want to enroll. ***You*** need to send ***your*** application and pay the ***premium***. If this is completed on time, ***you*** have enrolled in COBRA.
When is your first premium payment due?

Your first ***premium*** payment must be made within 45 days after the date of the COBRA election.

How much will COBRA coverage cost?
You and ***your dependents*** will pay 100% of the total COBRA plan costs.

Can you add a dependent to your COBRA coverage?
You may add a new ***dependent*** during a period of COBRA coverage. They can be added for the rest of the COBRA coverage period if:

- They meet the definition of an eligible ***dependent****;*
- ***You*** notified ***your*** employer within 31 days of their eligibility; and,
- ***You*** pay the additional required ***premiums***.

When does COBRA coverage end?
COBRA coverage ends if:

- Coverage has continued for the maximum period;
- The ***plan*** ends. If the ***plan*** is replaced, ***you*** may be continued under the new ***plan***;
- ***You*** and ***your dependents*** fail to make the necessary payments on time;

- ***You*** or a covered ***dependent*** become entitled to benefits under ***Medicare***; or,
- ***You*** or ***your dependents*** are continuing coverage during the 19th to 29th months of a disability, and the disability ends.

Continuation of Coverage for Other Reasons
To request an extension of coverage, call the toll-free Member Services number on ***your*** ID card.

Extension of Coverage Due to Total Disability

If ***Quartz*** terminates coverage under the ***policy*** for any reason other than the employer's failure to pay required ***premiums*** for all ***members*** of the group, and a ***member*** is ***totally disabled*** on the date of termination, ***Quartz*** will continue to provide coverage until:

- ***You*** or the ***dependent*** are no longer ***totally disabled****;*
- ***You*** become covered by another health benefits plan; or,
- Twelve consecutive months of coverage have passed since the date ***you*** or ***your dependent*** otherwise would have been terminated absent the ***total disability***.

The ***employee subscriber*** is ***totally disabled*** if ***you*** cannot work at ***your*** own occupation; or after 24 months, ***you*** cannot perform the duties of any gainful occupation for which ***you*** are reasonably fitted by training, education or experience.

Dependent - Total Disability. A ***dependent*** is ***totally disabled*** if that person cannot engage in most normal activities of a healthy person of the same age and gender.

Disabled Dependent

You have the right to extend coverage for ***your dependent child*** beyond the plan age limits if ***your*** disabled ***child***:

- Is not able to be self-supporting because of mental or physical disability; and,
- Depends mainly on ***you*** or another care ***provider*** for lifetime care and supervision.

The right to coverage will continue only as long as a ***physician*** certifies that ***your child*** still is disabled.

We may ask ***you*** to send us proof of the disability within 90 days of the date coverage would have ended. Before ***we*** extend coverage, ***we*** may ask that ***your child*** get a physical exam. ***We*** will pay for that exam.

We may ask ***you*** to send proof that ***your child*** is disabled after coverage is extended. ***We*** won't ask for this proof more than once a year. ***You*** must send it to ***us*** within 31 days of ***our*** request. If ***you*** don't, ***we*** can terminate coverage for ***your dependent child***.

Extension of Coverage Due to Medical Leave of Absence from School

We continue to provide coverage for a ***dependent*** college student who has taken a medical leave of absence or reduced to part-time status due to a catastrophic ***illness*** or ***injury***.

Continuation is subject to all the ***policy's*** terms and conditions and will terminate 12 months after the notice of the ***illness*** or ***injury*** or until coverage would have otherwise lapsed.

To extend coverage the leave of absence must:

- Begin while the ***dependent child*** is suffering from a serious ***illness*** or ***injury***;
- Cause the ***dependent child*** to lose status as a full-time student under the plan; and,
- Be certified by the treating doctor as ***medically necessary*** due to a serious ***illness*** or ***injury***.

The doctor treating ***your child*** will be asked to keep us informed of any changes.

Section 7: Claim Determination

If a Claim Is Denied or Not Paid in Full

If the claim for benefit is denied, ***you*** or ***your authorized representative*** will be notified in writing of the following:

1. The reasons for determination;
2. A reference to the ***benefit plan*** provisions on which the denial is based, or the contractual, administrative or protocol for the determination;
3. A description of additional information which may be necessary to perfect an ***appeal*** and an explanation of why such material is necessary;
4. Subject to privacy laws and other restrictions, if any, the identification of the ***claim***, date of service, health care ***provider***, ***claim*** amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
5. An explanation of ***Quartz's*** internal ***appeals*** and the ***external review*** processes (and how to initiate a review, ***appeal*** or ***external review***). Specifically, this explanation will include:
    - An explanation that if ***your*** case qualifies for ***external review***, an ***Independent Review Organization*** will review ***your*** case (including any data ***you'd*** like to add);
    - An explanation that ***you*** may ask for an ***external review*** with an ***Independent Review Organization (IRO)*** not associated with ***Quartz*** if ***your appeal*** was denied based on any of the reasons below. ***You*** may also ask for ***external review*** if ***Quartz*** failed to give ***you*** a timely decision, and ***your*** claim was denied for one of these reasons:
        - A decision about the medical need for or the experimental status of a recommended treatment;
        - ***Your*** health care coverage was rescinded;

To ask for an ***external review***, complete the Request for ***external review form*** that will be provided to ***you*** as part of this notice and available at insurance.illinois.gov/externalreview and submit it to the Department of Insurance at the address shown below for ***external reviews***;

- An explanation that ***you*** may ask for an expedited (urgent) ***external review*** if:
  - Failure to get treatment in the time needed to complete an ***expedited appeal*** or an ***external review*** would seriously harm ***your*** life, health or ability to regain maximum function;
  - ***Quartz*** failed to give ***you*** a decision within 48 hours of ***your*** request for an ***expedited appeal***; or,
  - The request for treatment is ***experimental or investigational*** and ***your*** health care ***provider*** states in writing that the treatment would be much less effective if not promptly started;
- If the written notice is for a ***final adverse benefit determination***, the notice will include an explanation that ***you*** may ask for an expedited (urgent) ***external review*** if the ***final adverse benefit determination*** concerns an admission, availability of care, continued stay, or health care service for which the covered person received ***emergency services***, but has not been discharged from a facility;
- Decisions on standard ***appeals*** are considered timely if ***Quartz*** sends ***you*** a written decision for ***appeals*** that need medical review within 15 business days after we receive any needed information, but no later than 30 calendar days of receipt of the request. All other ***appeals*** will be answered within 30 calendar days if ***you*** are appealing before getting a service or within 60 calendar days if ***you've*** already received the service. Decisions on ***expedited appeals*** are considered timely if ***Quartz*** sends ***you*** a written decision with 48 hours of ***your*** request for an ***expedited appeal***;

6. A statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
7. A statement in non-English language(s) that indicates how to access the language services provided by ***Quartz***;
8. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
9. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
10. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
11. In the case of a denial of an urgent care clinical claim, a description of the expedited review procedure applicable to such claims. An urgent care clinical claim decision may be provided orally, so long as written notice is furnished to the claimant within three days of oral notification; and,
12. The following contact information for the Illinois Department of Insurance consumer assistance and ombudsman:

For complaints and general inquiries:

Mail to Chicago or Springfield	Illinois Department of Insurance Office of Consumer Health Insurance 115 S. LaSalle Street, 13th Floor Chicago, IL 60603 Illinois Department of Insurance Office of Consumer Health Insurance

	4800 Wabash Avenue Springfield, IL 62711
Toll-free phone	(877) 527-9431
Fax number	(217) 558-2083
Email address	DOI.complaints@illinois.gov
Web	https://idoihelpcenter.illinois.gov/s/

For ***external review*** requests:

Mail to	Illinois Department of Insurance Office of Consumer Health Insurance External Review Unit 4800 Wabash Avenue Springfield, IL 62711
Toll-free phone	(877) 850-4740
Fax number	(217) 557-8495
Email address	Doi.externalreview@illinois.gov
Web	https://idoihelpcenter.illinois.gov/s/

Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of claim. There are three types of claims as defined below.

1. **Urgent Care Claim** is any pre-service claim that requires ***prior authorization***, as described in this ***certificate***, as a prerequisite for receiving benefits for medical care or treatment with respect to which the application of regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the

opinion of a ***physician*** with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without care or treatment.

2. **Pre-Service Claim** is any non-urgent request for benefits or a determination with respect to which the terms of the ***benefit plan*** condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.

3. **Post-Service Claim** is notification in a form acceptable to ***Quartz*** that a service has been rendered or furnished to ***you***. This notification must include full details of the service received, including ***your*** name, age, sex, identification number, the name and address of the ***provider***, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the ***claim charge***, and any other information which ***Quartz*** may request in connection with services rendered to ***you***.

Urgent Care Claims

Type of Notice or Extension	**Timing**
If ***your*** claim is incomplete, ***Quartz*** must notify ***you*** within:	**24 hours***
If ***you*** are notified that ***your*** claim is incomplete, ***you*** must then provide completed claim information to ***Quartz*** within:	**48 hours after receiving notice**
Quartz *must notify* ***you*** *of the claim determination (whether adverse or not)*:	

If the initial claim is complete as soon as possible (taking into account medical exigencies), but no later than:	**72 hours**
After receiving the completed claim (if the initial claim is incomplete), within:	**48 hours**

You do not need to submit ***appeals*** of urgent care claims in writing. ***You*** should call ***Quartz*** at the toll-free number listed on the back of ***your identification card*** as soon as possible to ***appeal*** an urgent care clinical claim.
*Notification may be oral unless the claimant requests written notification.

Pre-Service Claims

Type of Notice or Extension	**Timing**
If ***your*** claim is filed improperly, ***Quartz*** must notify ***you*** within:	**5 days***
If ***your*** claim is incomplete, ***Quartz*** must notify ***you*** within:	**15 days**
If ***you*** are notified that ***your*** claim is incomplete, ***you*** must then provide completed claim information to ***Quartz*** within:	**45 days after receiving notice**
Quartz *must notify* ***you*** *of the claim determination (whether adverse or not)*:	
If the initial claim is complete, within:	**15 days****

After receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
If ***you*** require post-stabilization care after an emergency within:	**The time appropriate to the circumstance not to exceed one hour after the time of request.*** **

* Notification may be oral unless the claimant requests written notification.
** This period may be extended one time by ***Quartz*** for up to 15 days, provided that ***Quartz*** both (1) determines that such an extension is necessary due to matters beyond the control of the ***plan*** and (2) notifies ***you***, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which ***Quartz*** expects to render a decision.
*** If after two documented good faith efforts the treating healthcare provider has not been able to reach ***Quartz***, costs for covered post-stabilization services will be reimbursed. See 215 ILCS 134/70.

Post-Service Claims

Type of Notice or Extension	**Timing**
If ***your*** claim is incomplete, ***Quartz*** must notify ***you*** within:	**30 days**
If ***you*** are notified that ***your*** claim is incomplete, ***you*** must then provide completed claim information to ***Quartz*** within:	**45 days after receiving notice**
Quartz *must notify* ***you*** *of the claim determination (whether adverse or not)*:	

If the initial claim is complete, within:	**30 days***
After receiving the completed claim (if the initial claim is incomplete), within:	**45 days**

* This period may be extended one time by ***Quartz*** for up to 15 days, provided that ***Quartz*** both (1) determines that such an extension is necessary due to matters beyond the control of the ***plan***, and (2) notifies ***you*** in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which ***Quartz*** expects to render a decision.

Concurrent Care

For benefit determinations relating to care that are being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of ***your claim*** for benefits.

Section 8: Complaint, Grievance and Appeal Procedure

Resolving Complaints and Grievances

If ***you*** have a ***complaint*** relating to any aspect of ***Quartz***, ***you*** may contact a Customer Success Representative who will assist in resolving the matter informally. If the ***complaint*** cannot be resolved to ***your*** satisfaction, ***you*** may file a ***grievance***.

Filing Grievances

To file a ***grievance***:

1. Submit the signed ***grievance*** and any supporting materials to the ***Reconsideration Committee*** at the following address, unless otherwise directed in a determination letter:

   Quartz
   Attn: Appeals Specialists
   2650 Novation Pkwy.
   Fitchburg, WI 53713

   Or, ***you*** may email ***your*** grievance to AppealsSpecialists@QuartzBenefits.com or fax it to (608) 644-3500.

   Quartz will acknowledge receipt of the ***grievance*** within 10 business days of receiving it.

2. ***Quartz*** will notify ***you*** of the time and place of the ***Reconsideration Committee*** meeting at least seven calendar days in advance. ***You***, or a person acting on ***your*** behalf, have the right to appear before the

Reconsideration Committee in person or by telephone to present written or oral information concerning the ***grievance***.

3. ***Quartz*** will notify ***you*** of the disposition of the ***grievance*** within 60 calendar days of receipt. If ***we*** are not able to resolve the ***grievance*** within 60 calendar days, the time period may be extended an additional 30 calendar days. If an extension is required, ***we*** will notify ***you*** in writing:
    - The reasons for extension; and,
    - When resolution may be expected.

Any documentation furnished to the ***Reconsideration Committee*** will be made available to ***you*** for review without charge no less than five business days prior to the ***Reconsideration Committee*** meeting.

Appeal Procedures

You have the right to ***appeal*** an ***adverse benefit determination***. There is one level of internal ***appeal*** available to ***you***.

Who May File an Appeal

Appeals can be filed by the ***member*** or a person authorized to act on ***your*** behalf. ***Your*** designation of a representative must be in writing. We require this to protect against disclosure of information about ***you*** except to ***your*** authorized representative. To obtain an Authorized Representative Form, ***you*** or ***your*** representative may call ***Quartz*** at the number on the back of ***your*** ID card. In urgent care situations, a doctor may act as ***your*** authorized representative without completing the form.

Standard Appeal

How to File

Within 180 days after ***you*** receive notice of an ***adverse benefit determination***, ***you*** may call or write to ***Quartz*** to request an ***appeal***. ***Quartz*** will need to know the reasons why ***you*** do not agree with the ***adverse benefit determination***.

In support of ***your appeal***, ***you*** have the option of presenting evidence and testimony to ***Quartz***. ***You*** and ***your*** authorized representative may ask to review ***your*** file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after ***you*** receive notice of an ***adverse benefit determination*** or at any time during the ***appeal*** process.

To request an ***appeal*** of an ***adverse benefit determination***, please submit the signed ***appeal*** and any supporting materials to ***Quartz*** at the following address, unless otherwise directed in a determination letter:

Quartz
Attn: Appeals Specialists
2650 Novation Pkwy.
Fitchburg, WI 53713

Or, ***you*** may email ***your appeal*** to AppealsSpecialists@QuartzBenefits.com or fax it to (608) 644-3500.

Acknowledgement

Quartz will acknowledge receipt of the grievance within 3 business days of receiving it and notify the party filing an ***appeal*** of all information that the plan requires to evaluate the ***appeal***.

Decision and Notice of the Resolution

Non-urgent concurrent or pre-service appeal. ***Quartz*** will render a decision of a ***non-urgent appeal*** as soon as practical, but in no event more than 15 business days after receipt of all required information. We will send ***you*** a written decision for ***non-urgent appeals*** that are related to health care services and not related to administrative matters or ***complaints*** or ***grievances*** within 15 business days after we receive any needed information, but no later than 30 calendar days (for non-urgent concurrent or pre-service ***appeals***) or 60 calendar days (for post-service ***appeals***) from receipt of the request.

Expedited Appeal

If an ***appeal*** involves an urgent situation, ***Quartz*** will treat it as an ***expedited appeal***. ***Quartz*** will notify the party filing the ***appeal*** as soon as possible, but in no event more than 24 hours after submission of the ***appeal***, of all the information needed to review the ***appeal***. ***Quartz*** will render a decision on the ***appeal*** within 24 hours after it receives the requested information, but in no event more than 48 hours after the ***appeal*** has been received by ***Quartz***.

You may request an ***expedited appeal*** by calling us at Toll Free (866)569-3426, emailing ***your*** request to AppealsSpecialists@QuartzBenefits.com, or faxing it to (608) 644-3500.

Review of Your Appeal

You may review ***Quartz's appeal*** file without charge, and may present evidence or testimony as a part of the appeals process. Any new or additional evidence or rationale considered, relied upon or generated by ***Quartz*** in connection with the ***appeal*** after the internal ***adverse benefit determination*** will be provided to ***you*** or ***your*** authorized representative sufficiently in

advance of the date a final decision on ***appeal*** is made in order to give ***you*** a reasonable opportunity to respond. ***Quartz*** may extend the time period described in this ***policy*** for its final decision on ***appeal*** to provide ***you*** with a reasonable opportunity to respond to such new or additional evidence or rationale.

If the initial benefit determination regarding the claim is based on medical judgment, the appeal will be conducted by individuals associated with ***Quartz*** and/or by external advisors, but who were not involved in making the initial denial of ***your*** claim. No deference will be given to the initial ***adverse benefit determination***. Before ***you*** or ***your*** authorized representative may bring any action to recover benefits the claimant must exhaust the ***appeal*** process and must raise all issues with respect to a claim and must file an ***appeal*** or ***appeals*** and the ***appeals*** must be finally decided by ***Quartz***.

If ***Quartz*** denies continued coverage of ongoing care ***you*** are receiving and ***you appeal*** our decision, ***you*** are entitled to continued coverage of that item, service or prescription drug, pending the outcome of the ***appeal***.

Filing Complaints with the Illinois Department of Insurance

You may resolve a problem contacting ***Quartz*** or by filing a complaint with the Illinois Department of Insurance. The Department of Insurance is a state agency that enforces Illinois' insurance laws. The Illinois Department of Insurance will notify ***Quartz*** of the ***complaint***. ***Quartz*** will have 21 days to respond to the Illinois Department of Insurance.

The operations of ***Quartz*** are regulated by the Illinois Department of Insurance. Filing an ***appeal*** does not prevent ***you*** from filing a complaint with the Illinois Department of Insurance or keep the Illinois Department of Insurance from investigating a ***complaint***.

You may file a consumer complaint online at the Illinois Department of Insurance's website or by mail. The Department maintains Consumer Divisions in Chicago and Springfield which are located at:

Mail to Chicago or Springfield	Illinois Department of Insurance Office of Consumer Health Insurance 115 S. LaSalle Street, 13th Floor Chicago, IL 60603 Illinois Department of Insurance Office of Consumer Health Insurance 4800 Wabash Avenue Springfield, IL 62711
Toll-free phone	(877) 527-9431
Fax number	(217) 558-2083
Email address	DOI.complaints@illinois.gov
Web	https://idoihelpcenter.illinois.gov/s/

If You Need Assistance

If ***you*** have any questions about the ***claims*** or ***appeal*** procedures or the review procedure, please write or call ***Quartz***.

Phone	Toll Free (866)569-3426
Address	Quartz Attn: Appeals Specialists 2650 Novation Pkwy. Fitchburg, WI 53713

If ***you*** need assistance with the internal ***claims*** and ***appeals*** or the ***external review*** processes that are described below, ***you*** may contact the health insurance consumer assistance office or ombudsman. ***You*** may contact the Illinois ombudsman program at (877) 527-9431, or call the number on the back of ***your*** ID card for contact information. In addition, for questions about ***your appeal*** rights or for assistance, ***you*** can contact the Employee Benefits Security Administration at (866) 444-EBSA (3272).

External Review (also called Independent Review)

You or ***your authorized representative*** have the right to request a:

- Standard ***external review***; or,
- Expedited ***external review*** of an ***adverse benefit determination*** or ***final adverse benefit determination***.

A **Final Adverse Benefit Determination** means an ***adverse benefit determination*** involving a ***covered service*** that has been upheld by ***Quartz*** or its designated utilization review organization, at the completion of ***Quartz's*** internal ***appeal*** process.

Standard External Review

1. **Submit a written request**

You or ***your authorized representative*** must submit a written request for a standard ***external review*** to the Illinois Department of Insurance ("IDOI") within four months of receiving an ***adverse benefit determination*** or ***final adverse benefit determination***. ***Your*** request should be submitted to the IDOI at the following address:

Illinois Department of Insurance
Office of Consumer Health Insurance External Review Unit
4800 Wabash Avenue
Springfield, IL 62711
Toll-free phone: (877) 850-4740
Fax number: (217) 557-8495
Email address: doi.externalreview@illinois.gov
Website: https://idoihelpcenter.illinois.gov/s/

2. **You may submit additional information**

You may submit additional information or documentation to support ***your*** request for the health care services. Within one business day after the date of receipt of the request, the IDOI will send a copy of the request to ***Quartz***.

3. **Preliminary Review**

Within five business days of receipt of the request from the IDOI, ***Quartz*** will complete a preliminary review of ***your*** request to determine whether:

- ***You*** were a covered person at the time health care service was requested or provided;
- The service that is the subject of the ***adverse benefit determination*** or the ***final benefit adverse determination*** is a ***covered service*** under this ***policy***, but ***Quartz*** has denied the health care service as not covered;
- ***You*** have exhausted ***Quartz's*** internal ***appeal*** process, unless ***you*** are not required to exhaust ***Quartz's*** internal ***appeal*** process pursuant to the Illinois Health Carrier ***external review*** Act; and,
- ***You*** have provided all the information and forms required to process an ***external review***.

For ***appeals*** relating to a determination based on treatment being ***experimental or investigational***, ***Quartz*** will complete a preliminary review to determine whether the requested service or treatment that is the subject of

the ***adverse benefit determination*** or the ***final adverse benefit determination*** is a ***covered service***, except for ***Quartz's*** determination that the service or treatment is ***experimental or investigational*** for a particular medical condition and is not explicitly listed as an excluded benefit. In addition, ***your*** health care ***provider*** has certified that one of the following situations is applicable:

- Standard health care services or treatments have not been effective in improving ***your*** condition;
- Standard health care services or treatments are not medically appropriate for ***you***; or,
- There is no available standard health care services or treatment covered by ***Quartz*** that is more beneficial than the recommended or requested service or treatment.

In addition, (1) ***your*** health care ***provider*** has certified in writing that the health care service or treatment is likely to be more beneficial to ***you***, in the opinion of ***your*** health care ***provider***, than any available standard health care services or treatments, or (2) ***your*** health care ***provider*** who is a licensed, board-certified or board-eligible physician qualified to practice in the area of medicine appropriate to treat ***your*** condition has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested is likely to be more beneficial to ***you*** than any available standard health care services or treatments.

4. **Notification**

Within one business day after completion of the preliminary review, ***Quartz*** will notify the IDOI, ***you*** and ***your*** authorized representative, in writing whether the request is complete and eligible for an ***external review***.

If the request is not complete or not eligible for an ***external review***, the IDOI, ***you*** and ***your*** authorized representative will be notified by ***Quartz*** in writing of what materials are required to make the request complete or the reason for its ineligibility. ***Quartz's*** determination that the ***external review*** request is

ineligible for review may be appealed to the IDOI by filing a complaint with the IDOI. The IDOI may determine that a request is eligible for ***external review*** and require that it be referred for ***external review***. In making such determination, The IDOI's decision will be in accordance with the terms of ***your plan*** (unless such terms are inconsistent with applicable laws) and will be subject to all applicable laws.

5. **Assignment of IRO**

When the IDOI receives notice that ***your*** request is eligible for ***external review*** following the preliminary review, the IDOI will, within one business day after the receipt of the notice, (1) assign an IRO on a random basis from those IROs approved by the IDOI, and (2) notify ***Quartz***, ***you*** and ***your*** authorized representative, if applicable, of the request's eligibility and acceptance for ***external review*** and the name of the IRO.

6. **Providing Information to the IRO**

Within five business days after the date of receipt of the notice provided by the IDOI of assignment of an IRO, ***Quartz*** provide to the assigned IRO the documents and any information considered in making the ***adverse benefit determination*** or the ***final adverse benefit determination***. In addition, ***you*** or ***your*** authorized representative may, within five business days following the date of receipt of the notice of assignment of an IRO, submit in writing to the assigned IRO additional information that the IRO will consider when conducting the ***external review***. The IRO is not required to, but may, accept and consider additional information submitted after five business days. If ***Quartz*** or its designated utilization review organization does not provide the documents and information within five business days, the IRO may end the ***external review*** and make a decision to reverse the ***adverse benefit determination*** or the ***final adverse benefit determination***. A failure by ***Quartz*** or designated utilization review organization to provide the documents and information to the IRO within five business days shall not delay the conduct of the ***external review***. Within one business day after making the decision to end

the ***external review***, the IRO shall notify ***Quartz***, ***you*** and, if applicable, ***your*** authorized representative, of its decision to reverse the determination.

If ***you*** or ***your*** authorized representative submitted additional information to the IRO, the IRO shall forward the additional information to ***Quartz*** within one business day of receipt from ***you*** or ***your*** authorized representative. Upon receipt of such information, ***Quartz*** may reconsider the ***adverse determination*** or the ***final adverse determination***. Such reconsideration shall not delay the ***external review***. ***Quartz*** may end the ***external review*** and make a decision to reverse the ***adverse determination*** or the ***final adverse determination***. Within one business day after making the decision to end the ***external review***, ***Quartz*** shall notify the IDOI, the IRO, ***you***, and if applicable, ***your*** authorized representative of its decision to reverse the determination.

7. **IRO's Decision**

In addition to the documents and information provided by ***Quartz*** and ***you***, or if applicable, ***your*** authorized representative, the IRO will also consider the following information if available and appropriate:

- ***Your*** pertinent medical records;
- ***Your*** health care ***provider's*** recommendation;
- Consulting reports from appropriate health care ***providers*** and other documents submitted to ***Quartz*** or its designee utilization review organization, ***you***, ***your*** authorized representative or ***your*** treating ***provider***;
- The terms of coverage under the benefit program;
- The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations. For mental health and substance use disorder services, these guidelines must comply with 215 ILCS 370c;
- Any applicable clinical review criteria developed and used by ***Quartz*** or its designated utilization review organization. For mental health and

substance use disorder services, these criteria must comply with 215 ILCS 370c; and,

- The opinion of the IRO's clinical reviewer or reviewers after consideration of the items described above.

Within one business day after the receipt of notice of assignment to conduct an ***external review*** with respect to a denial of coverage based on a determination that the health care service or treatment recommended or requested is ***experimental or investigational***, the IRO will select one or more clinical reviewers, as it determines is appropriate, to conduct the ***external review***, which clinical reviewers must meet the minimum qualifications set forth in the Illinois Health Carrier ***external review*** Act, and neither ***you***, ***your*** authorized representative, if applicable, nor ***Quartz*** will choose or control the choice of the physicians or other health care professional to be selected to conduct the ***external review***. Each clinical reviewer will provide a written opinion to the IRO within 20 days after being selected by the IRO to conduct the ***external review*** on whether the recommended or requested health care service or treatment should be covered.

The IRO will make a decision within 20 days after the date it receives the opinion of each clinical reviewer, which will be determined by the recommendation of a majority of the clinical reviewers.

Within five days after the date of receipt of the necessary information, but in no event more than 45 days after the date of receipt of request for an ***external review***, the IRO will render its decision to uphold or reverse the ***adverse benefit determination*** or the ***final adverse benefit determination*** and will notify the IDOI, ***Quartz***, ***you*** and ***your*** authorized representative, if applicable, of its decision.

With respect to ***experimental or investigational*** services or treatment, the IRO will make a decision within 20 days after the date it receives the opinion of each clinical reviewer, which will be determined by the recommendation of a majority of the clinical reviewers.

The written notice will include:

- A general description of the reason for the request for ***external review***;
- The date the IRO received the assignment from the IDOI;
- The time period during which the ***external review*** was conducted;
- References to the evidence or documentation including the evidence-based standards, considered in reaching its decision or in the case of ***external reviews*** of ***experimental or investigational*** services or treatments, the written opinion of each clinical reviewers as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;
- The date of its decisions;
- The principal reason or reasons for its decision, including what applicable, if any, evidence-based standards that were a basis for its decision; and,
- The rationale for its decision.

Upon receipt of a notice of a decision reversing the ***adverse benefit determination*** or the ***final adverse benefit determination***, ***Quartz*** will immediately approve the coverage that was the subject of the determination. Coverage will only be provided for those services and/or supplies that were the subject of the ***adverse benefit determination*** or the ***final adverse benefit determination*** and not for additional services or supplies beyond the scope of the ***external review***.

The IRO is not bound by any claim determination reached prior to the submission of information to the IRO. The IDOI, ***you***, and ***your*** authorized representative, if applicable, and ***Quartz*** will receive written notice from the IRO. If ***you*** disagree with the determination of the IRO, ***you*** may file a ***complaint*** with the Illinois Department of Insurance's Office of Consumer Health Insurance.

Expedited External Review

1. **When Available**

You may be eligible for an expedited ***external review*** in the following urgent circumstances:

- ***You*** have a medical condition where the timeframe for completion of (a) an expedited internal review of an appeal involving an adverse determination, (b) a final ***adverse benefit determination***, or (c) a standard ***external review*** would seriously jeopardize ***your*** life or health, or would jeopardize ***your*** ability to regain maximum function;
- If ***your*** ongoing inpatient or outpatient treatment for a substance use disorder or condition is no longer ***medically necessary*** (215 ILCS 5/370c (g)(4));
- If ***your*** ongoing treatment for a mental, emotional, nervous, or substance use disorder or condition related to ***your*** pregnancy, miscarriage or stillbirth, or postpartum complications is no longer ***medically necessary*** after the first 48 hours (215 ILCS 5/356z.40);
- If a final adverse benefit determination concerns an admission, availability of care, continued stay or health care service for which ***you*** received ***emergency services***, but ***you*** have not been discharged from a facility; or,
- In the case of ***experimental or investigational*** services, when ***your*** health care ***provider*** certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not started right away.

Expedited ***external review*** will not be provided for retrospective ***adverse*** or ***final adverse benefit determinations***.

2. **How to Request Expedited External Review**

Your request for an expedited independent ***external review*** may be submitted to the IDOI either orally (by calling the phone number) or in writing as set forth above for requests for standard ***external review***.

3. **Notification**

Upon receipt of a request for an expedited ***external review***, the IDOI shall immediately send a copy of the request to ***Quartz***. ***Quartz*** shall immediately notify the IDOI, ***you*** and ***your*** authorized representative, if applicable, whether the expedited request is complete and eligible for an expedited ***external review***. ***Quartz's*** determination that the ***external review*** request is ineligible for review may be appealed to the IDOI by filing a complaint with the IDOI. The IDOI may determine that a request is eligible for expedited ***external review*** and require that it be referred for an expedited ***external review***. In making such determination, IDOI's decision shall be in accordance with the terms of the benefit program (unless such terms are inconsistent with applicable law) and shall be subject to all applicable laws.

4. **Assignment of IRO**

If ***your*** request is eligible for expedited ***external review***, the IDOI shall immediately assign an IRO on a random basis from the list of IROs approved by the IDOI, and immediately notify ***Quartz*** of the name of the IRO.

5. **Providing Information to the IRO for Expedited Review**

Upon receipt from the IDOI of the name of the IRO assigned to conduct the ***external review***, ***Quartz*** or its designated utilization review organization shall, immediately (but in no case more than 24 hours after receiving such notice) provide to the assigned IRO the documents and any information considered in making the ***adverse benefit determination*** or ***final adverse benefit determination***. In addition, ***you*** or ***your*** authorized representative may

submit additional information in writing to the assigned IRO within 24 hours or additional information may accompany the request for an expedited independent ***external review***. If ***Quartz*** or its designated utilization review organization does not provide the documents and information within 24 hours, the IRO may end the ***external review*** and make a decision to reverse the ***adverse benefit determination*** or ***final adverse benefit determination***. Within one business day after making the decision to end the ***external review***, the IRO shall notify the IDOI, ***Quartz***, ***you*** and, if applicable, ***your*** authorized representative, of its decision to reverse the determination.

6. **Expedited External Review Decision**

As expeditiously as ***your*** medical condition or circumstances requires (but in no event more than 72 hours after the date of receipt of the request for an expedited ***external review***), the assigned IRO will render a decision whether or not to uphold or reverse the ***adverse benefit determination*** or ***final adverse benefit determination*** and will notify the IDOI, ***Quartz***, ***you*** and, if applicable, ***your*** authorized representative. If the initial notice regarding its determination was not in writing, within 48 hours after the date of providing such notice, the assigned IRO shall provide written confirmation of the decision to ***you***, the IDOI, ***Quartz*** and, if applicable, ***your*** authorized representative, including all the information outlined under the standard process above.

If the ***external review*** was a review of ***experimental or investigational*** treatments, each clinical reviewer shall provide an opinion orally or in writing to the assigned IRO as expeditiously as our medical condition or circumstances requires, but in no event less than five calendar days after being selected. Within 48 hours after the date it receives the opinion of each clinical reviewer, the IRO will make a decision and provide notice of the decision either orally or in writing to the IDOI, ***Quartz***, ***you*** and ***your*** authorized representative, if applicable.

If the IRO's initial notice regarding its determination was not in writing, within 48 hours after the date of providing such notice, the assigned IRO shall

provide written confirmation of the decision to ***you***, the IDOI, ***Quartz***, and if applicable, ***your*** authorized representative.

The assigned IRO is not bound by any decisions or conclusions reached during ***Quartz's*** utilization review process or ***Quartz's*** internal ***appeal***.

7. **We follow the External Review Decision**

Upon receipt of a notice of a decision reversing the ***adverse benefit determination*** or ***final adverse benefit determination***, ***Quartz*** shall immediately approve the coverage that was the subject of the determination. Coverage will only be provided for those services and/or supplies that were the subject of the ***adverse benefit determination*** or ***final adverse benefit determination*** and not for additional services or supplies beyond the scope of the ***external review***.

If ***you*** disagree with the determination of the IRO, ***you*** may file a ***complaint*** with the Illinois Department of Insurance's Office of Consumer Health Insurance.

An ***external review*** decision is binding on ***Quartz***. An ***external review*** decision is binding on ***you***, except to the extent ***you*** have other remedies available under applicable federal or state law. ***You*** and ***your*** authorized representative may not file a subsequent request for ***external review*** involving the same ***adverse benefit determination*** or ***final adverse determination*** for which ***you*** have already received an ***external review*** decision.

If the ***IRO*** upholds ***Quartz's*** determination that ongoing treatment for a mental, emotional, nervous, or substance use disorder or condition related to ***your*** pregnancy, miscarriage or stillbirth, or postpartum complications is no longer ***medically necessary*** after the first 48 hours, ***Quartz*** will cover the continued treatment through the day following the date the ***external review*** decision is made (215 ILCS 5/356z.40).

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:

Quartz
Attn: Appeals Specialist
2650 Novation Pkwy.
Fitchburg, WI 53713
Telephone: Toll Free (866)569-3426
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 9: Consent to Release Information

If ***Quartz*** requests, ***you*** must authorize any person or institution that has examined or treated ***you*** to furnish to ***Quartz*** any and all information and records or copies of records relating to the examination or treatment provided to ***you*** if related to ***claims*** payment. ***Quartz*** agrees that such information and records will be considered ***confidential*** to the extent required by law. ***Quartz*** has the right to submit any and all records concerning health care services provided to ***you*** to appropriate medical review personnel. The cost of obtaining medical records is ***your*** responsibility.

Quartz also has 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.

Section 10: General Provisions

Advance Directives

If ***you*** are over age 18 and of sound mind, ***you*** may execute a living will or durable power of attorney for health care. These documents tell others what ***your*** wishes are if ***you*** are physically or mentally unable to express ***your*** wishes in the future. If ***you*** have an advance directive, give a copy to ***your primary care provider***. ***You*** do not need to send the forms to ***Quartz***.

Care Management

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, diabetes, mental resiliency, and prenatal care coordination, including assessment, planning, referral, monitoring and advocacy services for individuals experiencing a high-risk pregnancy (215 ILCS 5/356z.40). 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. For additional information regarding ***Quartz care management*** services, please visit ***QuartzBenefits.com***.

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***.

Continuity of Care

Quartz will provide 60 days' notice of nonrenewal or termination of an ***in-network provider*** to both the ***provider*** and to their patients who are ***Quartz members*** (unless the ***provider*** is terminated due to licensure disciplinary reasons).

If ***you*** are under the care of an ***in-network provider*** who stops participating in ***Quartz's*** network, ***you*** may be able to continue receiving ***covered services*** with that ***provider***, at the ***in-network benefit level***, for:

- An ***ongoing course of treatment*** for a serious acute disease or condition requiring complex ongoing care that ***you*** are currently receiving (e.g., ***you*** are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition). This includes an ongoing course of institutional or inpatient care;
- An ***ongoing course of treatment*** for a life-threatening disease or condition and the likelihood of death is probable unless the course of the disease or condition is interrupted). This includes an ***ongoing course of treatment*** for a terminal ***illness*** with a life expectancy of six months or less;

- An ***ongoing course of treatment*** for pregnancy through the postpartum period;
- An ***ongoing course of treatment*** for a health condition of which a treating ***provider*** attests that discontinuing care by the ***in-network provider*** who is terminating from the network would worsen the condition or interfere with anticipated outcomes; or,
- A scheduled non-elective surgical procedure, including postoperative care.

You must request this continuation of care within 30 days from the time ***you*** receive notice that the ***in-network provider*** is leaving ***Quartz's*** network, and the ***provider*** must agree to continue to accept payment at ***Quartz's*** contracted reimbursement rates. Care may continue for 90 days or until the end of the course of treatment, whichever is sooner. However, in the case of pregnancy, continuity of care may continue through the postpartum period if care is directly related to the delivery.

You may also continue receiving covered services at the ***in-network benefit level*** for an ***ongoing course of treatment*** for 90 days from the date ***we*** provided notice to ***you***, if ***you*** have a confirmed appointment and the ***provider*** attests that the appointment was scheduled prior to the date of notification. This does not apply if ***you*** or ***your provider*** reschedules the appointment or schedule follow-up appointments after 90 days from the notification date.

If ***you*** are a new ***member*** under the care of an ***out-of-network provider*** who is within the ***Quartz*** service area, ***you*** may also be eligible to continue care for pregnancy or an ***ongoing course of treatment*** at the ***in-network benefit level***. ***You*** must request continuation of care within 15 days of the coverage start date of ***your Quartz plan***, and the ***provider*** must agree to accept payment at ***Quartz's*** contracted reimbursement rates. Care may continue for 90 days or until the end of the course of treatment, whichever is sooner. However, in the case of pregnancy, continuity of care may continue through the postpartum period if care is directly related to the delivery.

As a new ***member, you*** may also be eligible for continued care of an ***ongoing course of treatment*** at the ***in-network benefit level*** for 90 days from ***your effective date*** if ***you*** have a confirmed appointment with an ***out-of-network provider*** who is within ***our service area*** and the provider attests that the appointment was scheduled prior to ***your effective date***. This does not apply if ***you*** or ***your provider*** reschedules the appointment or schedule follow-up appointments after 90 days from ***your effective date***.

Continuity coverage described in this provision will continue until the treatment is complete (or postpartum) but will not extend for more than 90 days beyond the date the ***provider's*** termination takes effect.

Continuity of coverage does not apply if the ***provider*** is terminated from the ***provider network*** for misconduct, breach of contract, loss of license, or other similar reason; or if the ***physician*** is no longer practicing.

If ***you*** are new to ***Quartz***, ***we*** may also be required to comply with a ***prior authorization*** for health care services approved by ***your*** previous health benefit plan for at least the first 90 days that ***you*** are covered by ***Quartz*** (215 ILCS 200/70). If ***we*** deny a service because ***your in-network provider*** didn't obtain ***prior authorization***, ***you*** or ***your provider*** must submit documentation of the previous ***prior authorization*** to us in order to receive this continued ***prior authorization***. ***We*** may conduct our ***own*** utilization review of ***your*** services during these 90 days. Nothing in this section requires ***Quartz*** to cover services which are not otherwise covered under the ***policy***.

You have the right to ***appeal*** any decision made for a request for benefits under this provision as explained in the Complaint, Grievances and Appeal Procedure section.

How to File a Claim

In order to obtain ***your*** benefits under this ***policy***, a claim must be filed with ***Quartz***. To file a ***claim***, usually all ***you*** will have to do is show ***your Quartz*** ID card to ***your hospital*** or ***physician*** (or other ***provider***). They will file ***your*** claim for ***you***. ***In-network providers*** will submit ***claims*** on ***your*** behalf. Remember, however, it is ***your*** responsibility to assure that the necessary ***claim*** information has been provided to ***Quartz***.

Once ***Quartz*** receives ***your*** claim, it will be processed. The benefit payment for eligible ***claims*** will usually be sent directly to the ***hospital*** or ***physician***. ***You*** will receive a statement telling ***you*** how much was paid. In some cases, ***Quartz*** will send the payment directly to ***you*** (e.g., when ***you*** have already paid ***your physician***) or to the assignee designated on ***your*** valid Assignment of Benefits.

In certain situations, ***you*** will have to file ***your*** own ***claims***. This is primarily true when ***you*** are receiving services from ***out-of-network providers*** or services other than a ***hospital*** or ***physician*** (e.g., ambulance expenses).

To file ***your*** claim, follow these instructions:

1. **Notify us of your claim.**

You should call us or submit written notice of ***your claim*** within 20 days of any loss, or as soon thereafter as is reasonably possible. When ***you*** provide notice of ***your claim***, ***we*** will direct ***you*** to our Claim Form which lists the information ***we*** need to process the ***claim***.

In addition, upon receipt of a notice of ***claim***, ***Quartz*** will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this ***policy*** as to proof of loss upon submitting, within the time fixed in the ***policy***

for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

2. **Complete a Claim Form.**

Claim Forms are available at ***QuartzBenefits.com***.

3. **Attach copies of all bills to be considered for benefits.**

These bills must include the ***provider's*** name and address, the patient's name, the diagnosis (including appropriate codes), the date of service, a description of the service (including appropriate codes), and the ***claim charge***.

4. **Mail the completed Claim Form with attachments to:**

Quartz
2650 Novation Pkwy.
Fitchburg, WI 53713

Be sure to submit the itemized bill to ***Quartz*** within **90 days** from the date the services were provided.

Written proof of loss must be furnished to the company at its said office in case of claim for loss for which this ***policy*** provides any periodic payment contingent upon continuing loss within **90 days** after the termination of the period for which the company is liable and in case of claim for any other loss within **90 days** after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Claims You Have Already Paid

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

We will pay ***your claims*** within 30 days following receipt of written proof of loss. In the event we do not pay within 30 days, ***you*** are entitled to interest on the outstanding claim at the rate of 9% per annum from the 30th day. However, interest payment will not be made if the total amount of interest is $1.00 or less.

Legal Action

You must exercise the right to internal ***appeal*** as a precondition to taking any action against ***Quartz***, either at law or in equity. If ***you*** have an adverse ***appeal*** determination, ***you*** may file civil action in a state or federal court.

No civil action shall be brought to recover on this ***policy*** prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this ***policy***. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

You must file written proof of loss within 90 days of the date of service. This means that any legal action must be started within 39 months of the first date of service on which the action is based.

Other Insurance in this Company

Insurance effective at any one time on the insured under a like policy or policies in this company is limited to the one such policy elected by the insured, their beneficiary or their estate, as the case may be, and the company will return all premiums paid for all other such policies.

Physical Examination

Quartz, at its own expense, has the right and opportunity to examine any ***member*** when and as often as may be reasonably necessary to determine his or her eligibility for claimed services or benefits under this ***plan***, including, without limitation, issues relating to subrogation and COB. By executing an application for coverage under the ***plan***, each ***member*** is deemed to have waived any legal right he/she may have to refuse consent to such examination when performed or conducted for the purposes set forth above.

Physician and Hospital Reports

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

Premium Refund - Death of the Insured

In the event of the death of the insured (i.e., the person to whom this ***policy*** is issued), ***Quartz*** will provide a refund of any unearned premiums assessed following the death of the insured, provided that ***Quartz*** receives a written request for a ***premium*** refund from the representative of the estate of the insured or the person or entity so entitled.

Proof of Coverage

It is ***your*** responsibility to show ***your Quartz*** identification card each time ***you*** receive ***covered services*** from a ***provider***.

Reimbursement and Coding Policies

We develop our reimbursement and coding policy guidelines in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association;
- As reported by generally recognized professionals or publications;
- As directed in the Center for Medicare and Medicaid Services (CMS) coding guidelines used for ***Medicare***;
- As disclosed in the National Correct Coding Initiative (NCCI) recommendations; and,
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that ***we*** accept.

These reimbursement and coding policies are applied to claims submissions. ***We*** share ***our*** reimbursement and coding policies with ***providers*** and other interested parties through ***our*** public website. ***In-network providers*** may not

bill ***you*** for the difference between their contracted rate (including as modified by ***our*** reimbursement and coding policies), and the billed charge. However, ***out-of-network providers*** may bill ***you*** for any amounts ***we*** do not pay, including amounts that are denied or reduced because one of ***our*** reimbursement and coding policies does not reimburse, in whole or in part, for the service billed. ***You*** may get copies of ***our*** reimbursement and coding policies for ***yourself*** or to share with ***your out-of-network provider*** by contacting us at 800-362-3310 or visiting the Provider Manual page on ***QuartzBenefits.com***.

Retrospective Rating Agreement

The ***group*** is entitled to enter into a ***Retrospective Rating Agreement*** with ***Quartz***, where it may agree to adjust the ***premium*** owed based on the ***group's*** claims experience. Pursuant to 215 ILCS 125/5-3 (f), ***Quartz*** is required to inform ***you*** that the ***group*** may be issued a ***premium*** refund or assessed additional ***premium***, based on the terms of the Agreement. Such refund or additional payment is not intended to change the amount ***you*** contribute towards ***your premium***.

Right to Collect Needed Information

You must cooperate and, when asked, assist ***Quartz*** by:

- Authorizing the release of medical information, including the names of all ***physicians*** and ***providers*** from whom ***you*** received medical attention;
- Providing information regarding the circumstances of ***your injury*** or ***illness***; and,
- Providing information about other insurance coverage and benefits.

Your failure to assist ***us*** may result in the denial of ***claims***.

Physical Examination and Autopsy

Quartz, at its own expense, has the right and opportunity to examine ***your*** person when and as often as it may reasonably require during the pendency of a ***claim*** hereunder and to make an autopsy in case of death where it is not forbidden by law.

Premium – Unpaid

Upon the payment of a claim under this ***policy***, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Services Covered by Liability Insurance

Quartz will not refuse to cover health care services that ***you*** receive for which there is coverage under the ***plan*** on the basis that there may be coverage for the services under a liability insurance ***policy***.

Sharing Information

You agree to permit ***Quartz***, ***physicians***, ***providers*** and reviewers to share information about ***your*** care to promote the orderly delivery of care. Sharing information also promotes ***Quartz's*** quality assurance and cost control programs. When sharing information with others, ***Quartz*** agrees to preserve ***confidential matters*** in accordance with state and federal law.

Subrogation and Reimbursement

We are assigned the right to recover from the negligent ***third party***, or his or her insurer, to the extent of the benefits we paid for that sickness or ***injury***. ***You*** are required to furnish any information or assistance, or provide any documents that we may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the ***third party*** admits liability.

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.

Time Limit on Certain Defenses

If an ***Enrollment Form***, ***Health Questionnaire***, or ***Employer's Certification of Group Health Plan Coverage*** is required for enrollment in this ***plan***, ***Quartz*** may investigate information provided by the ***member*** in applying for coverage for two years after the original ***effective date*** of coverage.

After this ***policy*** has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is a person with a disability), it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability (as defined in the ***policy***) commencing after two years from the date of issue of this policy shall be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this ***policy***.

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***.

The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a ***policy*** or denial of a ***claim*** during such initial two-year period, nor to limit the application of section 357.15 through section 357.19 in the event of misstatement with respect to age or occupation or other insurance.

Misstatement of Age. If the age of the insured has been misstated, all amounts payable under this ***policy*** shall be such as the ***premium*** paid would have purchased at the correct age.

Travel Distances

Quartz has established criteria to ensure that ***members*** do not have to travel excessive distances to obtain health care services. Please contact ***Quartz*** Customer Success with questions regarding these criteria.

Wellness Programs

Quartz may provide a wellness program for ***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). ***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.

Notice of Non-Discrimination and Availability of Language Assistance Services and Auxiliary Aids and Services

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 (includes sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes). Quartz does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide reasonable modifications and free appropriate auxiliary aids and services to people with disabilities to communicate effectively with us and to participate in health programs or activities, such as -

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

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

- Qualified interpreters
- Information written in other languages.

If you need these services, contact Customer 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, you can file a grievance with-

Chief Compliance Officer
2650 Novation Parkway
Fitchburg, 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, our Chief 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.

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call (800) 362-3310, TTY: 711 / (800) 877-8973.

Spanish - ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al (800) 362-3310. TTY: 711 / (800) 877-8973 o hable con su proveedor.
Chinese -**注意**：**如果您**说[**中文**]，**我**们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 (800) 362-3310. TTY: 711 / (800) 877-8973 **或咨**询您的服务提供商。
Hmong - LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau (800) 362-3310. TTY: 711 / (800) 877-8973 los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.
Russian - ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону (800) 362-3310. TTY: 711 / (800) 877-8973 или обратитесь к своему поставщику услуг.
Vietnamese - LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số (800) 362-3310. TTY: 711 / (800) 877-8973 hoặc trao đổi với người cung cấp dịch vụ của bạn.
Laotian - ຊືນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ (800) 362-3310. TTY: 711 / (800) 877-8973 ຫຼື ລົມກັບໝູ່ໃຫ້ບໍລິການຂອງທ່ານ.
German - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie (800) 362-3310. TTY: 711 / (800) 877-8973 an oder sprechen Sie mit Ihrem Provider.

Pennsylvania Dutch – LET OP: als je Nederlands spreekt, zijn er gratis taalhulpdiensten voor je beschikbaar. Passende hulpmiddelen en diensten om informatie in toegankelijke formaten te verstrekken, zijn ook gratis beschikbaar. Bel (800) 362-3310. TTY: 711 / (800) 877-8973 of spreek met je provider."
Arabic – 3310-362 (800)1 اتصل على الرقم المجانية. كما تتوفر لك خدمات المساعدة اللغوية المجانية. فستتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. TTY: 711 / (800) 877-8973 أو تحدث إلى مقدم الخدمة".
Polish – UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer (800) 362-3310. TTY: 711 / (800) 877-8973 lub porozmawiaj ze swoim dostawcą.
French – ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le (800) 362-3310. TTY: 711 / (800) 877-8973 ou parlez à votre fournisseur.
Hindi – ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। I (800) 362-3310. TTY / TDD: 711 / (800) 877-8973 पर कॉल करें या अपने प्रदाता से बात करें।
Korean –주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. (800) 362-3310. TTY: 711 / (800) 877-8973 번으로 전화하거나 서비스 제공업체에 문의하십시오.
Albanian – VINI RE: Nëse flisni [shqip], shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi (800) 362-3310. TTY: 711 / (800) 877-8973 ose bisedoni me ofruesin tuaj të shërbimit.
Tagalog – PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa (800) 362-3310. TTY: 711 / (800) 877-8973 o makipag-usap sa iyong provider.
Somali – FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac (800) 362-3310. TTY: 711 / (800) 877-8973 ama la hadal bixiyahaaga. Gargaarsi gargaaraa fi tajaajilli sirrii ta'ee fi odeeffannoo bifa dhaqqabamaa ta'een kennuunis bilisaan ni argama.
Cushite (Oromo) – XIYYEEFFANNOO: Afaan Kushii yoo dubbattan tajaajilli gargaarsa afaanii bilisaan isiniif ni kennama. Gargaarsi gargaaraa fi tajaajilli sirrii ta'ee fi odeeffannoo bifa dhaqqabamaa ta'een kennuunis bilisaan ni argama. (800) 362-3310 bilbili. TTY: 711 / (800) 877-8973 ykn dhiyeessaa keessan waliin haasa'aa.
Amharic – ማሳሰቢያ፡- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ አጋዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር (800) 362-3310. TTY: 711 / (800) 877-8973 ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።
Karen – ဆူ– နမ့်ကတိၤ ထၢနှာ်လီၤဖဲအံၤ အဃိ, တၢ်အိဉ်ဒီး ကျိာ်တၢ်ဆိဉ်ထွဲမၤစၢၤ လၢတလာ် ဘူဉ်လာ်စ့ၤလၢနဂီၢ်လီၤ. တၢ်အိဉ်ဒီး တၢ်မၤစၢၤတၢ်နှၢ်ဟူပီးလီဒီး တၢ်မၤစၢၤတၢ်မၤ လၢအ ကြၢးအဘဉ် လၢကဟ့ဉ်တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢတၢ်မၤန့ၢ်အီၤသ့တဖဉ် လၢတလာ်ဘူဉ်လာ်စ့ၤ လၢနဂီၢ်လီၤ. ကိး (800) 362-3310. TTY: 711 / (800) 877-8973 မ့တမ့ၢ် ကတိၤတၢ်ဒီး နပှၤလၢဟ့ဉ် နၤတၢ်ကွၢ်ထွဲမၤစၢၤတကွၢ်.
Mon-Khmer, Cambodian (Khmer) – សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃដែរ។ ហៅទូរសព្ទទៅ (800) 362-3310. TTY: 711 / (800) 877-8973 ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។
Serbo-croatian (Serbian) – ПАЖЊА: Ако говорите српскохрватски, доступне су вам бесплатне језичке услуге. Бесплатна су и одговарајућа помоћна помагала и услуге за пружање информација у приступачним форматима. Позовите (800) 362-3 ТТИ: 711 / (800) 877-8973 или разговарајте са својим провајдером.
Thai – หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ (800) 362-3310. TTY: 711 / (800) 877-8973 หรือปรึกษาผู้ให้บริการของคุณ"
Gujarati – ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે મફત ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટે યોગ્ય સહાયક સહાય અને સેવાઓ પણ મફતમાં ઉપલબ્ધ છે. કૉલ કરો (800) 362-3310. TTY: / (800) 877-8973 અથવા તમારા પ્રદાતા સાથે વાત કરો.
Urdu – توجہ: اگر آپ اردو بولتے ہیں، تو آپ کے لیے مفت زبان کی مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ (800) 362-3310 پر کال یا اپنے فراہم کنندہ سے بات کریں۔ 877-8973 (800) / 711 :TTY کریں۔
Italian – ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'(800) 362-3310. TTY: 711 / (800) 877-8973 o parla con il tuo fornitore.
Greek – ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το (800) 362-3310. TTY: 711 / (800) 877-8973 ή απευθυνθείτε στον πάροχό σας.
Nepali – ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंलाई निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक सहायताहरू र सेवाहरू पनि निःशुल्क उपलब्ध छन्। कल (800) 362-3310। TTY: 711 / (800) 877-8973 वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।
Ukrainian – УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером (800) 362-3310. TTY: 711 / (800) 877-8973 або зверніться до свого постачальника.
Tibetan – ཉེ་སྐང་ཁག་ཅ་ཞིག་འདོན་པའི་སྐད་ཡིག་ནི་བོད་ཡིག་ཨིན་པ་ཨིན་པ་ལས། ཁྱེད་ལ་རོགས་རམ་གྱི་ཞབས་ཞུ་ཐུབ་པའི་ཞབས་ཞུ་དེ་དག་གིས་གནས་སྟལ་མེད་པར་ཁྱེད་ལ་ཡིད་ཆེས་དུ་སྐྱོང་ཐུབ་ཡི་ཡོད། ཁ་པར་(८००)३७२–४४७० TTY: 711 / (800) 877-8973 ཨང་ན་ཁྱེད་ཀྱི་མཁོ་སྐྱོང་ཞིབ་མཁན་པ་སྐད་རྩ་བཤད་རོགས།
Wolof – FÀTTAL: Sooy wax Wolof, ay serwiis yu lay jàppale ci làkk wi doo fay. Ay ndimbal ak ay serwiis yu war ngir joxe leeral ci formaa yu yomb am nañu ci te doo fay. Woowal (800) 362-3310. TTY: 711 / (800) 877-8973 wala nga waxtaan ak sa joxekat.