Offered by Quartz Health Plan MN Corporation

Health Maintenance Organization (HMO)

Individual Certificate of Coverage

State of Minnesota

2650 Novation Parkway
Fitchburg, WI 53713

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Health Maintenance Organization (HMO) Plan Certificate of Coverage

IMPORTANT ENROLLEE INFORMATION AND ENROLLEE BILL OF RIGHTS

1. **COVERED SERVICES**. Services provided by the ***health plan*** will be covered only if services are provided by in-network ***health plan providers*** or authorized by the ***health plan***. ***Your*** contract fully defines what services are covered and describes procedures ***you*** must follow to obtain coverage.

2. **PROVIDERS**. Enrolling in the ***health plan*** does not guarantee services by a particular ***provider*** on the list of ***providers***. When a ***provider*** is no longer part of the ***health plan you*** must choose among remaining ***health plan providers***.

3. **REFERRALS**. Certain services are covered only upon ***referral***. See Section 3of this ***Certificate*** for ***referral*** requirements. All ***referrals*** to non-health plan ***providers*** and certain types of health care ***providers*** must be authorized by the ***health plan***.

4. **EMERGENCY SERVICES**. ***Emergency services*** from ***providers*** who are not affiliated with the ***health plan*** will be covered. ***Your*** contract explains the procedures and benefits associated with ***emergency care*** from the ***health plan*** and non-health plan ***providers***.

5. **EXCLUSIONS**. Certain services or medical supplies are not covered. ***You*** should read this ***Certificate*** for a detailed explanation of all ***exclusions***.

6. **CONTINUATION**. ***You*** may continue coverage under certain circumstances. Continuation rights are explained fully in this ***Certificate***.

7. **CANCELLATION**. ***Your*** coverage may be canceled by ***you*** or the ***health plan*** only under certain conditions. This ***Certificate*** describes all reasons for cancellation of coverage.

8. **NEWBORN COVERAGE**. If ***your health plan*** provides for ***dependent*** coverage, a newborn infant is covered from birth, but only if services are provided by in-network ***health plan providers*** or authorized by the ***health plan***. Certain services are covered only upon ***referra***l. The ***health plan*** will not automatically know of the infant's birth or that ***you*** would like coverage under ***your plan***. ***You*** should notify the ***health plan*** of the infant's birth and that ***you*** would like coverage. If ***your*** contract requires an additional ***premium*** for each ***dependent***, the ***health plan*** is entitled to all ***premiums*** due from the time of the infant's birth until the time ***you*** notify the ***health plan*** of the birth. The ***health plan*** may withhold payment of any health benefits for the newborn infant until any ***premiums you*** owe are paid.

9. **PRESCRIPTION DRUGS AND MEDICAL EQUIPMENT**. Enrolling in the ***health plan*** does not guarantee that any particular ***prescription drug*** will be available or that any particular piece of medical equipment will be available, even if the drug or equipment is available at the start of the contract year.

10. ***Enrollees*** have the right to available and accessible services including ***emergency services***, as defined in this ***Certificate***, 24 hours a day and seven days a week.

11. ***Enrollees*** have the right to be informed of health problems, and to receive information regarding treatment alternatives and risks which is sufficient to assure informed choice.

12. ***Enrollees*** have the right to refuse treatment, and the right to privacy of medical and financial records maintained by the health maintenance organization and its health care ***providers***, in accordance with existing law.

13. ***Enrollees*** have the right to file a ***complaint*** with the health maintenance organization and the Commissioner of Health and the right to initiate a legal proceeding when experiencing a problem with the health maintenance organization or its health care ***providers***.

14. ***Enrollees*** have the right to a grace period of 31 days for the payment of each ***premium*** falling due after the first ***premium*** during which period the contract shall continue in force.

15. ***Medicare*** enrollees have the right to voluntarily dis-enroll from the health maintenance organization and the right not to be requested or encouraged to dis-enroll except in circumstances specified in federal law.

16. ***Medicare*** enrollees have the right to a clear description of nursing home and home care benefits covered by the health maintenance organization.

Quartz Health Plan MN Corporation (referred to throughout this document as "***Quartz***," "***us***," "***we***," "***our***," or "***health plan***") is a health maintenance organization that issues this health care ***benefit plan***. These shorthand terms may also be used to refer to the plan administrator or subcontractors performing administrative tasks on behalf of ***Quartz***.

This is ***your Certificate of Coverage*** (or ***policy***) as long as ***you*** are eligible for insurance and ***you*** become and remain insured with ***us***. The ***policy*** is the contract of insurance between ***Quartz*** and the ***policyholder***, and describes the essential features and terms of the insurance coverage offered. Unless otherwise explicitly indicated, ***Quartz*** has full discretion and authority to make all determinations required to administer the ***policy***, including eligibility for benefits and interpretation of terms under the ***policy***. This ***Certificate of***

Coverage replaces and supersedes all ***policies we*** may have previously issued to ***you***.

Providers are not employed by ***us***. ***We*** provide benefits for ***covered services*** under the ***policy***. ***We*** do not provide health care services.

The laws of the State of Minnesota and federal laws govern all terms, conditions and provisions of the ***policy***.

10-Day Right to Return Policy

Please read this ***policy*** carefully. If ***you*** are not satisfied with this ***policy*** for any reason ***you*** may, within 10 days after ***you*** receive it or have access to it electronically, whichever is earlier, return it for a full refund of the ***premium*** paid.

Guaranteed Issue & Renewability

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

Quartz *bases* ***medical necessity*** *decisions regarding coverage by consulting a variety of resources. This includes nationally-developed medical policies; commercially-recognized criteria sets; regionally-developed medical coverage policies; and locally-produced specialty medical coverage policies. Additionally, the* ***health plan*** *involves appropriate practitioners in development, adoption and review of criteria and medical coverage policies.*

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IMPORTANT PHONE NUMBERS

Customer Success Representatives	(608) 644-3430 or (800) 362-3310
For people who are deaf, hard of hearing, or speech impaired	711 or (800) 877-8973. ***You*** may also call through a video relay service company of ***your*** choice.
Free of Charge Language Assistance	(800) 362-3310
Appeals Specialist	(608)644-3416 or Toll Free (866)569-3426

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

IMPORTANT FAX NUMBERS

Medical Management	(608) 821-4207
Behavioral Health Care Management	(608) 471-4391
Appeals Specialists	(608) 644-3500
Pharmacy Management	608-471-4389 (Quartz) 844-403-1029 (OptumRx)

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

IMPORTANT NOTICES

Concerning General Provider Payment Methods

Minnesota Statute 62J.72

We pay ***in-network providers*** at a discounted rate set by contract. ***We*** pay certain ***in-network providers*** based on a capitation; other ***in-network providers*** are paid on a fee-for-service basis. No reimbursement methodology is used to create a financial incentive for health care ***providers*** to limit or restrict the care provided to ***enrollees***.

Usual and Customary Charges

Minnesota Statute 62A.61

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

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

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

- ***Emergency services*** received out-of-network, including emergency transportation by airplane or helicopter (air ambulance);
- Some ancillary services received from an ***out-of-network provider*** at an in-network facility; and,
- Services received from an ***out-of-network provider*** at an in-network facility without ***your informed consent***. ***Informed consent*** is *when an* **out-of-network provider** *operating at an in-network facility notifies* ***you*** *that their services are not considered in-network for* ***your Quartz plan****, and* **you** *agree that the* ***provider*** *may* ***balance bill you*** *for costs that* ***Quartz*** *does not cover*.

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

You may contact ***us*** before a procedure is performed to determine if the ***provider's*** estimated charge will be within the ***usual and customary charge***. ***You*** will need to provide ***us*** with the ***provider's*** estimated charge, the CPT or HCPCS code and the estimated date of service. ***We*** will respond within 10 business days from the time that a complete request was received by ***us*** (*Minnesota Statute 62J.81*). ***You*** may also be provided an advance ***Explanation of Benefits (EOB)*** if ***your provider*** notifies ***us*** that ***you*** are scheduled to receive services, as required under federal law.

If ***you*** have questions or would like to request a copy of the Determination of Benefits worksheet, please contact ***our*** Customer Success Representatives at the telephone number provided in the Important Phone Numbers section of

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

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

Statements in the Application for Insurance

Please read the copy of ***your enrollment form*** included with ***your Certificate of Coverage*** previously delivered to ***you*** by ***us***. Omissions or misstatements on the ***enrollment form*** could cause an otherwise valid ***claim*** to be denied. Carefully check the ***enrollment form*** and write to ***us*** within 10 days if any information shown on the form is not correct and complete. Insurance coverage is issued on the basis that the answers to all questions and any other material information shown on the ***enrollment form*** are correct and complete.

Your Rights Under Newborns' and Mothers' Health Protection Act

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

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

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

Changes in Eligibility

If ***you*** or ***your dependents*** have any change in eligibility, ***you*** must contact ***us*** as soon as possible.

Changes in eligibility include the following events:

1. Marriage or divorce;
2. Birth, adoption or Medical Child Support order;
3. A ***dependen***t reaches the maximum limiting age;
4. ***Medicare*** eligibility or entitlement; and,
5. Death of the ***policyholder*** or a ***dependent***.

Women's Health and Cancer Rights Act Of 1998

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

This ***policy*** provides coverage for mastectomies, including the procedures necessary to effect reconstruction of the breast on which the mastectomy was performed, and the cost of prostheses (implants, special bras, etc.) and physical complications of all stages of mastectomy, including lymphedema.

This mandate also requires this ***policy*** to provide the following coverage to a ***member*** who elects breast reconstruction in connection with such mastectomy:

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

Under the Women's Health Act, coverage of breast reconstruction benefits is subject to the same ***deductibles***, ***co-insurance*** and ***co-payments***, consistent with those established for other benefits under this ***policy***.

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

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

Availability of Language Services

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

Consumer Protections Against Balance Billing

Minnesota Statute 62Q.556

Balance billing is prohibited when an ***enrollee*** receives services from:

- An ***out-of-network provider*** at an in-network ***hospital*** or ambulatory surgical center as described by the No Surprises Act, including any federal regulations adopted under that act;
- An ***in-network provider*** sends a specimen taken from the ***enrollee*** in the ***in-network provider's*** practice setting to an out-of-network laboratory, pathologist, or other medical testing facility; or
- An ***out-of-network provider*** or facility providing ***emergency services*** and post-stabilization services as described in the requirements of the No Surprises Act.

The services described in this paragraph are subject to ***balance billing*** only if the ***enrollee*** provides ***informed consent*** prior to receiving services from the ***out-of-network provider*** acknowledging that the use of a ***provider***, or the services to be rendered, may result in costs not covered by the ***health plan***. The ***informed consent*** must comply with all requirements of the No Surprises Act and any federal regulations adopted under that Act; ***informed consent*** may never be provided for ***out-of-network providers*** to ***balance bill*** for ***emergency services***.

An ***enrollee's*** financial responsibility for the ***out-of-network provider*** services will be the same cost-sharing requirements, including ***co-payments***, ***deductibles, co-insurance***, coverage restrictions, and coverage limitations, as those applicable to services received by the ***enrollee*** from an ***in-network provider***. A ***health plan company*** must apply any ***enrollee*** cost-sharing requirements, including ***co-payments***, ***deductibles***, and ***co-insurance***, for ***out-of-network provider*** services to the ***enrollee's*** annual ***out-of-pocket limit*** to the same extent payments to an ***in-network provider*** would be applied.

A ***health plan company*** must attempt to negotiate the reimbursement, less any applicable ***enrollee*** cost sharing, for the applicable services with the ***out-of-network provider***. If the attempt to negotiate reimbursement for the ***out-of-network provider*** services does not result in a resolution, either party may initiate the federal independent dispute resolution process pursuant to the No Surprises Act, including any federal regulations adopted under the Act.

Out-of-Pocket Limit

The ***out-of-pocket limit*** is the most ***you*** pay during a policy period (usually a year) before ***your health insurance*** or ***plan*** begins to pay 100% of the allowed amount. This limit never includes ***your premium***, ***balance-billed*** charges or health care ***your health insurance*** or ***plan*** doesn't cover. The ***out-of-pocket limit*** for this ***plan*** can be found in ***your Schedule of Benefits (SOB)***.

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. However, the federal government annually sets a maximum ***out-of-pocket limit*** for in-network cost-sharing on ***essential health benefits***. ***Quartz*** ensures ***you*** will not exceed this annual limit.

"***Essential health benefits***" refers to benefits established under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations. Such benefits shall include at least the following general categories and the items and services covered with the categories:

- Ambulatory patient services;
- ***Emergency services***;
- ***Hospitalization***;
- Maternity and newborn care;
- Mental health and substance abuse 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.

Non-Discrimination Rule

Quartz complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex (includes sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity and sex stereotypes) or health status. ***Quartz*** does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

Quartz:

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

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

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

Chief Compliance Officer
2650 Novation Pkwy.
Fitchburg, WI 53713
Phone: (800) 362-3310 or (608) 644-3430
TTY: 711 or (800) 877-8973
Fax: (608) 644-3500
Email: AppealsSpecialists@QuartzBenefits.com

You can file a grievance in person or by mail, fax or email. If ***you*** need help filing a grievance, ***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 at ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail at:

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

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

PLAN DESCRIPTION INFORMATION

This is a fully-insured individual ***health benefit plan***. ***Quartz*** is the shorthand name for the administrator of this ***policy*** and the insurance underwriting company, ***Quartz Health Plan MN Corporation*** (also referred to as "***us***," "***we***," "***our***," or "***health plan***"). These shorthand terms may also be used to refer to the plan administrator or subcontractors performing administrative tasks on behalf of ***Quartz***. This ***policy*** contains information regarding eligibility requirements, termination provisions, a description of the benefits provided, and other general ***plan*** information.

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

PLAN NAME:	Quartz HMO
TYPE OF PLAN:	An individual ***health plan*** providing certain medical benefits to covered ***subscribers*** and ***dependents***.
CLAIMS ADMINISTRATOR:	***Quartz*** Attn: Claims Department 2650 Novation Pkwy. Fitchburg, WI 53713 (608) 644-3430 or (800) 362-3310 For people who are deaf, hard of hearing or speech impaired, please call 711, (800) 877-8973, or ***you*** may call through a video relay service company of ***your*** choice.

SECTION 1 – 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 Determination
Any decision ***we*** make relating to an admission, extension of stay, or health care service that is partially or wholly adverse to ***you***, including denial as not ***medically necessary*** or ***authorization*** of a less intensive service than the service requested.

Advanced Premium Tax Credit (APTC)
Payment of the tax credits specified in section 36B of the Code (as added by Section 1401 of the Affordable Care Act) which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan through MNSure.

Allowable Expense
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.

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

Attending Physician
The ***physician*** or other health care professional who is treating ***you***.

Authorization
A determination by ***Quartz*** that an admission, extension of stay, or other health care service has been reviewed and that, based on the information

provided, it satisfies the requirements to be covered under the ***policy***. Coverage is determined by the terms and conditions of the ***policy***.

Authorized Representative
An individual authorized by ***you*** to act on ***your*** behalf in pursuing payment of a ***claim***, obtaining a ***referral***/***prior authorization*** or in dealing with any of the levels of the appeal process.

Autism Spectrum Disorder(s) The conditions as determined by criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Balance Billing
When a ***provider*** bills ***you*** for amounts above the ***usual and customary charge. 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***. 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.

Benefit Period (or Benefit Year)
A 12-month period of ***health insurance*** coverage used for calculating ***deductibles***, ***co-insurance***, benefit limitations, and out of pocket maximums.

Care Management
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.

Certificate of Coverage (or Certificate)
This document contains information regarding eligibility requirements, termination provisions, a description of the benefits provided, and other general ***plan*** information.

Chemotherapy
Intravenously, injected, or orally administered anticancer medication that is used to kill or slow the growth of cancerous cells.

Child
Any of the following:

1. The ***subscriber's*** natural ***child***, stepchild, or foster ***child***;
2. A ***member's*** legally adopted ***child*** or ***child*** placed for adoption with a ***member***; or,
3. A ***child*** for whom the ***subscriber*** or ***subscriber's*** spouse has legal guardianship, including a ***child*** who is a legal ward.

Claim
A demand for payment due in exchange for health care services provided.

Clinical Trainee
A staff person who:

1. Is enrolled in an accredited graduate program of study for independent licensure as a mental health professional and who is participating in a practicum or internship with the license holder through the individual's graduate program; or,
2. Has completed an accredited graduate program of study for independent licensure as a mental health professional and who is in compliance with the requirements of the applicable health-related licensing board, including requirements for supervised practice; or,
3. Has completed an accredited graduate program for independent licensure as a mental health professional, has completed a practicum or internship and has not yet taken or received the results from the required test or is waiting for the final licensure decision.

Co-insurance
A percentage of the allowed charge for ***covered expenses*** that ***you*** are required to pay. ***You*** are responsible for the payment to the ***provider*** for any ***co-insurance*** amount.

Complaint
Any grievance against ***us*** relating to an expression of dissatisfaction submitted orally or writing to ***us*** which is not under litigation regarding the provision of health care services including but not limited to the scope of coverage for health care services; retrospective denials or limitations of payment for services; eligibility issues; denials, cancellations or nonrenewal of coverage; administrative operations; and the quality, timeliness and appropriateness of health care services rendered.

Complications of Pregnancy
Conditions due to pregnancy, labor and delivery, that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section are not considered ***complications of pregnancy***.

Confinement (or Confined)

1. The period of time between the admission to an inpatient or outpatient health care facility through the time of discharge. The health care facility may be a ***hospital***, a substance use treatment center, a ***skilled nursing facility*** or a licensed ***ambulatory surgery center***; and,
2. 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.

Concurrent Review
Utilization review conducted during an ***enrollee's hospital*** stay or course of treatment.

Contraceptive Method
A drug, device, or other product approved by the Food and Drug Administration to prevent unintended pregnancy.

Contraceptive Service
Consultation, examination, procedures, and medical services related to the prevention of unintended pregnancy, excluding vasectomies. *This includes but is not limited to voluntary sterilization procedures, patient education, counseling on contraceptives, and follow-up services related to* ***contraceptive methods or services****, management of side effects, counseling for continued adherence, and device insertion or removal*.

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

Co-payment
A specific dollar amount that ***you*** are responsible for before ***we*** assume any liability for the remaining part of the charges for that service.

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***, for which any applicable ***prior authorization*** has been obtained.

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*** as determined 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.

For the purpose of ***behavioral health*** services, ***custodial care*** includes group homes and halfway houses for supportive and maintenance care for mental illness or substance use disorders.

Deductible
An amount of money that ***you*** must pay before benefits are payable by ***us***. The ***deductible*** applies to each ***member*** each ***benefit period***. Only allowable charges that qualify as ***covered expenses*** may be used to satisfy the ***deductible***. The amount of the ***deductible***, if any, is stated on the ***Schedule of Benefits*** and the Summary of Benefits and Coverage.

Dependent
One or more of the following:

1. The ***employee's*** legally-recognized spouse;
2. A married or unmarried ***child***, under age 26; or,
3. A grandchild under the age of 25 who has lived with a grandparent covered under this ***Certificate*** and has been financially dependent on the covered grandparent continuously since birth *(Minnesota Statutes 62.042 and 62A.302, Subd. 4)*.

Developmental 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***.

Durable Medical Equipment (DME)
Equipment that must:

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

Effective Date
The date on which ***you*** and ***your*** eligible ***dependents***, if any, become enrolled and entitled to benefits specified in ***your Schedule of Benefits*** and Summary of Benefits and Coverage.

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

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

Essential Health Benefits
Benefits established under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations. Such benefits shall include at least the following general categories and the items and services covered with the categories:

- Ambulatory patient services;
- ***Emergency services***;
- ***Hospitalization***;
- Maternity and newborn care;

- Mental health and substance abuse 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 medical service or supply listed in this section, or not listed as a ***covered service*** in Section 5 - Benefits: Covered and Non-Covered of this ***Certificate of Coverage***.

Experimental, Investigative, or Unproven Service (or Experimental or Investigative)
A drug, device, medical treatment, diagnostic procedure, technology, or procedure for which reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes.

Explanation of Benefits (EOB)
An ***EOB*** is 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
A request for independent, ***external review*** of the final decision made by ***Quartz*** through its internal ***appeal*** process.

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-Affirming Health Care Services (or Gender-Affirming Care)
All medical, surgical, counseling, or ***referral*** services, including telehealth services, that an individual may receive to support and affirm that individual's gender identity or gender expression and that are legal under the laws of the State of Minnesota.

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

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 evaluation without transport, treatment without transport, and paramedic intercept.

Habilitative Services (Habilitative)
Health care services and devices that help a person keep, learn or improve skills and functioning for daily living (e.g., therapy for a ***child*** who isn't walking or talking at the expected age). These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Benefit Plan
A policy, contract, or certificate issued by a ***health plan company*** for the coverage of medical, dental, or hospital benefits.

Health Insurance
A contract that requires ***your*** health insurer to pay some or all of ***your*** health care costs in exchange for a ***premium***.

Health Plan (or Benefit Plan or Plan)
The overall program of health services insured and administered by ***Quartz***.

Health Plan Company
A health carrier meaning an insurance company or health maintenance organization licensed to offer, sell, or issue an insurance policy.

Home Care Nursing
Ongoing hourly nursing ordered by a ***physician***, advanced practice registered nurse, or physician assistant and services performed by a registered nurse or licensed practical nurse, in order to maintain or restore a person's health. This term also includes “complex home care nursing,” defined as home care nursing services provided to recipients who meet the criteria for regular home care nursing and require life-sustaining interventions to reduce the risk of long-term injury or death.

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

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:

1. 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***;
2. Provides continuous nursing service by or under the supervision of registered professional nurses;
3. Is not a federal ***hospital*** or, other than incidentally, a place for rest, a place for the aged or a nursing home; and,
4. 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.

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, mother, father, grandparents, children, grandchildren, brothers, sisters, mother-in-law, father-in-law, brothers-in-law, sisters-in-law, daughters-in-law, and sons-in-law. Adopted and step relationships are also included in ***immediate family***.

Independent Review Organization (IRO)
An entity certified under state or federal law to review ***Quartz's*** decisions.

Infertility
The inability to establish pregnancy within one year by a ***member*** and the ***member's*** covered spouse, or by a ***member*** and the ***member's*** domestic partner who is covered in accordance with a ***Domestic Partner Amendment*** attached to this ***Certificate***, who are (1) both of reproductive age, and (2) both expect pregnancy to be accomplished by unprotected sex.

Informed Consent
When ***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.

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

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

Maintenance Therapy
On-going therapy delivered after the acute phase of an ***illness*** has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated.

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

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

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 Enrollee)
The ***subscriber*** and any ***dependents*** covered under the ***policy*** issued by ***Quartz***.

Non-Covered Services
Health care services that ***your health insurance*** or ***plan*** doesn't pay for or cover.

Open Enrollment Period
A period of time when all potential members are allowed to enroll for coverage, whether or not they are currently enrolled in an individual ***health benefit plan***.

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 and customary charge***.

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

Out-of-Network Provider
A ***physician*** or other health care ***provider*** who has not signed a participating provider contract with ***us*** to provide medical treatment, services or supplies to ***members***.

Outpatient Services
Procedures or services performed on a basis other than as an inpatient, and includes obstetrical, psychiatric, chemical dependency, dental, and chiropractic services.

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

Plan Benefits
Medical, ***hospital***, behavioral health and substance use, chiropractic, ***home health care***, ***skilled nursing facility***, ***emergency care*** and other specified ***covered services*** as defined in this ***policy***, the ***Schedule of Benefits*** and ***benefit riders*** to which a ***member*** is entitled by membership in the ***plan***.

Policy
An agreement between ***Quartz*** and a ***subscriber*** wherein ***Quartz*** agrees to provide a ***health plan*** to the ***subscriber*** and their eligible ***dependents***. The ***policy*** sets forth all of the obligations, rights and responsibilities of the parties.

Policyholder
The person to whom ***Quartz*** has issued this ***policy*** for the benefit of the ***members*** on the ***policy***. The ***policyholder*** is legally responsible for payment of ***premium*** under this ***policy***.

Premium
The amount that must be paid for ***your health insurance*** or plan. ***Your premium*** is due monthly.

Preventive Services
Preventive medical services in the absence of symptoms, ***illness*** or ***injury***.

Primary Care Provider (also PCP)
A ***physician*** (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), 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***.

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.

Prior authorization does not guarantee that services will be fully covered. Coverage is determined by the terms and conditions of the ***policy***. Services

and items requiring ***prior authorization*** are listed on ***Quartz's*** website at ***QuartzBenefits.com/MNPAList***.

Provider
A licensed health care facility, ***physician***, or other health care professional that delivers health care services to an ***enrollee***.

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 Find A Doctor at ***QuartzBenefits.com/FindADoctor*** or contact ***Quartz*** Customer Success for assistance in navigating the ***provider network***.

Provider Directory
A listing 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 median contracted rate for ***Quartz providers*** in the geographic region.

Quartz
The marketing name for ***Quartz Health Plans MN Corporation***, its plan administrator, and the overall program of health benefits that are insured and administered pursuant to the ***policy***.

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 internet domain name for this site is ***QuartzBenefits.com***.

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.

Referrals and Standing Referrals
A written form that authorizes ***you*** to receive coverage for certain health care services. The purpose is to determine and authorize the following:

1. The specific type and extent of care that is necessary;
2. The number of visits or the period of time during which care will be provided; and,
3. The ***provider*** to whom the ***member*** is being referred.

Requests for ***referrals*** must be submitted to ***Quartz*** for consideration and review before the requested services are obtained. Such services will be covered only if the ***referral*** request is authorized by ***Quartz*** before services are obtained.

No ***referral*** is necessary for obstetrical or gynecological care provided by ***in-network providers*** who specialize in obstetrics or gynecology.

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

Referral Form
A form prepared in writing by an ***in-network provider*** for ***you*** in order for ***you*** to receive coverage for medical treatment, services, or supplies from an ***out-of-network provider***.

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

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

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

Schedule of Benefits (SOB)
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 ***Quartz*** has determined that there are enough ***in-network providers*** to serve its ***members***.

Skilled Care
Medical services rendered by a registered or licensed practical nurse, physical, occupational or speech therapist.

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

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

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***.

Sound Natural Tooth
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.

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
The person to whom ***Quartz*** has issued this ***policy***.

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

Telehealth Visit
A remote scheduled appointment with ***your*** usual ***provider*** during clinic hours using a telephone call or video chat. Under Minnesota law, it also includes "store-and-forward technology," which is the asynchronous electronic transfer or transmission of a patient's medical information or data from an originating site to a distant site for the purposes of diagnostic and therapeutic assistance in the care of a patient.

Therapeutic Equivalent Version
A drug, device, or product that can be expected to have the same clinical effect and safety profile when administered to a patient under the conditions specified in the labeling, and that:

- Is approved as safe and effective;
- Is a pharmaceutical equivalent containing identical amounts of the same active drug ingredient in the same dosage form and route of administration and meeting compendial or other applicable standards of strength, quality, purity, and identity;

- Is bioequivalent in that the drug, device, or product does not present a known or potential bioequivalence problem and meets an acceptable in vitro standard or, if the drug, device, or product does present a known or potential bioequivalence problem, it is shown to meet an appropriate bioequivalence standard;
- Is adequately labeled; and,
- Is manufactured in compliance with current manufacturing practice regulation.

Urgent Care
The care that ***you*** need sooner than a scheduled ***physician's*** visit, but is not an emergency.

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.

Usual and Customary Charge
The charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area.

Utilization Review
The evaluation of the necessity, appropriateness, and efficacy of the use of health care services, procedures, and facilities, for the purpose of determining the medical necessity of the service or admission.

Virtual Visit
An on-demand consultation with a provider using a computer or mobile device.

We/Us/Our
Quartz Health Plans MN Corporation, referred to in this ***policy*** as "***Quartz***," and its plan administrator. These shorthand terms may also be used to refer to subcontractors performing administrative tasks on behalf of ***Quartz***.

You/Your
A ***member*** enrolled in a ***Quartz health plan***.

Other definitions that apply to specific coverages are defined within this ***Certificate***.

SECTION 2 – INTRODUCTION

It is important that ***you*** understand this ***policy*** in order to effectively utilize the benefits available to ***you***. ***You*** will gain a basic understanding the first time ***you*** read this ***policy***; however, thorough understanding will only be gained if ***you*** review the ***policy*** whenever ***you*** plan to receive medical services.

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

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

SECTION 3 – ACCESS TO COVERED HEALTH CARE

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

Provider Network

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

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

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

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

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

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

- They are ***covered services*** for urgent/emergent care or for a ***rare disease or condition*** as described in Section 5; or,
- An ***in-network provider*** has provided ***us*** with a written ***referral***, and ***our*** Medical Management Staff has approved the ***referral*** prior to services being provided. ***Referrals*** for out-of-network services will not be granted/approved when capability exists for a particular expertise or service within ***our provider network***.

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

From time to time, ***providers*** will leave ***our network*** of ***providers***. ***We*** are required to update ***our provider network*** listing monthly (*Minnesota Statute 62K.075*), or on a more frequent basis as required under federal law. In certain circumstances, as part of a ***prior authorization*** review, ***we*** will notify ***enrollees*** before receiving services that a ***provider*** is no longer an ***in-network provider***. ***You*** have rights – if ***we*** fail to keep ***our provider*** listing up-to-date and do not alert ***you*** prior to receiving services that a ***provider*** is out-of-network, ***you*** may notify ***us*** and ***we*** will reprocess ***your*** out-of-network ***claims*** as in-network ***claims***.

Your Rights Under Continuity of Care Statutes

Minnesota Statutes 62Q.56 and 62M.17; Section 2799A-3 of the PHSA

If ***you*** receive services from a ***provider*** listed in ***our*** current ***provider directory***, and ***we*** deny coverage for those services because the ***provider*** is not an ***in-network provider***, please contact ***our*** Customer Success

Representatives at the telephone number provided in the Important Phone Numbers section of this ***COC*** to discuss ***your*** rights under this law.

Our ***provider directory*** lists the ***in-network providers*** that are contracted with ***us***. The ***provider directory*** is available to ***you*** upon enrollment and again upon ***your*** request. In order to provide ***you*** with the most current list of ***in-network providers***, please refer to the online version that is located on ***our*** website at ***https://quartzbenefits.com/ProviderDirectoryPDFs***.

In accordance with *Minnesota Statute 62Q.56*, if a ***provider*** is under contract at the time of ***your*** enrollment or at the time of the annual ***provider directory*** update, whichever is later, and ***you*** receive services from that ***provider***, ***we*** may be required to cover those services regardless of whether the ***provider*** is an ***in-network provider***. If the ***provider*** is a ***primary care physician***, or ***you*** are undergoing a course of treatment with an ***in-network provider*** who is a specialty ***physician***, and whose participation in ***our network*** terminates, ***we*** shall provide coverage for eligible services for the remainder of the course of treatment or for 120 days after the ***provider's*** participation terminates, whichever is shorter. Coverage may extend until end of life if a ***physician*** certifies that the ***enrollee*** has an expected lifetime of 180 days or less.

If the course of treatment is for maternity care, coverage will be provided until the completion of postpartum care for ***you*** and ***your*** infant.

We are also required to continue covering services for up to 90 days regardless of whether they are rendered by an ***in-network provider*** if ***you*** are undergoing a course of institutional or inpatient care or ***you*** are scheduled to undergo non-elective surgery.

This continuity of care requirement does not apply if the ***provider*** is terminated due to misconduct.

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 60 days that ***you*** are covered by ***Quartz*** (*Minnesota Statute 62M.17*). 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 60 days. Nothing in this section requires ***Quartz*** to cover services which are not otherwise covered under the ***policy***.

Prior Authorization

Minnesota Statute 62A.59

We recognize that ***your physician*** is responsible for making medical recommendations regarding ***your*** care. However, in order to monitor the frequency, intensity and appropriateness of services rendered to ***you***, ***we*** require ***prior authorization*** for certain services. The ***prior authorization*** process determines both benefit determinations and medical necessity (see definition below). Services that require a ***prior authorization*** are listed on ***our*** website at ***QuartzBenefits.com/MNPAList***. ***Quartz*** will not deny or limit coverage of a service ***you*** have already received solely on the basis of lack of ***prior authorization***, if the service would have otherwise been covered under the ***policy***.

Per *Minnesota Statute 62M.07*, ***Quartz*** cannot require ***prior authorization*** for any of the following:

- Emergency ***confinement*** or an ***emergency service***;
- Outpatient mental health treatment or outpatient substance use disorder treatment, except for treatment which is a medication;
- Antineoplastic cancer treatment that is consistent with guidelines of the National Comprehensive Cancer Network, except for treatment which is a medication;
- Services that currently have a rating of A or B from the United States Preventive Services Task Force, immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or preventive services and screenings

provided to women as described in Code of Federal Regulations, title 45, section 147.130;
- Pediatric ***hospice services*** provided by a licensed hospice provider; or,
- Treatment delivered through a neonatal abstinence program operated by pediatric pain or palliative care subspecialists.

If ***we*** prior authorize treatment of a chronic health condition, the ***authorization*** will not expire unless the standard of treatment for the condition expires. For the purpose of this section, a chronic health condition is one that is expected to last at least 12 months and (1) requires ongoing medical attention to effectively manage the condition or prevent an adverse health, or (2) limits one or more ***activities of daily living*** (*Minnesota Statute 62M.07, Subd. 5*).

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

Medical Prior Authorization
Medical ***prior authorization*** requests are handled by ***our*** Medical Management Department or its delegate. ***In-network providers*** are required to submit a ***prior authorization*** request on ***your*** behalf. Please read this ***policy***, ***your*** Summary of Benefits and Coverage and ***your Schedule of Benefits*** carefully to see what ***covered services*** require ***prior authorization***. It is recommended that ***you*** contact ***us*** for ***prior authorization*** requirements before receiving care so that ***we*** may determine in advance whether benefits are available. Please call the Customer Success Department at the telephone number located in the Important Phone Numbers section of this ***policy*** (*Minnesota Statute 62M.07)*.

Drug Prior Authorization
Drug ***prior authorization*** activities are conducted by ***our*** Pharmacy Management Department or its delegate. Certain ***prescription drugs*** require ***prior authorization***. To determine which drugs or drug classes require ***prior authorization***, please refer to the ***formulary*** and related pharmacy content on ***our*** website at ***QuartzBenefits.com*** or call the Customer Success Department at the telephone number provided in the Important Phone

Numbers section of this ***COC***. Please refer to Section 5 - Prescription Drugs, of this ***policy*** to review covered and non-covered pharmacy services. Due to periodic changes of the ***prescription drug prior authorization*** list, it is recommended that ***you*** contact ***us*** for ***prior authorization*** before receiving care.

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

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

The fact that a ***physician***, ***in-network provider***, or any other ***provider***, has prescribed, ordered, recommended or approved a treatment, service or supply, or has informed ***you*** of its availability, does not make the treatment, service or supply ***medically necessary***. ***Quartz*** cannot retrospectively deny or limit coverage for a ***covered service*** for which ***prior authorization*** was not required.

Obtaining Prior Authorization

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

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

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

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

Optum
Attn: Prior Authorization Department
P.O. Box 2975
Mission, KS 66201
Fax: (844) 403-1029
www.benefitrx.com

For prescription standard determinations, ***Quartz*** will make its decision and notify ***you***, ***your authorized representative*** and the prescribing ***physician*** of its coverage determination according to the shortest timeline required by state or federal law, or accreditation standards. The period of the initial decision may be extended if ***we*** determine it is necessary due to such matters beyond ***our*** control (including a failure to submit necessary information), if ***we*** notify ***you*** to explain the circumstances regarding an extension.

You or ***your*** prescriber can request an ***expedited review*** based on ***exigent circumstances***. ***Exigent circumstances*** *exist when an* ***enrollee*** *is suffering from a health condition that may seriously jeopardize the* ***enrollee's*** *life, health, or ability to regain maximum function or when an* ***enrollee*** *is undergoing a current course of treatment using a* ***non-formulary drug***. ***Exigent circumstances*** also exist when the ***enrollee's*** attending ***provider*** attests that an ***expedited review*** is needed based on exigent circumstances. For prescription expedited determinations, ***Quartz*** will make its decision and notify ***you***, ***your authorized representative*** and the prescribing ***physician*** of its coverage determination according to the shortest timeline required by

state or federal law, or accreditation standards. The period of the initial decision may be extended if ***we*** determine it is necessary due to such matters beyond ***our*** control (including a failure to submit necessary information), if ***we*** notify ***you*** to explain the circumstances regarding an extension.

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

Referral Authorizations

If ***your in-network provider*** feels ***you*** require specialty care beyond that available from other ***in-network providers***, they may submit a ***referral form*** to request services from an ***out-of-network provider***. Medical care, treatment, services or supplies that are received through a ***referral*** are subject to the ***exclusions*** and limitations of this ***policy***. ***Referrals*** must be submitted and approved in writing by ***our*** Medical Management before any recommended treatment, services or supplies are obtained for a ***covered expense***.

The definition of ***out-of-network provider*** is *a* ***physician*** *or other health care* ***provider*** *who has not signed a participating* ***provider*** *contract with* ***us*** *to provide medical treatment, services or supplies to* ***members****.* Except for ***emergency care*** or ***urgent care*** outside the ***service area***, benefits are excluded when ***you*** receive medical treatment, services, or supplies from an ***out-of-network provider*** without a written ***referral*** from an ***in-network provider***, which has been approved in writing by **our *medical director***. ***Referrals*** are not valid without ***our medical director's*** approval. ***Referrals*** for out-of-network services will not be granted/approved when capability exists for a particular expertise or service within ***our provider network***.

You will be notified in writing of the decision. If approved, the ***referral form*** will state the ***provider***, type or extent of treatment being authorized, the number

of visits, and the period of time during which the ***referral*** is valid. Take a copy of the approved written ***referral*** with ***you*** when ***you*** receive the services.

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

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

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

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

Emergency Care

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

Please contact ***our*** Customer Success Department at the telephone number provided in the Important Phone Numbers section of this ***policy*** to initiate the ***prior authorization*** process. See Section 5 – Benefits for the definition and coverage guidelines of ***urgent care services***.

New Technology

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

1. The technology must not be ***experimental or investigative***, as defined in Section 5 – Benefits – Experimental or Investigative Treatments or Services;
2. The new technology must be approved by the appropriate regulatory body;
3. Research and review of evidence-based medicine demonstrates that the new technology has a positive effect on health and is safe; and,
4. New technology is more beneficial or less expensive than current alternative treatments.

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

SECTION 4 – ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

Eligibility

Subscriber Coverage

A ***subscriber*** must reside in the ***Quartz service area*** and cannot be entitled to benefits under ***Medicare*** Part A or enrolled under ***Medicare*** Part B. ***Quartz*** considers a ***subscriber's*** "residence" to be the location in which he/she spends at least nine months out of a 12-month period. A ***dependent*** need not reside within the ***Quartz service area*** to be eligible for coverage under the ***plan***.

Dependent Coverage

An eligible ***dependent*** is:

1. ***Your*** legally-recognized spouse or domestic partner. See the Domestic Partners section below for more information;
2. ***Your*** married or unmarried ***child***, under age 26, that is a:
   - Natural ***child***;
   - Legally-adopted ***child***;
   - Minor ***child*** placed with ***you*** for the purpose of adoption;
   - Foster ***child***;
   - Stepchild;
   - Grandchild who has lived with ***you*** and been financially dependent on ***you*** continuously since birth *(Minnesota Statutes 62.042 and 62A.302, Subd. 4)*; or,
   - Minor ***child*** for whom ***you*** have legal guardianship, including a minor ***child*** who is ***your*** legal ward.

Your eligible ***dependents*** are covered under this ***policy*** when:

- ***You*** apply to ***Quartz*** in writing for ***dependent*** coverage;
- ***You*** pay the appropriate ***premium*** to ***Quartz***; and,
- ***You*** are notified in writing that ***Quartz*** has approved the ***dependent*** coverage.

See below for adding a newborn ***child*** and/or adopted ***child*** to existing coverage.

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

Effective Dates

Enrollment and Effective Date
You may apply for enrollment by submitting a completed ***enrollment form***. ***Quartz*** will notify ***you*** of the ***effective date*** of ***your*** coverage. The **effective date** is defined as *the date on which* ***you*** *and* ***your*** *eligible* ***dependents****, if any, become enrolled and entitled to benefits specified in this* ***policy***. For ***members*** who complete an application for coverage through the Health Insurance Marketplace, or MNSure, ***we*** rely on MNSure's determination of ***your effective date***.

You are eligible to enroll for coverage during a Special Enrollment Period or during an ***open enrollment period***.

Changes to the original ***enrollment form***, other than physician changes, must be made by completing a new ***enrollment form*** or submitting the change electronically by visiting ***QuartzBenefits.com***. For ***members*** who enrolled through MNSure, enrollment change requests must be made through MNSure.

Open Enrollment Period
A period of time when all potential ***members*** are allowed to enroll for coverage, whether or not they are currently enrolled in an individual ***health benefit plan***. ***Your enrollment form*** must be received during the ***open enrollment period*** in order to be considered eligible for coverage.

Special Enrollment Periods

1. **Birth, Adoption or Placement for Adoption**

   The date of eligibility for newborn children is the date of birth. The date of eligibility for adoption or placement for adoption is (1) the date a minor ***child*** is placed in the ***subscriber's*** home for adoption or (2) the date that a court issues a final order granting adoption or legal guardianship of the minor ***child*** to the ***subscriber***, whichever occurs first. ***You*** may enroll ***your child*** retroactive to the eligibility date by submitting an ***enrollment form*** up to 60 days following the event and paying any additional ***premiums*** due from the eligibility date. During this 60-day period, ***you*** may also add other ***dependents*** to ***your policy***.

   Per *Minnesota Statute 62A.042, Subd 2 (a)* and *Minnesota Statute 62A.27(d)*, ***you*** may add ***dependent*** coverage for a newborn or adopted ***child*** to an existing ***policy*** up to one year after the eligibility date if ***you*** pay all past ***premium*** for the coverage period.

2. **Other Court Orders for Dependent Children**
   Enrollment form must be received within 60 days from the date of the order.

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

3. **Marriage**
   Enrollment form must be received within 60 days of the date of marriage.

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

4. **Involuntary Loss of Minimum Essential Coverage**
   Enrollment form must be received within 60 days of the loss of coverage.

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

5. **Loss of Medicaid or SCHIP Coverage**
   Enrollment form must be received within 60 days from the date of loss of ***your*** coverage.

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

Domestic Partners

Definitions

Domestic Partners

Domestic Partners are two individuals who, together, meet all 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 Minnesota;
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 the following requirements:

1. Meet the definition of Domestic Partners as specified in the "Definitions" section above;
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 his or her 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 his or her Domestic Partner currently reside at, and intend to continue to reside in, the same principal residence; and,
6. The ***subscriber*** and his or her Domestic Partner must be jointly prepared to demonstrate at least two 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 his or her 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 six 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 Minnesota statutory requirements; or,
  - For health which satisfies Minnesota statutory requirements;
- The ***subscriber's*** last will and testament which specifies that his/her 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 his or her 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

1. A Domestic Partnership Affidavit must be fully completed within 60 days of the ***subscriber's*** initial eligibility; and,
2. **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 60 days of both:
   - The establishment of a domestic partner relationship; and,
   - The execution of a fully completed Domestic Partnership Affidavit certifying the date that the domestic partnership began and compliance with eligibility guidelines.

Termination of Domestic Partner Coverage

1. 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;
2. 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 Criteria – Domestic Partners" section; or,

- When there is a change in one or more of the qualifying conditions above, in the "Eligibility Criteria – Children of Domestic Partners" section.

When Coverage Ends

Coverage terminates for ***subscribers*** and covered ***dependents*** on the date that one of the following occurs:

- The ***policy*** terminates;
- The ***policy*** is not renewed; or,
- A service is no longer a ***covered service*** under the ***policy***, except that termination then relates only to that ***covered service***.

Coverage also terminates for ***subscribers*** and covered ***dependents*** for any of the following reasons:

- The ***subscriber*** ceases to meet eligibility requirements, including the requirement that ***subscribers*** reside in the ***Quartz service area***;
  - The **Departure Date** is *the date the **member** establishes residence outside the **service area**, or when **Quartz** receives notice of the **member's** intent to establish residence outside the **service area**, whichever is later*;
  - If the departure date is between the first and 15th of the month, the termination is effective at 11:59 p.m. on the last day of the month. For example, a ***member*** permanently leaving the ***service area*** on June 10 will have coverage terminated at 11:59 p.m. on June 30; or,
  - If the departure date is between the 16th and the end of the month, the termination is effective at 11:59 p.m. on the last day of the next month. For example, a ***member*** leaving the ***service area*** on the June 20 will have coverage terminated July 31.

  If ***you*** obtained coverage through MNSure, ***you*** must notify MNSure of ***your*** change of residence. MNSure will determine ***your*** effective date of termination;
- ***You*** request voluntary termination for ***you*** or for ***your dependents***;

- At ***your*** request, ***Quartz*** will terminate ***your*** coverage at 11:59 p.m. on the date of ***your*** request, or on a prospective date requested by ***you***, whichever is later, or;
- If ***you*** obtained coverage through MNSure, ***you*** must request disenrollment through MNSure. MNSure will determine ***your*** effective date of termination.

Only a ***subscriber***, the ***subscriber's*** spouse, or the ***subscriber's*** Domestic Partner may voluntarily terminate this ***policy***. Adult ***dependents*** may only voluntarily terminate their own enrollment in the ***plan*** but may not voluntarily terminate the entire ***policy***;

- The ***subscriber*** dies;
- The required ***premium*** is not paid in a timely fashion;
  - For ***members*** <u>not</u> receiving ***APTC***, ***your*** grace period for paying ***premiums*** is 31 days from the first of the month. If a ***premium*** payment is not received by the end of the grace period, ***your*** coverage under this ***policy*** terminates at 11:59 p.m. on the last day of the last month for which ***premium*** was paid in full. ***You*** will be responsible for paying ***your provider(s)*** for services after the date ***your policy*** terminates; or,
  - If ***you*** are receiving ***APTC***, the termination effective date is the last day of the first month in the three-month grace period;
- A ***dependent*** no longer qualifies as an eligible ***dependent***:
  - The termination effective date is 11:59 p.m. on the last day of the year in which the ***dependent*** no longer qualifies as an eligible ***dependent*** under this ***policy***;
  - A ***dependent*** ceases to be a ***dependent*** on the date they:
    - Are insured as a ***subscriber*** in or through any other Health ***plan***; or,
    - Are on active duty with the military service, including National Guard or reserves, other than for duty of less than 30 days;
  - A ***child dependent*** also ceases to be a ***dependent*** when they turn age 26, unless coverage is extended due to physical or mental impairment (see below);
- A ***member*** allows a non-member to use the ***member's*** Identification Card to obtain services. In this situation, the termination date will be the earliest date permitted by state law;

- The ***member*** has performed an act, practice or omission that constitutes fraud in applying for coverage. In this situation, the termination date will be the earliest date permitted by state law. At least 30 days' advance written notice will be provided to each ***member*** who would be affected by the disenrollment;
- The ***member*** is unable to establish or maintain a satisfactory physician–patient relationship with the ***physician*** responsible for the ***enrollee's*** care. Disenrollment will only occur once ***we*** have (1) provided the ***enrollee*** with the opportunity to select an alternate ***primary care provider***, (2) made a reasonable effort to assist the ***enrollee*** in establishing a satisfactory patient–physician relationship, and (3) informed the ***enrollee*** that they may file a grievance on this matter. In this situation, the termination date will be the earliest date permitted by state law. This disenrollment provision does not apply to ***members*** who receive coverage through MNSure.

Extension of Coverage for Children

Minnesota Statute 62A.14

Physical or Mental Impairment
Children who are currently covered under the ***policy*** 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, disfigurement or anatomical loss affecting one or more of the following body systems:

1. Neurological;
2. Musculoskeletal;
3. Special sense organs, including speech organs;

4. Respiratory;
5. Cardiovascular;
6. Reproductive;
7. Digestive;
8. Genitourinary;
9. Hemic and lymphatic;
10. Skin; or,
11. Endocrine.

Coverage may be continued as long as ***you*** remain insured under the ***policy*** and ***your child*** remains incapacitated and dependent upon ***you***. ***You*** must provide ***us*** with written proof of incapacity within 31 days after the ***child's*** attainment of the limiting age. Dependency proof will be verified by submitting a copy of ***your*** annual tax return that lists this ***child*** as a ***dependent***. Annually, or at reasonable intervals during the first two years of the continued coverage, ***we*** may request that an ***in-network provider*** examine ***your child***. ***You*** must notify ***us*** immediately of a cessation of incapacity or dependency.

Benefit Changes

An increase or decrease in benefits will become effective on the first day of **Your Contract Year**.

SECTION 5 – BENEFITS: COVERED AND NON-COVERED SERVICES

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

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

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

Please refer to Section 3 of this ***policy***, as well as ***your*** Summary of Benefits and Coverage for a list of services that require ***prior authorization***. Because ***we*** may periodically add, remove or otherwise change the ***prior authorization*** list, it is recommended that ***you*** contact ***us*** for ***prior authorization*** for the services listed. Please call the Customer Success Department at the telephone number provided in the Important Phone Numbers section of this ***policy***.

It is ***your*** responsibility to use ***in-network providers***. Non-emergency services from an ***out-of-network provider*** are not covered unless (1) they are a ***covered service*** as described in this section, and (2) an ***in-network provider*** has provided ***us*** with a written ***referral*** and ***our medical director*** has approved the ***referral*** prior to the services being provided.

If ***you*** would like to request a copy of a medical coverage ***policy***, please call the Customer Success Department at the telephone number provided in the Important Phone Numbers section of this ***policy***.

Acupuncture

Covered Services

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

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

Allergy Services

Covered Services

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

Non-Covered Services

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

Ambulance Services

Minnesota Statute 62J.48

Covered Services

1. Emergently needed transportation by a professionally licensed ground or air ambulance service to the nearest ***hospital*** equipped to adequately treat ***your*** condition. This includes ***ground ambulance service*** provided by a ground ambulance service provider, regardless of whether the patient was transported, if the service was provided pursuant to method of summoning emergency service 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***.
2. Urgent ***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 services.

Covered with Prior Authorization

1. Scheduled or prearranged non-emergent ambulance transportation as ordered or requested by ***your attending physician*** or attending nurse.

Autism Spectrum Disorders

Minnesota Statute 62A.3094

Covered Services

1. Diagnosis, evaluation, multidisciplinary assessment, and ***medically necessary care*** of children under 18 with ***autism spectrum disorders***, including but not limited to the following:
    - Assessment of the child's developmental skills, functional behavior, needs, and capacities;
    - Early intensive behavioral and developmental therapy based in behavioral and developmental science, including, but not limited

to, all types of applied behavior analysis, intensive early intervention behavior therapy, and intensive behavior intervention;
- Neurodevelopmental and behavioral health treatments and management;
- Speech therapy;
- Occupational therapy;
- Physical therapy; and
- Medications.

2. Treatment in accordance with an individualized treatment plan prescribed by the ***member's*** treating ***physician*** or mental health professional.

Quartz may request an updated treatment plan only once every six months, unless ***we*** and the treating ***physician*** or mental health professional agree that a more frequent review is necessary due to emerging circumstances.

An independent progress evaluation conducted by a mental health professional with expertise and training in ***autism spectrum disorder*** and child development must be completed to determine if progress toward function and generalizable gains, as determined in the treatment plan, is being made.

Behavioral Health and Substance Use Disorders

Quartz covers services for mental health diagnoses as described in the current edition of International Classification of Diseases (ICD), published by the U.S. Department of Health and Human Services, or as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM). Nationally recognized criteria are used to determine the level of care, continued stay and discharges for mental health and alcohol and other drug addictions are ***medically necessary***. All programs and services must be licensed by and meet the requirements of the local Health and Human Services Department.

Mental Health Parity Disclosure. ***You*** have rights to parity in mental health and substance use disorder treatment as required by the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and *Minnesota Statute 62Q.47*. These laws require that mental health and substance use disorder treatment are covered similarly to medical services. Cost-sharing for mental health and substance abuse services can be no more restrictive than cost-sharing for similar medical services. If ***you*** have questions regarding these rights, ***you*** may call member services, file a ***complaint*** with ***us***, or file a ***complaint*** with the Minnesota Department of Health.

Covered Services

1. ***Emergency*** behavioral health services provided by an emergency room or crisis stabilization program certified by the appropriate credentialing body in their state are covered for persons who are experiencing a behavioral health crisis or who are in a situation likely to turn into a behavioral health crisis if emergency support is not provided;
2. **Outpatient Services. *Quartz*** covers outpatient professional services for mental health and substance use disorders for evaluation and treatment of the condition. Services must be ***medically necessary*** and provided by licensed psychiatrists, psychologists, social workers, marriage and family therapists or licensed alcohol and drug counselors and ***clinical trainees***, as appropriate in each case. Mental health centers and mental health clinics must adhere to the licensure requirements of the State of Minnesota. This type of care would include:
    - Individual, group, family and multi-family psychotherapy. Mental health services for a minor include family therapy if an ***in-network provider*** recommends family therapy (*Minnesota Statute 62D.102*);
    - Services provided in adult, ***child*** or adolescent day treatment programs by ***in-network providers*** who are certified by the appropriate credentialing body in their state;
    - Services for persons with chronic mental illness provided through a community support program certified by the appropriate credentialing body in their state;

- Services provided in partial hospitalization programs by ***in-network providers*** who are certified by the appropriate credentialing body in their state;
- Services provided in intensive outpatient programs by ***in-network providers*** who are certified by the appropriate credentialing body in their state;
- A range of digital care options may also be available and are covered when received through ***in-network providers*** or a ***Quartz***-sponsored ***care management*** program.
- Medications provided as part of an outpatient treatment program;
- Medication management provided by a ***physician***, certified nurse practitioner or physician's assistant;
- Opiate replacement therapy including methadone treatment;
- Ambulatory detoxification service;
- Psychological testing services to determine diagnosis and treatment planning when receiving mental health services;
- ***Medically necessary*** services delivered through the psychiatric Collaborative Care Model (*Minnesota Statute 62Q.47(h)*);
- Covered services provided by ***clinical trainees*** will be reimbursed at a rate at least equal to 100 percent of the rate that would be paid to an independently licensed mental health professional performing the same services (*Minnesota Statute 62Q.47 (l)*).

3. Any treatment or therapy which is court-ordered, ordered as a condition of parole, probation, custody, or visitation evaluation unless the treatment or therapy is normally a ***non-covered service*** by ***Quartz***. Evaluations and treatment must be provided by an ***in-network provider***. A copy of the court order must be provided to ***Quartz*** (*Minnesota Statute 62Q.535*);
4. Treatment provided to an ***enrollee*** by the Department of Corrections while the ***enrollee*** is committed to the custody of the commissioner of corrections following a conviction for a first-degree driving while impaired offense (*Minnesota Statute 62Q.137*);
    - The treatment must be part of a sentencing order and the Department of Corrections must recommend treatment based on a chemical assessment;

- ***Quartz*** must be given a copy of the court's preliminary determination, supporting documents and the assessment conducted by the Department of Corrections;
- Payment rates for treatment provided by the Department of Corrections shall not exceed the lowest rate for outpatient substance use disorder services paid by the ***health plan company*** to an ***in-network provider*** of the ***health plan company***; and,
- Treatment provided by the Department of Corrections shall not be subject to a separate medical necessity determination under the health plan company's ***utilization review*** procedures; and,

5. Second opinion received from an ***in-network*** or ***out-of-network provider*** (*Minnesota Statute 62D.103*).

Covered with Prior Authorization

Quartz may cover ***medically necessary care*** that is provided in a less restrictive manner than inpatient treatment, but in a more intensive manner than outpatient treatment. The following services require ***prior authorization*** by ***Quartz*** and apply to the inpatient services benefits:

1. **Inpatient Services.** The ***plan*** covers ***medically necessary*** inpatient treatment of nervous and mental disorders or substance user disorders while ***confined*** in a ***qualified treatment facility***. A **qualified treatment facility** is defined as *a facility, institution, or clinic duly licensed and operating within the scope of its license.* This type of care would include programs approved under the following:
   - Medically managed inpatient treatment service;
   - Medically managed detoxification;
   - Medically monitored residential detoxification;
   - Medically monitored treatment;
   - A psychiatric unit including detoxification and psychiatric bed of an acute care general ***hospital***; or,
   - A psychiatric residential treatment facility.
2. Services provided in adult, ***child*** or adolescent residential treatment programs including residential treatment for emotionally disabled children when provided by a ***hospital*** or residential treatment center

licensed by the local state or Health and Human Services Department (*Minnesota Statute 62A.151*).

Non-Covered Services

1. Hypnotherapy, relationship counseling, or biofeedback relating to mental health services;
2. Sexual counseling services including but not limited to the treatment of sexual dysfunction, sexual inadequacy and inhibited desire;
3. Services by a non-payable ***provider*** as determined by ***us***, including ***providers*** practicing in non-certified facilities within the State of Minnesota;
4. Residential treatment as a substitute for legal actions or to provide respite for the family;
5. Recreational or non-skilled services or activities conducted through wilderness and camp programs, therapeutic boarding schools and academy-vocational programs;
6. Group homes and halfway houses for supportive and maintenance care;
7. Shelter services, correctional services, detention services, group residential services and foster care services;
8. Services provided by a ***clinical trainee*** that:
    - Are not within the ***clinical trainee***'s scope of practice; or,
    - Are not covered when performed by an independently licensed mental health professional at the same clinic; and,
9. Crisis intervention programs and services that do not meet the requirements or are not licensed by the local Health and Human Services Department. ***Covered services*** must be ***medically necessary*** and provided by licensed psychiatrists, psychologists, social workers, marriage and family therapists or licensed alcohol and drug counselors as appropriate in each case.

Biofeedback

Covered Services

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

Non-Covered Services

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

Cancer Treatment

Covered Services

1. ***Medically necessary*** cancer screenings. See the Preventive Services section for more information;
2. ***Medically necessary*** cancer treatment, including but not limited to coverage for off-label drugs as required under *Minnesota Statute 62Q.525*. Note - ***Quartz*** does not discriminate in cost-sharing between oral ***chemotherapy*** and intravenous ***chemotherapy*** drugs. See the Oral Chemotherapy Drug Disclosure in the Prescription Drugs (Outpatient) section for more information;
3. During a cancer clinical trial, ***routine patient care*** is covered including:
   - Health care services, items and drugs that are typically provided in health care, including health care services, items and drugs provided to a patient during the course of treatment in a cancer clinical trial for a condition or any of its complications, and that are consistent with the usual and customary standard of care, including the type and frequency of any diagnostic modality.

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

Coverage of ***routine patient care*** not associated with the clinical trial is subject to all terms, conditions, restrictions, ***exclusions*** and other requirements under the ***policy***;

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

Non-Covered Services

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

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

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

Cardiac Rehabilitation

Covered Services

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

Non-Covered Services

1. Cardiac rehabilitation in a home exercise program or rehabilitation that is no longer medically supervised care.

Chiropractic Services

Covered Services

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

Non-Covered Services

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

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

Chronic Diseases

Minnesota Statute 62Q.481

Co-payments or ***co-insurance*** for ***prescription drugs*** prescribed to treat a ***chronic disease*** will be no more than: (1) $25 per one-month supply for each ***prescription drug***, regardless of the amount or type of medication require to fill the prescription; and (2) $50 per month in total for all ***related medical supplies***. These cost-sharing limits do not increase with the number of ***chronic diseases*** for which ***you*** are being treated.

Deductible is waived unless it would disqualify a high deductible health plan from eligibility for a health savings account because the IRS minimum deductive has not been met.

"***Chronic disease***" for this provision means diabetes, asthma, and allergies requiring use of epinephrine auto-injectors.

"***Related medical supplies***" for this provision means syringes, insulin pens, insulin pumps, test strips, glucometers, continuous glucose monitors, epinephrine auto-injectors, asthma inhalers, and other medical supply items necessary to effectively and appropriately treat a ***chronic disease*** or administer a ***prescription drug*** prescribed to treat a ***chronic disease***.

Clinical Trials

Covered Services

1. Routine costs, items and services associated with the clinical trial are covered to the same extent they would otherwise be eligible for coverage;
    - The clinical trial must be a Phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition;
    - The ***member*** participating in the clinical trial must be eligible to participate in the trial according to the trial protocol and the referring health care professional's medical information establishing appropriateness; and,
    - The trial must be approved by one of the following:
        - The National Institute of Health or one of its cooperative groups or centers under the Federal Department of Health and Human Services;
        - The Federal Food and Drug Administration (FDA);
        - The Federal Department of Defense; and,
        - The Federal Department of Veterans Affairs.

Non-Covered Services

1. ***Routine patient care*** does not include the health care service, item or investigational drug that is the subject of the clinical trial. It does not include any health care service, item or drug provided solely to satisfy

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

Dental and Oral Surgery

Covered Services

1. **Routine Dental Care**. Routine dental care is covered for both pediatric and adult ***members*** when received from in-network dental providers. ***Covered services*** include but are not limited to preventive dental services, evaluations, and fillings performed at a dentist's office. For the purpose of dental coverage under this routine dental care provision only, an adult patient is a ***member*** who is age 20 or older, and a pediatric patient is a ***member*** who is under the age of 20.
   The following care is covered subject to these stated limitations, as well as the coinsurance amount disclosed in the member's ***Schedule of Benefits*** (SOB):
   - Class A – Basic – Diagnostic and Preventive Procedures
     - Oral examinations, limited to once every six months;
     - Prophylaxis (regular teeth cleaning), limited to once every six months;
     - Fluoride application is limited to once every six months for pediatric ***members***, and once every 12 months for adult ***members***;

  - Sealant application on 1st and 2nd permanent molars for pediatric ***members*** only, limited to one sealant per tooth every 36 months;
  - Bitewings, limited to one set every 12 months;
  - Panoramic films or a complete intra-oral series of radiographic images, limited to one set every five years;
  - Space maintainers only for pediatric ***members***;
- Class B – Intermediate – Basic Restorative Procedures, General Procedures
  - Fillings, either posterior resin/white fillings or amalgam/silver fillings;
  - Prefabricated stainless steel crowns for primary (D2930) and permanent (D2931) teeth;
  - Some periodontal procedures, such as maintenance, scaling and root planning;
- Class C – Major – Major Restorative Procedures, Endodontic Procedures, Periodontal Procedures
  - Crowns for permanent teeth, limited to one per tooth every five years for ***members*** 12 years and older;
  - Frequency limits at 24 months may apply;
  - Having a pre-treatment estimate submitted by ***your*** in-network dental provider is recommended;
- Class D – Orthodontic Procedures, only for pediatric ***members*** and subject to ***medical necessity***. ***Quartz's*** dental vendor calculates payment for all orthodontic treatment schedules as follows:
  - Twenty-five percent of the total maximum plan allowance (subject to the ***member's*** applicable ***co-insurance*** amount) is the initial payment made by the ***plan***;
  - The remainder of the maximum ***plan*** allowance is divided by the months of treatment, and the resulting amount is paid monthly by the ***plan*** (subject to the ***member's*** applicable ***co-insurance*** amount).

There is no ***deductible*** for routine dental care covered under this provision.

If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the ***covered expense*** will be equal to the charge for the least expensive procedure. This provision is not intended to dictate a course of treatment; instead, it is designed to determine the amount of the ***covered expense*** for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, ***you*** may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

2. Anesthesia and ***hospital*** or ***ambulatory surgery center*** charges when necessary for dental care or oral surgery for an individual under age five, or a chronically disabled individual that is attributed to a mental or physical impairment or combination of mental or physical impairments; is likely to continue indefinitely; results in substantial functional limitations in one or more of the following areas of major life activity; self-care; receptive and expressive language; learning; mobility; capacity for independent living; and economic self-sufficiency; or the individual has a medical condition that requires ***hospitalization*** or anesthesia;
3. Extraction of teeth to prepare jaw for radiation treatment or in preparation for a covered transplant;
4. Oral surgery for partially or completely unerupted impacted teeth, e.g., wisdom teeth (*Minnesota Statute 62E.06(12)*), a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;
5. Oral surgical services, including related consultation or office visit, x-rays and anesthesia, limited to the excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth; and
6. Sealants or topical fluoride treatment to existing teeth in preparation for ***chemotherapy***.

Covered with Prior Authorization

1. Procedures to repair and/or replace a ***sound natural tooth*** (free from decay or defect) damaged as a result of accidental trauma to the

teeth or jaw, regardless of whether the individual was covered under the ***policy*** during the time of the accidental ***injury***.

- A dental repair method may be covered in lieu of extraction;
- Replacement may be considered if approved by ***us*** prior to the service; and,
- Treatment must commence within 90 days of the accident and will be covered for a maximum of 12 months after treatment begins.

2. ***Temporomandibular Joint Dysfunction (TMJ)*** (*Minnesota Statute 62A.043, Subd. 3*) ***TMJ*** is defined as *a disorder of the jaw joint(s) and/or associated parts, resulting in pain or inability of the jaw to function properly.* Coverage is provided for surgical and nonsurgical correction (including orthodontics) of ***TMJ***, including craniomandibular dysfunction (CMD), reduction of dislocations and displacements. Surgical procedures are covered when 1) the condition is caused by a ***congenital***, developmental or acquired deformity, disease or ***injury***, 2) the procedure is reasonable and appropriate for the diagnosis or treatment of the condition, and 3) the procedure is being performed to control or eliminate pain, infection, disease or dysfunction. Nonsurgical treatment of ***TMJ*** including intraoral splint therapy is covered when considered ***medically necessary***.

Non-Covered Services

1. Services and/or treatment not prescribed by or under the direct supervision of a dentist;
2. Services and/or treatment determined to be ***experimental or investigative*** or not dentally necessary;
3. Plaque control programs, oral hygiene instruction or dietary instructions;
4. Gold foil restorations;
5. Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
6. Sealants for teeth other than permanent molars;
7. Precision attachments, personalization, precious metal bases and other specialized techniques;
8. Fabrication of athletic mouth guard;

9. Internal bleaching;
10. Nitrous oxide;
11. Oral sedation;
12. Orthodontic Procedures (Class D) for adult ***members*** unless necessary for the treatment of ***TMJ***;
13. Procedures determined to be partially or wholly cosmetic in nature;
14. Repair or replacement of a ***sound natural tooth*** where damage is sustained due to chewing;
15. Repair or replacement of a ***member's*** dental implants damaged during an accident;
16. Dental and oral surgery treatment, services and supplies not specifically indicated as ***covered services***.

Diabetes Services

Minnesota Statute 62A.3093

Covered Services

1. Diabetic self-management education programs;
2. Preferred diabetic supplies, including blood glucose meters, insulin syringes; blood test strips and tablets (glucose and ketone), urine test strips and lancets when provided by an ***in-network pharmacy***. Diabetic supplies are limited to those listed in ***our*** current ***drug formulary***/diabetic supply Listing. ***You*** can review the current listing by visiting ***our*** website at ***QuartzBenefits.com/formulary***;
3. 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;
4. Cost-sharing limits apply to ***prescription drugs*** and related medical supplies as described in the "Chronic Diseases" section.

Covered with Prior Authorization

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

Non-Covered Services

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

Drugs and Biologicals

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

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

Some drugs or biologic products covered under the medical benefit require ***prior authorization***. To control costs, ***Quartz*** may require ***members*** to receive designated products from select ***in-network providers***. Failure to obtain the

drug at an approved ***in-network provider*** will result in a denial of coverage for the drug.

Dietary Counseling and Supplements

Covered Services

1. Dietary counseling when (1) provided in conjunction with treatment of an ***illness***, such as diabetes, hypertension or morbid obesity, and (2) ordered by an ***in-network provider*** consistent with the medical protocol for treatment of that diagnosis;
2. Dietary counseling visits for treatment of hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease; and,
3. Phenylketonuria testing, diagnosis and treatment including dietary management, ***care management***, intake and screening, assessment, comprehensive care planning and service ***referral*** (*Minnesota Statute 62A.26, Subd.2*).

Covered with Prior Authorization

1. Enteral feedings, equipment, and supplies are covered when the following are met:
   - Feedings must be ordered by an ***attending physician*** and/or registered dietician;
   - Meets all medical necessity criteria;
   - ***Prior authorization*** must be updated at least annually;
2. LINX procedure for the treatment of GERD (i.e., acid reflux); and
3. Amino acid-based elemental formulas for the treatment of phenylketonuria in infants, and when ***medically necessary*** for all individuals, pursuant to *Minnesota Statute 62Q.531*.

Non-Covered Services

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

Disposable Medical Supplies

Covered Services

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

Non-Covered Services

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

Durable Medical Equipment

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

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

Examples include but are not limited to mattresses, TENS/neurostimulators, power-operated vehicles, crutches, wheelchairs, hospital beds, equipment used in the administration of oxygen. Rental or purchase of items is at ***our*** option, based on cost effectiveness and the type of equipment. See the "Orthotic and Prosthetic Devices" for information on coverage for ***orthotic*** and ***prosthetic devices*** including but not limited to artificial limbs.

In comparing equipment alternatives, ***we*** consider whether distinct medical advantages justify greater cost or more frequent replacement. Thus, ***we*** do

not cover added costs for equipment that has no advantage over a suitable alternative other than convenience or personal preference. ***We*** also do not cover repair or replacement of equipment damaged because of negligent use or abuse. ***We*** reserve the right to determine whether to rent or purchase. If more than one piece of ***durable medical equipment*** can meet ***your*** functional needs, benefits are available only for the equipment that meets the minimum specifications for ***your*** needs.

Exhaustion of an active warranty is required before ***Quartz*** will replace ***durable medical equipment***.

Covered Services

1. Purchase or repair of ***medically necessary durable medical equipment***. Certain durable medical equipment may require ***prior authorization*** for coverage. Please review the list of items and services that require ***prior authorization*** on ***our*** website at ***QuartzBenefits.com/MNPAList***;
2. Compression stockings when prescribed by an ***in-network provider***, up to a maximum of two pairs (four stockings) per ***benefit year***;
3. Standard breast prosthesis is limited to one per side every 24 months. Two mastectomy bras are allowed per ***benefit year*** when obtained from an ***in-network provider***;
4. Certain blood pressure cuffs and connected scales may be covered when medically appropriate, as determined by ***Quartz***, including services for remote monitoring of these devices; and
5. Replacement batteries for electric wheelchairs.

Covered with Prior Authorization

1. Purchase or repair of ***medically necessary durable medical equipment*** for items requiring ***prior authorization***. Note, ***prior authorization*** is never required for the purchase of hearing aids;
2. Equipment rental;
3. Prothrombin (INR) Time Home Testing System;
4. Home infusion therapy and associated services and supplies; and,
5. Mobility devices (scooter, stroller, or wheelchair) - only one type is covered at a time.

Non-Covered Services

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

management to ***members*** who are eligible for and enrolled in a ***Quartz***-sponsored clinical or disease management program.

Emergency Services

Minnesota Statute 62Q.55

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

Covered Services

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

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

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

Non-Covered Services

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

Experimental or Investigative Treatment and Services

Minn. Rule 4685.0100

Non-Covered Services

1. ***Experimental, investigative, or unproven services*** are not covered. ***Experimental, Investigative or unproven services*** means *a drug, device, medical treatment, diagnostic procedure, technology, or procedure for which reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes*.

   Quartz will make its determination on whether a services is ***experimental or investigative*** based upon a preponderance of evidence after the examination of the following reliable evidence, none of which shall be determinative in and of itself:
   - Whether there is final approval from the appropriate government regulatory agency, if approval is required;

- Whether there are consensus opinions and recommendations reported in relevant scientific and medical literature, peer-reviewed journals, or the reports of clinical trial committees and other technology assessment bodies; and,
- Whether there are consensus opinions of national and local health care ***providers*** in the applicable specialty or subspecialty that typically manages the condition as determined by a survey or poll of a representative sampling of these ***providers***.

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

Gender-Affirming (Transgender) Services

Gender-affirming **health care services** means *all medical, surgical, counseling, or referral services, including telehealth services, that an individual may receive to support and affirm that individual's gender identity or gender expression and that are legal under the laws of the State of Minnesota*.

Gender dysphoria means *psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity*.

Covered

1. ***Medically necessary gender-affirming health care services*** for the treatment of ***gender dysphoria*** are covered. ***Quartz*** may base its criteria for coverage on multiple national standards of care and the expert advice of practitioners in the ***Quartz provider network***; however, they will be no more restrictive than allowed under *Minnesota Statute*

62Q.585, Subd. 2. See ***our*** website at *QuartzBenefits.com/MNPAList* for a list of services that require ***prior authorization***.

Non-Covered Services

1. ***Gender dysphoria***-related treatment that is not based on the most recent published medical standards set forth by nationally-recognized medical experts in the transgender health field; and,
2. Conversion therapy. "Conversion therapy" refers to any practice by a mental health care ***provider*** that attempts to change a person's sexual orientation or gender identity.

Genetic Testing

Covered Services

1. Routine testing for prenatal genetic screening.

Covered with Prior Authorization

1. Genetic testing for predisposition or carrier status for a genetic disorder when a certified genetic counselor has determined it is likely that ***you*** carry a gene mutation that substantially increases ***your*** risk of developing the disorder and the presence of a mutation will lead to modifications in future medical care;
2. Testing when ***you*** are already diagnosed with the disorder if therapy or surveillance will be modified based on the presence of a mutation;
3. BRCA testing;
4. Biomarker testing to diagnose, treat, manage, and monitor ***illness*** or disease if the test provides clinical utility demonstrated by medical and scientific evidence in accordance with *Minnesota Statute 62Q.473*; and
5. Rapid whole genome sequencing ("rWGS") is covered when all of the following conditions have been met:
    - The ***member*** is 21 years of age or younger and a Minnesota resident;

- The ***member*** has a complex or acute ***illness*** of unknown etiology that is not confirmed to have been caused by an environmental exposure, toxic ingestion, an infection with a normal response to therapy, or trauma; and,
- The ***member*** is receiving inpatient hospital services in an intensive care unit or neonatal or high acuity pediatric care unit when ***medically necessary*** as specified under *Minnesota Statute 62A.3098*.

Cost-sharing applicable to diagnostic testing applies.

Non-Covered Services

1. Testing that is done for the purpose of identifying a mutation that is for the benefit of a non-covered family ***member***.

Hearing Services

Minnesota Statute 62Q.675

Covered Services

1. Initial hearing screening test(s), limited to one per ***benefit year***;
2. Hearing screenings payable under the wellness benefit for children up to age 21;
3. Hearing examinations provided as part of the treatment for medical conditions;
4. Hearing aids, which include any externally wearable instruments or devices designed to enhance hearing, that are:
   - Prescribed by a ***physician*** or audiologist in accordance with accepted professional medical or audiological standards;
   - For ***members*** who have coverage under the ***policy*** or ***plan***, and who are certified as deaf or hearing impaired by a ***physician*** or an audiologist;
   - Coverage for hearing aids is limited to one hearing aid per ear every three years; and,

- Prescribed hearing aids must be obtained from an ***in-network provider*** and are limited to specific models. To obtain a list of covered hearing aid models, contact Customer Success or visit ***QuartzBenefits.com/hearingaids***.
    - ***Quartz*** will also cover the cost of over-the-counter hearing aids in lieu of prescribed hearing aids;
    - If the hearing aid recommended is not on ***Quartz's*** list of covered hearing aid models, including over-the-counter models, coverage will be limited to $1,500 per hearing aid, per ear, every three years; and

5. Bone anchored hearing aids when medically indicates.
6. **Treatment** (defined as *services, diagnoses, procedures, surgery, and therapy provided by a health care professional*) related to hearing aids and cochlear implants is also covered.

Covered with Prior Authorization

1. Cochlear implants; and,
2. Implantable instruments or devices designed to enhance hearing (except ***prior authorization*** is not required for bone anchored hearing aids).

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

Non-Covered Services

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

Home Health Care

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

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

Home health care is limited to 120 visits in any 12-month period for each person covered under the ***policy***. Up to four consecutive hours in a 24-hour period of home health aide service shall be considered as one ***home health care*** visit. The 12-month period begins each ***benefit period***.

Covered with Prior Authorization

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

2. Only as required by *Minnesota Statute 62A.155*, coverage for up to 120 hours of services provided by a home care nurse or personal care assistant to a ventilator-dependent person during the time the ventilator-dependent person is in a ***hospital***. The personal care assistant or home care nurse shall perform only the services of communicator or interpreter for the ventilator-dependent patient during a transition period of up to 120 hours to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient;
3. Physical, respiratory, occupational, speech therapy or nutritional counseling;
4. Home infusion therapy;
5. Medical supplies, drugs and laboratory services covered to the same extent they would have been covered if ***you*** were ***confined*** in a ***hospital***; and
6. For enrollees who are concurrently covered by both the ***health plan*** and enrolled in medical assistance under Minnesota Statute, Chapter 256B, ***medically necessary home care nursing*** required under *Minnesota S*tatute 62Q.545. **Quartz's** coverage under this paragraph will adhere to the duration, location, frequency and provider restrictions for home care nursing services at Minnesota Statute section 256B.0625, subdivision 7, only to the extent that an enrollee's care is covered under their medical assistance benefits.

Non-Covered Services

1. Homemaker or caretaker services, including sitter or companion services, housecleaning, or household maintenance.

Hospice Services

Hospice services are designed to meet the needs of a terminally ill patient, and are provided when a ***member's attending physician*** certifies the ***member*** has a life-limiting condition. Approved services can be provided in a

facility or in the home. ***We*** require notification only for the initial admission to hospice and any inpatient hospice admission.

Covered Services

1. ***Hospice care*** when provided by a hospice facility that is approved by us. There are four levels of care provided by a licensed hospice program: routine home care, continuous home care, inpatient respite care, and general inpatient care;
2. A ***hospice care*** program consists of but is not limited to the following: hospice ***physician*** services, professional services of a registered nurse or licensed practical nurse, physical therapy, occupational and speech therapy, medical and surgical supplies, ***durable medical equipment***, prescribed drugs, in-home laboratory services, medical social service consultations and dietitian services;
3. Pastoral services and family counseling related to ***your*** condition including bereavement counseling for one year after ***your*** death; and,
4. ***Medically necessary*** ambulance transportation including non-emergent ambulance transportation.

Non-Covered Services

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

Hospital Services

Covered Services

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

1. Daily room and board in a semi-private room, ward, intensive care or coronary care unit, including general nursing care. Benefits for a private or single room are limited to the charges for a semi-private room in the ***hospital*** where ***you*** are ***confined*** unless ***medically necessary***;
2. Hospital services and supplies furnished for ***your*** treatment during ***confinement***, including drugs administered to ***you*** as an inpatient; and,
3. Inpatient ***confinement*** in an out-of-network ***hospital*** in the case of an ***emergency medical condition***, a rare disease or condition, or with an approved ***referral***.

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

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

Non-Covered Services

1. Continued ***hospital*** stay if the ***attending physician*** has documented that care could effectively be provided in a less acute care setting (e.g., a ***skilled nursing facility***);

2. ***Hospital*** or observation stays which are extended for reasons other than medical necessity, such as lack of transportation, lack of caregiver and inclement weather;
3. Take-home medications and supplies which are outpatient drugs dispensed in a ***provider's*** office or nonretail pharmacy locations. This includes pharmacy supply fees and dispensing fees on medical benefit drugs dispensed for self-administration at the patient's home;
4. Convenience items such as guest trays;
5. Educational materials; and,
6. A private room that is not ***medically necessary***, or is at ***your*** request.

Immunizations

Covered Services

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

Non-Covered Services

1. Immunizations solely for the purpose of travel, employment or education regardless of whether they are recommended by the Centers for Disease Control, unless otherwise ***medically necessary*** or covered under the Wellness section of this ***Certificate***.

Intermittent Catheters

Up to 180 intermittent urinary catheters per month are covered if intermittent catheterization is recommended by ***your*** health care ***provider***. This coverage includes medically appropriate insertion supplies.

Kidney Disease Treatment

This benefit includes but is not limited to dialysis, transplantations, donor-related services, diagnostic and therapeutic testing, related outpatient medications and related ***physician*** charges.

Covered Services

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

Covered with Prior Authorization

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

Lyme Disease Treatment

Minnesota Statute 62A.265

Covered Services

1. ***Medically necessary*** Lyme disease treatment that meets the current standards of medical practice.

Maternity/Newborn

Minnesota Statutes 62A.0411 and 62A.047

Covered Services

1. Treatment of pregnancy includes the following:
    - ***Prenatal care***, defined as *the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology,*

when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists;

- Support care that may be available through ***Quartz's*** contracted doula and midwifery service ***providers***;
- Coverage for inpatient hospital care;
- Postnatal care;
- Comprehensive postnatal visits are covered according to *Minnesota Statute 62Q.521*;
- ***Complications of pregnancy*** are payable as any other covered ***illness*** at the point the complication sets in;
- Forty-eight (48) hours of inpatient hospital care following vaginal delivery and 96 hours of inpatient hospital care following a caesarean section delivery. The length of stay coverage begins is when a delivery occurs in a ***hospital*** (at the time of delivery). For deliveries outside the ***hospital***, the stay begins at the time the mother and/or newborn are admitted. The decision of whether an admission is in connection with childbirth is a medical decision to be made by ***your*** attending ***provider***, not us. Coverage will be provided for a shorter length of stay if the attending ***provider***, in consultation with the mother, decides on an earlier discharge. Coverage will be provided for a longer length of stay if ***medically necessary***. ***We*** are prohibited from requiring **prior authorization** for the minimum stay; however, ***we*** may impose continued stay approval for the portion of stay after the 48 or 96 hours;

2. Expenses related to transfer of the mother, newborn and newborn siblings to a different medical facility, if transfer of the mother or newborn is recommended by the health care ***provider***. Cost-sharing is waived unless it would disqualify a high deductible health plan from eligibility for a health savings account because the IRS minimum ***deductible*** has not been met (*Minnesota Statute 62A.0411*);
3. Nursery room, board and care;
4. Routine examination and other routine professional services rendered to the newborn ***child*** before release from the ***hospital***;
5. Coverage is provided for one home visit by a registered nurse within four days following early discharge. Services provided by the nurse will

include parent education, assistance and training in breast and bottle feeding and any appropriate and necessary clinical tests;
6. Circumcisions;
7. Necessary care and treatment of all medically diagnosed ***congenital*** defects, birth abnormalities, prematurity and the functional repair or restoration of any body part when necessary to achieve normal body functioning.
8. Well-baby care rendered after release from the ***hospital***; and,
9. Breastfeeding support and counseling, including the purchase of one basic electric breast pump or one basic manual breast pump, and supplies, in conjunction with each birth.

Non-Covered Services

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

Orthotic and Prosthetic Devices

Minnesota Statute 62Q.665, 62Q.6651

Orthotic device means *an external medical device custom-fabricated or custom-fitted to a specific individual based on the individual's unique physical condition, applied to a part of the body to correct a deformity, provide support and protection, restrict motion, improve function, or relieve symptoms of a disease, syndrome,* **injury***, or postoperative condition*.

Prosthetic device means *an external device used to replace or restore a missing limb, appendage, or other external body part*.

Quartz renders benefit determination reviews for coverage of ***orthotic*** or ***prosthetic devices*** in a nondiscriminatory manner and will not deny coverage for ***habilitative*** or rehabilitative benefits, including prosthetics or orthotics, solely on the basis of a ***member's*** actual or perceived disability. ***We*** will not deny a ***prosthetic*** or ***orthotic*** benefit for an individual with limb loss or absence that would otherwise be covered for a nondisabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

If the ***medically necessary orthotic*** or ***prosthetic device*** is not available from an ***in-network provider***, ***Quartz*** will refer ***you*** to an ***out-of-network provider*** and in-network cost-sharing will apply.

Covered Services

1. ***Orthotic device*** or ***prosthetic devices***, supplies, accessories, and services customized to the ***member's*** needs, at least equal to coverage provided under ***Medicare***, when deemed ***medically necessary*** by a prescribing ***physician*** or an appropriately licensed health care ***provider***.
    - ***Quartz*** covers the most appropriate model as determined by ***your provider*** that meets ***your*** needs for purposes of performing physical activities including but not limited to running, biking, swimming and maximizing limb function.
    - ***Orthotic*** and ***prosthetic devices*** for showering or bathing are also covered.
2. Any provision, repair or replacement of a covered ***orthotic*** or ***prosthetic device*** that is performed by an accredited facility in comprehensive orthotic or prosthetic services or an appropriately licensed health care ***provider***.
    - Replacement of a device or part of a device is covered if the ordering ***provider*** determines replacement is necessary because the patient's physiological condition has changed, the device or part cannot be repaired, or the cost of repairs would exceed 60% of the cost of replacement;
    - ***Quartz*** may require ***provider*** confirmation that replacement is necessary if the device or device part is less than three years old;
    - Replacement batteries for prosthetics are also covered;

3. Orthopedic shoes, foot orthotics, and other supportive devices will also be covered under the following conditions:
   - Shoes when the shoe is an integral part of a leg brace and its expense is included as part of the cost of the brace;
   - Custom-molded foot orthotics for treatment of diabetic-related foot conditions;
   - Custom-molded foot orthotics for treatment of foot conditions related to Peripheral Vascular Disease;
   - Therapeutic shoes for persons with diabetes or peripheral vascular disease; and,
   - For children up to the age of three years old with the diagnosis of metatarsus adductus, atavistic great toe and/or club feet. Covered for infants up to one year old with diagnosis of severe calcaneal valgus.

Non-Covered Services

1. Orthopedic shoes not listed above, and other non-medically necessary supportive devices.
2. Back-up supplies, equipment or prostheses (i.e., a second set); and,
3. Repairs and replacement of supplies, equipment or prostheses if lost, stolen or if unusable and non-functioning due to misuse, abuse or neglect.

Ovarian Cancer Screening

Minnesota Statute 62A.30

Covered Services

1. Surveillance testing for ovarian cancer for women ***at risk for ovarian cancer***, including CA-125 serum tumor marker testing, transvaginal ultrasound, pelvic examination, or other proven ovarian cancer screening tests currently being evaluated by the federal Food and Drug Administration or by the National Cancer Institute.

Under *Minnesota Statute 62A.30*, "**at risk for ovarian cancer**" means *testing positive for BRCA1 or BRCA2 mutations or having a family history of*:

- *One or more first- or second-degree relatives with ovarian cancer;*
- *Clusters of women relatives with breast cancer; or,*
- *Nonpolyposis colorectal cancer.*

Non-Covered Services

1. Surveillance testing for ovarian cancer for women not considered "***at risk for ovarian cancer***" under *Minnesota Statute 62A.30*.

PANDAS/PANS

Minnesota Statute 62A.3097

Covered Services

1. Diagnosis of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS); and,
2. ***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.

Non-Covered Services

1. Services generally excluded under the ***policy***, such as:
   - Non-urgent, non-emergent services obtained from ***out-of-network providers***;
   - ***Experimental, investigative, or unproven services***; and,
2. Services outside the standards of care for PANDAS/PANS, as determined by ***Quartz***.

Phenylketonuria (PKU) and Elemental-Based Infant Formulas

Minnesota Statute 62A.26

Covered with Prior Authorization

1. Special dietary treatment for PKU;
2. Special dietary treatment for other inborn errors of metabolism, including but not limited to enteral or elemental-based infant formulas.

Pharmacist Services

Minnesota Statute 62D.1071

In addition to coverage described under the Prescription Drug Benefit section, ***Quartz*** provides coverage for medical services performed by a licensed pharmacist to the extent the services are within the pharmacist's scope of practice.

Physician/Clinician Services

A **qualified practitioner** must be *state licensed, practicing within the scope of their license, and practicing in a state licensed facility/office in accordance with the health plan standards and based on Minnesota law.*

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

A **clinician** is defined as *a physician assistant, clinical nurse practitioner, nurse midwife, medical technician, physical therapist, and other similar*

*health care **providers** that provide services under the supervision of an* **in-network provider**.

Covered Services

1. Office visits;
2. Inpatient visits;
3. Surgery services;
4. Anesthesia services;
5. Telemedicine services; and,
6. Second opinion received from an ***in-network provider***.

Podiatric Services

Covered Services

1. Podiatric services, including non-operative treatment for a condition of the foot, including, but not limited to the following:
   - Mycotic nails;
   - Metabolic, neurologic or peripheral vascular disease; or,
   - When performed as a necessary and integral part of an otherwise ***covered service***, such as diagnosis and treatment of ulcers, wound, or infections;
   - Routine hygiene and maintenance care such as trimming corns, calluses, and nails; or,
   - Cutting, trimming, or other non-operative partial removal of toenails;

Non-Covered Services

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

Prescription Drug Benefit

DEFINITIONS

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*** product) and has been shown to have no clinically meaningful differences from the ***biologic 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***.

Covered Drug
Subject to ***Quartz's formulary*** and any ***prior authorization*** or step therapy requirements, a ***covered drug*** is:

1. Any ***prescription frug*** on ***Quartz's formulary list*** as a ***formulary drug***, including prescription contraceptives;
2. Injectable insulin, insulin syringes, glucose test strips and certain continuous glucose monitors on ***Quartz's formulary list*** as ***formulary drugs***;
3. 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;

4. 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 do not require a prescription; or,
5. A ***medical food Quartz*** determines is a ***formulary drug***. The ***medical food*** must be listed on ***Quartz's formulary list*** as a ***formulary drug*** and obtained from a pharmacy with a written ***prescription order*** from a ***physician*** who is supervising its use.

Formulary

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

Formulary Drug

A medication designated as a ***formulary drug*** by ***Quartz's*** Pharmacy and Therapeutics Committee and listed on ***Quartz's formulary list***.

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*** can also view the most current ***formulary list*** by visiting ***our*** web site.

Generic Drug
A medication determined to be a generic by ***Quartz***. A ***generic drug*** is typically a medication that has been approved by the FDA through an Abbreviated New Drug Application (ANDA) as equivalent to a FDA-approved innovator product (***brand drug***). Authorized generics approved by the FDA through a New Drug Application (NDA) when there are no generic competitors of the same medication approved through an ANDA may be considered to be ***brand drugs*** by ***Quartz***.

HDHP $0 Drug
A medication that has been designated by ***Quartz*** on the ***formulary list*** as being covered at $0 before ***deductible*** for High Deductible Health Plans (HDHPs).

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

In-Network Pharmacy
Any pharmacy that has contracted with ***Quartz***, or ***Quartz's*** designee, to provide pharmacy services or supplies to ***Quartz members***. Please visit ***Quartzbenefits.com*** for a list of ***in-network pharmacies***.

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 provided by a pharmacy and required to identify or treat a ***member's illness*** or ***injury***, and which are, as determined by the ***plan***:

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

The ***member's*** prescriber makes decisions regarding service and treatment. The ***plan***, using criteria approved by ***Quartz's*** Pharmacy & Therapeutics Committee, has the authority to determine whether a service, treatment, procedure, ***prescription drug***, device or supply is ***medically necessary*** and eligible for coverage under the ***plan***.

Non-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 (2) has been reviewed and approved for marketing by the FDA through either a new drug, abbreviated new drug or Biologic License Application.

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

Preventive Medication
A medication, including both prescription and ***over-the-counter drugs***, determined by CMS to be a Preventive Health Service as defined in 45 CFR § 147.130.

Restricted Drug or Restricted Medication
A drug that is covered only when specific clinical criteria are met and ***Quartz*** issues an ***authorization*** for coverage of the drug. The clinical criteria for some ***restricted drugs*** require the failure of prerequisite therapies. When the criteria only consist of previous failure of a certain

medication or medications and are implemented with on-line edits, it is referred to as "step therapy."

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

Specialty Pharmaceutical
A drug that is designated by the Pharmacy & Therapeutics Committee as being a ***specialty pharmaceutical***. Drugs designated as ***specialty pharmaceuticals*** will be listed as specialty on ***Quartz's formulary list*** at ***QuartzBenefits.com/formulary*** and are subject to change.

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

BENEFITS

Prescription drug benefits are available for ***covered drugs*** prescribed by or at the direction of a ***provider***. The ***prescription drug*** must be deemed ***medically necessary*** by ***Quartz*** and must have an approved ***prior authorization***, 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***. ***Quartz*** provides a process for ***you*** or ***your provider*** to request coverage of a ***non-formulary drug*** on an exception basis. An exception request can be made using ***Quartz's*** Medication Prior Authorization Form, available at ***QuartzBenefits.com***, or by calling (800) 496-7509. The timeline for ***our*** review of an exception request will vary based on the urgency of ***your*** situation. ***We*** will inform ***you*** of ***our*** decision on a standard request within 72 hours of receipt. Urgent requests made in exigent circumstances will be reviewed within 24 hours. Exigent circumstances exist when an ***enrollee*** is suffering from a health condition that may seriously jeopardize the ***enrollee's*** life, health, or ability to regain maximum function or when an ***enrollee*** is undergoing a current course of treatment using a ***non-formulary drug***. If a standard request is approved, ***we*** will authorize coverage of the ***non-formulary drug*** for the duration of the prescription, including refills. If an exigent request is approved, ***we*** will authorize coverage of the ***non-formulary drug*** for the duration of the exigency. Co-pay or ***co-insurance*** will be at the non-preferred or Tier 4 level, depending on the status of the medication.

Benefits are payable for charges made by an ***in-network pharmacy*** for each separate prescription ***claim***. ***Restricted medications*** require approved ***prior authorization*** for coverage. Requests for exceptions to step therapy requirements will be reviewed based on *Minnesota Statute 62Q.184* (see below). Continuation of therapy criteria may apply to ***members*** who were previously approved for coverage. Persons who were not previously approved for coverage but who instead initiated therapy using a manufacturer-sponsored free drug program, ***provider*** samples or vouchers will not be considered to have met continuation of therapy criteria for coverage.

Prescription ***claims*** may be subject to ***co-payment, deductible***, or ***co-insurance***. ***Members*** with ***co-payment plans*** are subject to one ***co-payment*** for each ***claim*** dispensed up to a 30-day supply (i.e., 1 – 30

day supply = 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, as determined by ***Quartz***, for the purposes of synchronizing refills for the ***member***, a prorated ***co-payment*** will apply based on the percentage of a 30-day supply dispensed. Refer to ***your Schedule of Benefits*** for details or contact ***Quartz*** Customer Success.

If ***you*** use a pharmaceutical manufacturer program or other cost assistance to off-set ***out-of-pocket co-payment***, ***deductible***, or ***co-insurance*** for ***your prescription drug*** costs, those amounts [will be applied to ***deductibles*** and ***out-of-pocket limits*** as indicated on the ***claim*** received by ***Quartz***][will not be applied to ***your*** annual ***deductible*** or ***out-of-pocket limit***, unless required under state or federal law]. If ***you*** have a high deductible health plan designed to be compatible with a Health Savings Account (HSA), using cost-sharing assistance before the minimum ***deductible*** has been met may disqualify ***you*** from making compliant HSA contributions during the plan year.

In order for ***Quartz*** to keep ***prescription drug*** benefits affordable, cost-sharing for certain specialty medications may vary and be set to approximate the maximum of any available manufacturer-funded copay assistance programs. However, in no case will true ***out-of-pocket*** costs to the participant be greater than the maximum ***co-payment*** published in the ***Schedule of Benefits*** Summary of Benefits and Coverage (SBC).

If the ***Quartz*** Pharmacy & Therapeutics Committee makes a formulary change that will result in a change to a ***member's out-of-pocket*** cost or coverage of a medication, including removals or tier changes, the change will not apply to a ***member*** previously prescribed the drug until the ***member's*** plan year ends unless one of the following applies:

- For a brand name drug, ***Quartz***:
  - Adds to the ***formulary*** a ***generic*** or multisource ***brand name drug*** rated as therapeutically equivalent according to the

FDA Orange Book, a biologic drug rated as interchangeable according to the FDA Purple Book, or a ***biosimilar*** at the same or lower cost to the ***member***; and,

- Provides at least a 60-day notice to prescribers, pharmacists, and affected ***members***; or,

- The drug has been deemed unsafe by the FDA; or,
- The drug has been withdrawn by the FDA or drug manufacturer; or,
- An independent source of research, clinical guidelines, or evidence-based standards has issued drug-specific warnings or recommended changes with respect to a drug's use for reasons related to previously unknown and imminent patient harm.

Quartz will provide written notice to the ***member*** at least 30 days in advance of the change (often more than 90 days).

When prescribed by a ***physician*** or other health care ***provider***, ***formulary drugs*** listed on ***Quartz's formulary list*** as ***preventive medications*** are covered without ***member*** cost share when used in accordance with recommended preventive care guidelines. This includes coverage of ***smoking cessation medications***, when prescribed by a healthcare ***provider***, for a 90-day treatment regimen for at least two tobacco cessation attempts per year.

Benefits are <u>not</u> payable for ***prescription drugs*** obtained from an ***out-of-network pharmacy*** except for the abortifacients included on the ***formulary***. ***Out-of-pocket*** payments for drugs other than covered abortifacients obtained from an ***out-of-network pharmacy*** in the United States may be reimbursed on an exception basis. ***Your out-of-pocket*** costs are <u>only</u> eligible for reimbursement in cases of acute need when an exception request is submitted to ***Quartz*** with a completed Direct Member Reimbursement Form and an itemized paid prescription receipt. Amounts in excess of the ***usual, customary and reasonable charge*** are not covered benefits and are the responsibility of the ***member***.

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

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

Brand drugs for which there is an available equivalent ***generic drug*** may be non-formulary and require an approved formulary exception for coverage. As a cost-saving measure, ***Quartz*** may opt to cover a ***brand drug*** as the preferred option instead of the equivalent ***generic drug***.

Biologic reference products for which there is an approved ***biosimilar*** may be non-formulary and require an approved formulary exception for coverage. As a cost-saving measure, ***Quartz*** may opt to cover the ***biologic reference*** as the preferred option instead of the ***biosimilar***.

Coverage for Drugs Prescribed and Dispensed by Pharmacies (Minnesota Statute 62Q.529)

Quartz will cover self-administered hormonal contraceptives, nicotine replacement medications, and opiate antagonists for the treatment of an acute opiate overdose prescribed and dispensed by a licensed pharmacist under the same terms of coverage that would apply had the ***prescription drug*** been prescribed by a licensed ***physician***, physician assistant, or advanced practice nurse practitioner.

Drugs Coverage in Emergency Situations (Minnesota Statutes 62Q.528 and 151.211, Subd. 3)

Quartz will cover a ***prescription drug*** dispensed by a pharmacist using sound professional judgment and in accordance with accepted standards of practice, without a current ***prescription drug*** order from a licensed practitioner if all of the following apply:

- The ***member*** has been compliant with taking the medication and has consistently had the drug filled or refilled as demonstrated by records maintained by the pharmacy;
- The pharmacy from which the ***prescription drug*** is dispensed has a record of a ***prescription drug*** order for the drug in the name of the ***member*** who is requesting it, but the ***prescription drug*** order does not provide for a refill or the time during which the refills were valid has elapsed;
- The pharmacist has tried but is unable to contact the practitioner who issued the ***prescription drug*** order, or another practitioner responsible for the ***member's*** care, to obtain ***authorization*** to refill the prescription;
- The drug is essential to sustain the life of the ***member*** or to continue therapy for a chronic condition;

- Failure to dispense the drug to the ***member*** would result in harm to the health of the ***member***; and
- The drug is not a controlled substance listed in Minn. Stat. Section 152.02, Subdivisions 3 to 6, except for a controlled substance that has been specifically prescribed to treat a seizure disorder, in which case the pharmacist may dispense up to a 72-hour supply.

If the above conditions are met, the amount of the drug dispensed will not exceed a 30-day supply, or the quantity originally prescribed, whichever is less, except a drug that is a controlled substance prescribed to treat a seizure disorder is covered as stated above. If the standard unit of dispensing for the drug exceeds a 30-day supply, the amount of the drug dispensed or sold will not exceed the standard unit of dispensing.

Quartz will cover the drug dispensed under this provision no more than one time in any 12-month period. Coverage will be provided under the same terms that would apply had the ***prescription drug*** been dispensed according to a prescription.

Insulin Cost-Sharing (Minnesota Statute 62Q.48)
Insulin cost-sharing will not exceed the net price of the ***claim*** to the ***plan***.

Oral Chemotherapy Drug Disclosure (Minnesota Statute 62A.3075(f))
Quartz covers multiple oral ***chemotherapy*** drugs which are listed on ***Quartz's drug formulary***. Covered oral ***chemotherapy*** drugs are available on ***formulary*** tiers. See ***your Schedule of Benefits*** or the Summary of Benefits and Coverage for the benefits paid at each Tier. Regardless of what tier an oral **chemotherapy** drug is listed on, cost-sharing will not exceed the Tier 3 *(**Non-preferred Drug**)* value of ***your*** prescription drug plan for a 30-day supply after any applicable ***deductibles*** are met.

Chronic Diseases Cost-Sharing (Minnesota Statute 62Q.481)
Cost-sharing limits also apply to ***prescription drugs*** prescribed for diabetes, asthma, and allergies requiring use of epinephrine auto-injectors as described in the "Chronic Diseases" section.

Antipsychotic Medications (Minnesota Statute 62Q.527)
Special considerations for non-formulary antipsychotic medications and the ongoing care for diagnosed mental ***illness***. The ***plan*** will accept and provide coverage of non-formulary antipsychotic medications to treat mental ***illness*** if the following criteria are met:

- Prescriber provides written explanation for the ***non-formulary drug*** to ***Quartz*** Pharmacy Management indicating:
  - The prescription must be dispensed as written;
  - All equivalent formulary options have been considered; and,
  - The ***non-formulary drug*** will be the best medication for treating the ***member's*** condition;
- If these conditions are met, approval for the drug will be given for no less than one year. The benefits and coverage that relate to formulary antipsychotic options will be applied and no additional cost share will be imposed for the ***member***;
- Prescriber can request annual renewal of the medication by simply submitting a new exception request and if all conditions continue to be met, the ***member*** will be granted continuing coverage on the non-formulary antipsychotic medication for no less than an additional year. There is no limit of years as long as the prescriber continues to provide written documentation as needed and determine the medication is the best course of treatment;
- Note: The only exception to the above would be in the event that the requested non-formulary antipsychotic drug was removed from the ***formulary*** for a safety reason. In this case, the ***plan*** would reach out to the prescriber to collaborate on an appropriate alternative solution.

Step Therapy Override (Minnesota Statute 62Q.184)
You may request that a ***non-formulary drug*** be covered by ***Quartz*** using the ***formulary*** exception process. An exception request may also be submitted to waive the step therapy requirements for a certain drug. See Obtaining Prior Authorization in Section 2 – Access to Covered Health Care of this ***COC***. ***Quartz*** will respond to a step therapy override request within five days, or within 72 hours if there are exigent circumstances. ***You*** have the right to appeal ***Quartz's*** decision not to grant a step therapy override request. See Appeals Procedure in Section 8 of this ***COC***.

Step therapy override requests will be granted if ***you*** provide sufficient documentation that any of the following situations exist:

- The ***prescription drug*** required under the step therapy protocol is contraindicated pursuant to the pharmaceutical manufacturer's prescribing information for the drug or, due to a documented adverse event with a previous use or a documented medical condition, including a comorbid condition, is likely to do any of the following:
  - Cause an adverse reaction to ***you***;
  - Decrease ***your*** ability to achieve or maintain reasonable functional ability in performing daily activities; or,
  - Cause physical or mental harm to ***you***;
- ***You*** have had a trial of the required ***prescription drug*** covered by ***your*** current or previous health plan, or another ***prescription drug*** in the same pharmacologic class or with the same mechanism of action, and ***you*** were adherent during such trial for a period of time sufficient to allow for a positive treatment outcome, and the ***prescription drug*** was discontinued by ***your*** health care ***provider*** due to lack of effectiveness, or an adverse event. ***Quartz*** may require ***you*** to try another drug in the same pharmacologic class or with the same mechanism of action if that therapy sequence is supported by the evidence-based and peer-reviewed clinical practice guideline, Food and Drug Administration label, or pharmaceutical manufacturer's prescribing information; or,

- ***You*** are currently receiving a positive therapeutic outcome on a ***prescription drug*** for the medical condition under consideration if, while on ***your*** current ***health plan*** or the immediately preceding health plan, ***you*** received coverage for the ***prescription drug*** and ***your*** prescribing health care ***provider*** gives documentation to ***Quartz*** that the change in ***prescription drug*** required by the step therapy protocol is expected to be ineffective or cause harm to ***you*** based on ***your*** known characteristics and the known characteristics of the required ***prescription drug***.

Step Therapy Prohibited for Metastatic Cancer
Pursuant to Minnesota Statute 62Q.1841, ***Quartz*** has removed step therapy requirements from ***formulary drugs*** used to treat Stage 4 metastatic cancer. However, if ***your*** doctor prescribes ***you*** a drug to treat ***your*** Stage 4 cancer that is both on ***our formulary*** and includes a step therapy protocol, ***you*** may use the step therapy override process to waive the requirements to try prerequisite drugs. See Obtaining Prior Authorization in Section 3 – Access to Covered Health Care of this ***COC***. ***Quartz*** will respond to a step therapy override request within five days, or within 72 hours if there are exigent circumstances.

Step Therapy and Prior Authorization Prohibited for Prevention of HIV or AIDS
Pursuant to Minnesota Statute 62Q.46 Subd 1(8)(e), ***Quartz*** covers without ***prior authorization*** or step therapy, at least one therapeutic equivalent of a drug, device, or product for HIV preexposure prophylaxis or HIV postexposure prophylaxis.

LIMITATIONS

Day Supply Limits
Coverage for medications under this rider are 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 quantity; or,
- A 30-day supply of ***specialty pharmaceuticals***.

Prescription Eye Drops Early Refill

Per Minnesota Statute 62A.3095, ***Quartz*** will not deny coverage of a ***member's*** request for an early refill of prescription eye drops for:

- A 30-day refill supply if the request is made between 21 and 30 days from the later of the original date that the prescription was distributed to the ***member*** or the date the most recent refill was distributed to the ***member***; or,
- A 90-day refill supply if the request is made between 75 and 90 days from the later of the original date that the prescription was distributed to the ***member*** or the date the most recent refill was distributed to the ***member***.

Specialty Pharmaceuticals

A drug designated by the Pharmacy & Therapeutics Committee as a ***specialty pharmaceutical*** is covered only if obtained from pharmacies participating in ***Quartz's*** Specialty Pharmacy Network. Failure to obtain the drug at a ***Quartz*** Specialty Pharmacy Network pharmacy may result in a denial of coverage for the drug.

EXCLUSIONS

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

1. Any ***non-formulary drug***, unless an exception request has been approved by ***Quartz***;
2. Any ***formulary drug*** when the ***formulary*** requirements for coverage have not been met. For example, step therapy not completed, ***prior authorization*** not approved, or specialty drugs obtained outside ***Quartz's*** Specialty Pharmacy Network, among

others. See ***Quartz's formulary list*** on ***our*** website for the requirements applicable to ***our formulary drugs***;

3. Medical devices or 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 facility***, emergency room or ***urgent care*** center, ambulatory clinic, infusion center, or similar institution;
6. Any drug labeled "Caution: limited by Federal Law to investigational use" or other wording with similar intent, experimental drugs, or FDA approved drugs being used in an experimental manner (non-evidence based indication, dosage regimen, etc.) even though a charge is made to ***you***, except that coverage will be provided for any ***prescription drug*** that meets the following criteria:
    - Is prescribed for the treatment of ***HIV*** infection or an ***illness*** or medical condition arising from or related to ***HIV*** infection; and,
    - Is approved by the federal Food and Drug Administration for the treatment of ***HIV*** infection or an ***illness*** or medical condition arising from or related to ***HIV*** infection, including each investigational new drug that is approved under 21 C. F. R. 312.34 to 312.36, and that is in or has completed a phase-3 clinical investigation; and,
    - If the drug is an investigational new drug described in the second bullet above, and is prescribed and administered in accordance with the treatment protocol approved for the investigational new drug under 21 C. F. R. 312.34 to 312.36;
7. Any refill of a ***prescription drug*** that is in excess of what is prescribed, or any refill dispensed beyond the legally-allowed time limits;

8. Anabolic Steroids and athletic performance enhancing medications;
9. Anti-obesity drugs, anorexients and any drug for which weight modification is the primary mechanism by which indicated results are achieved or is the primary purpose the medication is prescribed;
10. Medications used to prevent hair loss (e.g., topical minoxidil and finasteride);
11. Medications used to enhance or facilitate fertility;
12. Any ***prescription drug*** for a procedure not covered by ***your*** medical ***health insurance Certificate of Coverage***;
13. Any ***prescription drug*** for an ***Illness*** or ***Injury*** not covered by ***your*** medical ***health insurance Certificate of Coverage***;
14. Over-the-counter medications, with or without a ***prescription order***, unless the medication has been approved by ***Quartz***. Any such approved medication is listed on ***Quartz's formulary list*** as a ***formulary drug***;
15. ***Prescription drugs*** that are covered, or the ***member*** is entitled to receive, from any workers' compensation law or any municipal state or federal program. This includes ***prescription drugs*** the ***member*** is entitled to receive without charge;
16. Nutritional products and special food or feedings. This ***exclusion*** does not apply to ***medically necessary*** elemental-based infant formula prescribed for ***members*** with Phenylketonuria (PKU), or other inborn errors of metabolism;
17. Any ***prescription drug*** dispensed to a ***member*** prior to the ***member's effective date*** of coverage under the ***plan*** or after the ***member's*** termination date;
18. ***Prescription drugs*** used for cosmetic treatment, including but not limited to Tretinoic Acid (Retin A);
19. Irrigation solutions and supplies;
20. Early refills. This ***exclusion*** does <u>not</u> apply to Prescription Eye Drops per *Minnesota Statute 62A.3075*;
21. Homeopathic medications;
22. Medications used to facilitate, obtain, maintain, enhance or prevent pain with sexual performance;

23. Vaccines, unless the vaccine has been approved by ***Quartz***;
24. Any ***prescription drug*** that is a ***restricted medication*** or that requires ***prior authorization***, unless ***prior authorization*** is requested and approved;
25. Medications purchased from a pharmacy or other establishment located outside the United States for consumption inside the United States;
26. ***Medical foods*** not listed on ***Quartz's formulary list*** as ***formulary drugs***, regardless of whether they are prescribed to ***you***;
27. 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;
28. 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;
29. 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,
30. ***Prescription drugs*** with open Drug Efficacy Study Implementation (DESI) proceedings with the FDA unless specifically selected by the ***Quartz*** Pharmacy & Therapeutics Committee for inclusion on the ***formulary***. These drugs were approved by the FDA before it was required to evaluate effectiveness for approval (pre-1963). Drugs with open DESI proceedings have yet to be approved by the FDA as effective despite still being available on the market.

Preventive Services

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

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

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

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

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

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

2. **Well child exams** (*Minnesota Statute 62A.047*)
   Well child visits have no coverage limit through age two. Beginning at age three, one visit is covered per ***benefit year***. Well child exams may include developmental screenings and other tests, such as vision screenings.

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

4. **Immunizations**
   Preventive services include routine immunizations such as:
   - COVID-19;
   - Hepatitis B (Hep B);
   - Diphtheria, Tetanus, Pertussis (Dtap and Tdap);
   - Inactivated Poliovirus (IPV);
   - Haemophilus influenzae type b (Hib);
   - Pneumococcal;
   - Rotavirus;
   - Influenza (flu shot);
   - Measles, Mumps and Rubella (MMR);
   - Varicella;
   - Hepatitis A (HepA);
   - Meningococcal;
   - Human Papilloma Virus (HPV);
   - Mpox;
   - Respiratory syncytial virus (RSV); and,
   - Herpes Zoster (Shingles).

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

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

7. **Preventive medications or supplements such as:**
   - Tobacco cessation medication, limited to 180 days per year;
   - Folic acid supplements for individuals who may become pregnant;
   - Low-dose aspirin for individuals who are at a high risk for preeclampsia;
   - Fluoride supplements for children age six months to five years without fluoride in their water source;
   - Iron supplements for children age six to 12 months at risk for anemia;
   - ***HIV*** Preexposure Prophylaxis (PrEP) drugs, including support services recommended by the United States Preventive Services Task Force (USPSTF), for everyone ages 15 to 65, and others at increased risk;
   - ***HIV*** Postexposure Prophylaxis (PEP) when used for the prevention or treatment of human immunodeficiency virus, including but not limited to all postexposure prophylaxis as defined in any guidance by the USPSTF, or the Centers for Disease Control;
   - Metformin prescribed as a diabetic or pre-diabetic intervention for adults age 35 and older; and,
   - Statin ***preventive medication*** for adults age 40 to 75 at high risk.

8. **Screening labs and x-rays**

   The following list includes wellness screening labs and x-rays covered at 100% when completed in the absence of symptoms. Please note, these labs are also eligible if symptoms are present. However, in that case, they apply to medical benefits and ***your*** cost-sharing will apply.

To learn about whether you may be due for a preventive screening, refer to the Preventive Care Guidelines at healthcare.gov/coverage/preventive-care-benefits.	
Screening Labs and X-rays	**Applicable Limit**
Breast cancer screening and relevant patient navigation services. Includes digital breast tomosynthesis (3-D imaging) Additional diagnostic services or testing after a mammogram are covered with no cost-sharing when a health care ***provider*** determines such services are required, except if such coverage would disqualify a high deductible health plan from eligibility for a health savings account because the IRS minimum deductible has not yet been met, or if waiving cost-sharing would violate catastrophic plan rules at 42 U.S. Code § 18022 (e)(1)(b) (*Minnesota Statute 62A.30, Subds. 5 and 6).*	▪ For ages 40 and older, an annual mammogram, including additional imaging to address findings and pathology evaluation when indicated; ▪ Mammogram 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***; ▪ 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 additional testing to complete screening and follow-up on initial findings.	▪ For individuals 21-29 years, pap test every three years; ▪ 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.

Sexually transmitted disease testing ▪ Chlamydia ▪ Syphilis ▪ Gonorrhea ▪ HIV	One of each per ***benefit year***
Syphilis screening	Early during pregnancy for pregnant individuals
Cholesterol screening (total lipid profile)	One every five ***benefit years*** for adults
Diabetes screening (fasting glucose/blood sugar)	One every three ***benefit years*** for adults, or as recommended for non-pregnant individuals with a history of gestational diabetes
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.
Hepatitis C infection screening	For adults ages 18-79
Prostate Cancer Screenings ▪ Prostate specific antigen (PSA) ▪ Screening digital rectal exam	Each test is covered once per ***benefit year***
Hemoglobin to screen for iron deficiency anemia	One at age 1

Colorectal cancer screening	The following are covered for ages 45-75 when billed with a screening diagnosis: ▪ Colonoscopy screening exams as recommended by a doctor, including up to two colonoscopy preparation prescriptions per ***benefit year***, and the first colonoscopy following a positive stool or direct visualization screening test; ▪ Sigmoidoscopy/barium enema (covered once every five ***benefit years***); ▪ Fecal occult blood testing (covered once per ***benefit year***).
Screening for gestational diabetes for pregnant individuals	One during weeks 24 - 28 of gestation and one if identified as high risk for diabetes
Tuberculosis screening	For adults only
Bacteriuria urinary tract or other infection screening	For pregnant individuals
Lung cancer screening	For adults ages 50-80 who are heavy smokers or who quit smoking in the last 15 years

9. **Counseling for sexually transmitted infections**

10. **Preeclampsia screening for pregnant individuals**

11. **Urinary incontinence screening**

12. **Screening and counseling for intimate partner and domestic violence**

13. **Skin cancer counseling for infants, children and younger adults ages 6 months to 24 years who have fair skin**

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

15. **Anxiety screening, once annually**

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

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

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

19. **Screening for depression in the general adult population**

20. **Vision screening for amblyopia in children age six months to five years; one annual vision screening for children 18 and under (cost-sharing applies to subsequent exams)**

21. **Contraceptive methods and counseling**
    All Food and Drug Administration (FDA)-approved ***contraceptive methods and services***, sterilization procedures and patient education and counseling as prescribed by ***your provider***. At least one of each type of FDA-approved ***contraceptive method*** is covered in ***our formulary***. If more than one ***therapeutic equivalent version*** of a

contraceptive method is FDA-approved, some ***therapeutic equivalent versions*** may be excluded.

If ***your provider*** recommends a particular ***contraceptive method or service*** based on their determination that is ***medically necessary*** for ***you***, ***Quartz*** must cover that ***contraceptive method or service*** without cost-sharing. For the purpose of this determination only, medical necessity includes but is not limited to considerations such as severity of side effects, difference in permanence and reversibility of a ***contraceptive method or service***, and ability to adhere to the appropriate use of the ***contraceptive method or service***, as determined by ***your provider***.

A 12-month supply for any "prescribed contraceptive" is covered if a 12-month supply is prescribed by the prescribing health care ***provider***, except that a prescribed contraceptive for this purpose does not include an emergency contraceptive drug that prevents pregnancy when administered after sexual contact (e.g., Preven or Plan B) (*Minnesota Statute 62Q.523*).

22. **Preventive counseling for a healthy diet**

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

23. **Referral for and provision of lactation support, training, and counseling (including behavioral counseling interventions)**

During pregnancy or at any time following delivery for breast-feeding for ***you*** and ***your*** family members when ***you*** get it from appropriately certified individuals.

Rare Diseases or Conditions

Minnesota Statute 62Q.451

"***Rare disease or condition***" means *any disease or condition*:

- *That affects fewer than 200,000 persons in the United States and is chronic, serious, life-altering, or life-threatening;*
- *That affects more than 200,000 persons in the United States and a drug for treatment has been designated as a drug for a **rare disease or condition** pursuant to United States Code, title 21, section 360bb;*
- *That is labeled as a **rare disease or condition** on the Genetic and Rare Diseases Information Center list created by the National Institutes of Health; or,*
- *For which an **enrollee**:*
    - *Has received two or more clinical consultations from a **primary care provider** or specialty **provider** that are specific to the presenting complaint;*
    - *Has documentation in the **enrollee's** medical record of a **developmental delay** through standardized assessment, developmental regression, failure to thrive, or progressive multisystemic involvement; and,*
    - *Had laboratory or clinical testing that failed to provide a definitive diagnosis or resulted in conflicting diagnoses.*

A ***rare disease or condition*** does not include an infectious disease that has widely available and known protocols for diagnosis and treatment and that is commonly treated in a primary care setting, even if it affects less than 200,000 persons in the United States.

Covered services received to diagnose, monitor, or treat a ***rare disease or condition*** are covered whether they are rendered by an ***in-network*** or ***out-of-network provider***. ***You*** do not need a ***referral*** to see an ***out-of-network provider*** to diagnose, monitor, or treat a ***rare disease or condition***, although certain services may require ***prior authorization***. Services that require a ***prior authorization*** are listed on ***our*** website at ***QuartzBenefits.com/MNPAList***.

Specialty pharmaceuticals must however be obtained from ***Quartz's*** Specialty Pharmacy Network. ***Specialty pharmaceuticals*** will be listed as such on ***Quartz's formulary list*** at ***QuartzBenefits.com/formulary*** and are subject to change.

Your out-of-pocket expenses for ***covered services*** related to the diagnosis, monitoring, and treatment of a ***rare disease or condition*** by an ***out-of-network provider*** will be no greater than if ***you*** received the services from an ***in-network provider***.

If ***you*** were receiving services for a ***rare disease or condition*** under the "undiagnosed" ***enrollee*** clause in the fourth bullet above, and are definitively diagnosed with a disease or condition that does not meet the definition of ***rare disease or condition***, ***we*** will continue to cover services received from the ***out-of-network provider*** for up to 60 days following receipt of notice of a definitive diagnosis by ***you***, or by ***Quartz***, whichever is later.

After this 60-day period ends, non-emergency services from the ***out-of-network provider*** will not be covered unless an ***in-network provider*** has provided ***us*** with a written ***referral*** and ***our medical director*** has approved the ***referral*** prior to the services being provided. If ***you*** receive an approved ***referral*** to obtain additional services from an ***out-of-network provider***, ***you*** may be subject to ***balance billing***.

Nothing in this section requires ***Quartz*** to cover services which are not otherwise covered under the ***policy***. This section does not apply to medications obtained from a retail pharmacy as defined in *Minnesota Statute 62W.02, Subd. 18*.

Reconstructive Surgery or Procedures

Covered Services

1. ***Medically necessary*** correction of a functional defect caused by an ***injury*** or ***illness***;

2. ***Reconstructive surgery*** performed as a result of an ***injury***, ***sickness*** or other diseases of the involved part (*Minnesota Statute 62A.25)*;
3. ***Reconstructive surgery*** for a ***congenital*** disease or anomaly of a ***child*** which results in a functional defect including treatment of port-wine stains and cleft palate (*Minnesota Statute 62A.304*);
4. Breast reconstruction to correct a functional impairment caused by a ***congenital*** condition; and,
5. Breast reconstruction following mastectomy (*Minnesota Statute 62A.25*);
    - Reconstruction of the breast on which the mastectomy has been performed;
    - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and,
    - Prostheses and coverage of physical complications at all stages of a mastectomy including lymphedemas.

Non-Covered Services

1. Treatment, services and supplies for cosmetic or beautifying purposes. This ***exclusion*** includes removal of keloids. However, treatment is covered:
    - When it serves to correct a functional impairment related to ***congenital*** bodily disorders or conditions; or,
    - When associated with covered ***reconstructive surgery*** due to an ***illness*** or accidental ***injury*** (including subsequent removal of a ***prosthetic device*** that was related to such ***reconstructive surgery***).

Psychological reasons do not represent a medical/surgical necessity.

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

Reproductive Health

For the purpose of this section, the following definitions apply:

Contraceptive method means *a drug, device, or other product approved by the Food and Drug Administration to prevent unintended pregnancy*.

Contraceptive service means *consultation, examination, procedures, and medical services related to the prevention of unintended pregnancy, excluding vasectomies. This includes but is not limited to voluntary sterilization procedures, patient education, counseling on contraceptives, and follow-up services related to* ***contraceptive methods or services****, management of side effects, counseling for continued adherence, and device insertion or removal*.

Therapeutic equivalent version means *a drug, device, or product that can be expected to have the same clinical effect and safety profile when administered to a patient under the conditions specified in the labeling, and that*:

- *Is approved as safe and effective;*
- *Is a pharmaceutical equivalent containing identical amounts of the same active drug ingredient in the same dosage form and route of administration and meeting compendial or other applicable standards of strength, quality, purity, and identity;*
- *Is bioequivalent in that the drug, device, or product does not present a known or potential bioequivalence problem and meets an acceptable in vitro standard or, if the drug, device, or product does present a known or potential bioequivalence problem, it is shown to meet an appropriate bioequivalence standard;*
- *Is adequately labeled; and,*
- *Is manufactured in compliance with current manufacturing practice regulations.*

Covered Services

1. ***Contraceptive methods and services*** determined to be ***medically necessary*** by the ***member's attending physician*** are covered without **referral**, restriction or delay, and with no cost-sharing.
    - At least one of each type of FDA-approved ***contraceptive method*** is covered in ***our formulary***. If more than one ***therapeutic equivalent version*** of a ***contraceptive method*** is FDA-approved, some ***therapeutic equivalent versions*** may be excluded;
    - If ***your provider*** recommends a particular ***contraceptive method or service*** based on their determination that is ***medically necessary*** for ***you***, ***Quartz*** must cover that ***contraceptive method or service*** without cost-sharing. For the purpose of this determination only, medical necessity includes but is not limited to considerations such as severity of side effects, difference in permanence and reversibility of a ***contraceptive method or service***, and ability to adhere to the appropriate use of the ***contraceptive method or service***, as determined by ***your provider***;
    - A 12-month supply for any "prescribed contraceptive" is covered if a 12-month supply is prescribed by the prescribing health care ***provider***, except that a prescribed contraceptive for this purpose does not include an emergency contraceptive drug that prevents pregnancy when administered after sexual contact (e.g., Preven or Plan B) (Minnesota Statute 62Q.523).
2. Elective sterilizations, including vasectomies and tubal ligation. Sterilization for women is covered at 100%;
3. ***Physician***-prescribed emergency over-the-counter contraception, such as Preven and Plan B; and,
4. Abortions and abortion-related services, including pre-abortion services and follow-up services. "Abortion" means any medical treatment intended to induce the termination of a pregnancy with a purpose other than producing a live birth (*Minnesota Statute 62Q.524*).

The following services have open access and may be obtained from any ***provider*** as covered benefits:

1. Family planning services including abortion services (*Minnesota Statute 62Q.14);*
2. Services necessary for the initial diagnosis of ***infertility***, including sonoHSG and HSG, progesterone level outside pregnancy, FSH/estradiol, and semen analysis (each covered once per lifetime for the initial diagnostic evaluation of ***infertility***) (*Minnesota Statute 62Q.14*);
3. Testing and treatment of sexually transmitted diseases (*Minnesota Statute 62Q.14*);
4. Testing for AIDS or other ***HIV*** related conditions (*Minnesota Statute 62Q.1*4).

Non-Covered Services

1. Donor sperm or embryo;
2. The reversal of elective sterilization procedures;
3. Treatment, services or supplies for a surrogate mother who is not a ***member*** under this ***plan***;
4. Amniocentesis or chorionic villi sampling (CVS) solely for gender determination;
5. ***Infertility*** services including testing, treatment, evaluation and medication (oral and injectable) following the diagnosis of ***infertility*** (other than the diagnostic tests listed in ***covered services***);
6. Contraceptives which do not require the order of a ***physician***;
7. Emergency over-the-counter (OTC) contraceptives, such as Preven or Plan B, unless prescribed by a ***physician***;
8. Services, including counseling, devices or medication for the treatment of sexual dysfunction (whether prescribed by an ***in-network provider*** or not); and,
9. Counseling and treatment including but not limited to erection devices, vacuum erection devices, implants and medication for sexual or erectile dysfunction (whether prescribed by an ***in-network provider*** or not).

Scalp Hair Prosthesis

Minnesota Statute 62A.28

Covered Services

1. Scalp hair prosthesis including all equipment and accessories necessary for regular use of scalp hair prostheses, worn for hair loss suffered as a result of a health condition, including but not limited to alopecia areata or the treatment of cancer, unless there is a clinical basis for limitation. The prosthesis must be prescribed by a doctor and coverage is limited to one per ***benefit year***, up to a maximum of $1,000 per ***benefit year***.

Non-Covered Services

1. Hair prosthesis, hair transplants or implants and wigs, unless specifically provided for under ***covered services***.

Skilled Nursing Facility Care

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

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

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

Confinement must be within 24 hours after discharge from a covered ***hospital confinement***, and ***you*** must be ***confined*** for continued treatment of the same condition for which ***you*** required ***hospitalization***. ***Your physician*** must certify that ***your confinement*** is ***medically necessary*** for ***skilled care*** or treatment of the ***injury*** or ***illness*** that caused the ***hospital confinement***. ***Skilled nursing facility services*** are limited to 120 days per ***confinement*** (medical or surgical condition) (*Minnesota Statute 62E06, Subd.(1)(b)(4)).*

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

Covered with Prior Authorization

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

Non-Covered Services

1. ***Custodial care*** and services, including room and board while residing in an assisted living facility. The definition of **custodial care** is *a provision of room and board, nursing care, personal care or other care designed to assist an individual in the* ***activities of daily living****.* Such care does not entail or require the continuing attention of trained

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

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

Swing Bed Care

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

Skilled Care is defined as *medical services rendered by a registered or licensed practical nurse, physical, occupational or speech therapist.* Patients receiving ***skilled care*** are usually quite ill and often have been recently hospitalized. Examples are patients with complicated diabetes, recent stroke resulting in speech or ambulatory difficulties, fractures of the hip, and patients requiring complicated wound care. In the majority of cases, ***skilled care*** is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, children, or other family or relatives. Examples of care provided by "nonskilled" persons include range of motion exercises, strengthening exercises, wound

care, ostomy care, tube and gastrostomy feedings, administration of medications, and maintenance of urinary catheters. Daily care such as assistance with getting out of bed, bathing, dressing, eating, maintenance of bowel and bladder function, preparing special diets, assisting patients with taking their medicines, or 24-hour supervision for potentially unsafe behavior, do not require ***skilled care*** and are considered to be custodial.

Confinement must be within 24 hours after discharge from a covered ***hospital confinement***, and ***you*** must be ***confined*** for continued treatment of the same condition for which ***you*** required ***hospitalization***. ***Your physician*** must certify that ***your confinement*** is ***medically necessary*** for ***skilled care*** or treatment of the ***injury*** or ***illness*** that caused the ***hospital confinement***. ***Swing bed*** services are limited to 120 days per ***confinement*** (medical or surgical condition). Benefits for ***swing bed*** services are included and applied to the ***skilled nursing facility*** maximum benefit limits.

Covered with Prior Authorization

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

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

Telehealth Visits

A ***telehealth visit*** *is a remote scheduled appointment with* ***your*** *usual* ***provider*** *during clinic hours using a telephone call or video chat. It also includes "store-and-forward technology," which is the asynchronous electronic transfer or transmission of a patient's medical information or data from an originating site to a distant site for the purposes of diagnostic and therapeutic assistance in the care of a patient. Under Minnesota law, telehealth also includes audio-only communication between a health care* ***provider*** *and a patient for substance use disorder treatment services and mental health care services if the communication was initiated by the* ***enrollee*** *while in an* ***emergency*** *or crisis situation and a scheduled appointment was not possible due to the need of an immediate response.* Unless otherwise disclosed in ***your Schedule of Benefits***, cost-sharing for a ***telehealth visit*** is the same as an in-person visit.

Telehealth visits with ***in-network providers*** are covered in the same manner as in-person visits. ***Quartz*** does not impose restrictions on ***telehealth visits*** which are prohibited under *Minnesota Statute 62A.673*.

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.

Telemonitoring

Telemonitoring is *the remote monitoring of clinical data related to vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a health care* **provider** *for analysis.* ***Telemonitoring*** is intended to collect an ***enrollee's*** health-related data for the purpose of assisting a health care ***provider*** in assessing and monitoring the ***enrollee's*** medical condition or status.

Covered Services

1. ***Telemonitoring*** as part of an established, ***Quartz***-sponsored ***care management*** program.

Covered with Prior Authorization

1. Rental or purchase of ***telemonitoring*** equipment; and,
2. Other ***telemonitoring*** not associated with a ***Quartz***-sponsored program, subject to medical necessity and appropriateness.

Non-Covered Services

1. ***Telemonitoring*** when the patient is residing at a location with health care staff on site.

Therapy (Physical, Speech & Occupational)

Covered Services

1. ***Medically necessary*** outpatient physical, speech and occupational therapy when provided for restoration of a function or ability that was present or was lost due to bodily ***injury*** or ***illness***. Therapy must be ordered by an in-network ***physician*** and provided by an ***in-network provider***, and must result in documented sustained improvement;
2. Outpatient therapy for the treatment of mental health and substance use disorders is covered based on medical necessity; no specific visit limits apply to traditional therapy services. However, ***you*** may also have access to additional therapy ***telehealth visit*** options for mental health and substance use disorders. Contact ***Quartz*** Customer Success for more information;
3. ***Medically necessary*** rehabilitative health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy and speech-language pathology and pulmonary rehabilitation in a variety of inpatient and/or out-patient settings.

Therapy must be ordered by a qualified ***physician*** and be provided by a qualified ***provider***;

4. ***Medically necessary habilitative*** health care services that help a person keep, learn or improve skills and functions for daily living. An example is therapy for a ***child*** who isn't walking or talking at the expected age. These services may include physical and occupational therapy and speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Therapy must be ordered by a qualified ***physician*** and be provided by a qualified ***provider***; and,
5. Therapy for treatment of ***autism spectrum disorder*** **(*ASD*)**, consistent with *Minnesota Statute 62A.3094*.

Covered with Prior Authorization

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

Non-Covered Services

1. ***Maintenance therapy*** or treatment that does not result in documented sustained improvement. ***Maintenance Therapy*** is defined as *ongoing therapy delivered after the acute phase of an* ***illness*** *has passed.* It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. ***We*** make the determination of what constitutes ***maintenance therapy*** after reviewing an individual's case history or treatment plan submitted by a ***provider*** of health care;
2. Art, dance, or music-based therapies;
3. Second opinions for school or education assessments and evaluations;
4. Alternative communication devices including but not limited to a dynamic screen communicator;
5. Therapy services such as recreational or education therapy, physical fitness or exercise programs which are not ***medically necessary***;

6. Any treatment or therapy which is court-ordered, ordered as a condition of parole, probation, custody, or visitation evaluation, unless such treatment or therapy is normally covered by us;
7. Services provided by a therapist living in the patient's home or who is a ***member*** of the ***immediate family***;
8. Educational or vocational therapy including but not limited to counseling, evaluation, testing, treatment, videos or video games and books; and,
9. Vocational assessments, testing and counseling, including evaluation and treatment.

Tobacco/Smoking Cessation

Covered Services

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

Transplants

Covered Services

1. Cornea transplants.

Covered with Prior Authorization

1. Other ***medically necessary*** transplantation and re-transplantation of solid organ and bone marrow are covered as long as the procedure has been established to be reasonable by nationally recognized academic transplant centers and is approved by us.
   Claims for donor expenses are covered only when the transplant recipient is a ***Quartz member*** under this ***plan***. The ***provider*** must submit ***claims*** for donor expenses under the transplant recipient's name.

Non-Covered Services

1. Purchase price of bone marrow, organ or tissue that is sold rather than donated;
2. ***Experimental or investigative*** transplant services, such as implanting artificial organs;
3. Lodging and transportation expenses; and,
4. Transplant services from ***providers*** and/or facilities not approved by us.

Urgent Care

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

Covered Services

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

Non-Covered Services

1. Services that do not meet the definition of ***urgent care***. These services are not covered under the urgent care benefit (however, they may be

covered under another category in Section 5 – Benefits: Covered and Non-Covered Services).

Virtual Visits

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

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

Covered Services

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

Vision Care

Covered Services

1. Eye exam provided as part of the treatment for medical conditions;
2. Routine eye exam (with or without refraction);
3. Initial lenses (standard glass, plastic, polycarbonate or contacts) after cataract surgery, one lens per surgical eye when provided within 12 months of surgery (frames not included);

4. Vision therapy or orthoptics treatment (eye exercises), limited to 10 visits per ***benefit year***;
5. Contact lenses when determined to be ***medically necessary*** and appropriate in the treatment of patients affected by certain conditions. An initial external lens per eye may be covered when determined ***medically necessary*** for each of the following reasons: (1) to heal from surgery, (2) due to a malformation of the eye, and (3) due to an ***injury*** to the eye. Any subsequent contact lenses after the initial lens per eye for each reason (1) – (3) will not be covered. ***Medically necessary*** contact lenses are dispensed in lieu of other eyewear. ***In-network providers*** will obtain the necessary ***prior authorization*** for these services.
    - Examples of conditions for which contact lenses may be determined to be ***medically necessary*** include but are not limited to: Keratoconus, Keratoconjunctivitis sicca (severe dry eyes), Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, and Irregular Astigmatism;
6. Corrective eyewear through ***in-network providers*** only. Includes coverage for:
    - One standard pediatric or standard adult frame per year;
    - One pair of standard lenses (glass, plastic or polycarbonate) lenses per year. Standard lenses include single vision, bifocal, and trifocal lenses;
    - Contact lenses may be substituted for eyeglasses and are limited to one supply of lenses per eye per calendar year.

Quartz's contribution to adult vision hardware is limited to $100 after the cost-sharing that applies under the DME benefit.

Non-Covered Services

1. Deluxe frames;
2. All surgical procedures to correct visual acuity;
3. All refractive surgical procedures to correct visual acuity and refractive disorders of the eye;

4. The additional cost of a specialty intraocular lens (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. If a ***member*** chooses to have a specialty intraocular lens implanted, the ***member*** may pay for the additional cost of this lens.

X-Ray & Laboratory Tests

Covered Services

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

SECTION 6 – GENERAL EXCLUSIONS

An **exclusion** is defined as *any medical service or supply listed in this section, or not listed as a* **covered service** *in Section 5 - Benefits: Covered and Non-Covered Services of this COC.*

The following are general exclusions of ***your plan***:

1. Any and all types of modifications to the home and the items associated with the modifications (e.g., ramps, grab bars, stair lifts, elevators);
2. Any loss caused while engaged in active military or reservist duties as a result of war or any act of war, declared or not, or any act of international armed conflict or any conflict involving armed forces of any international authority;
3. Any services in excess of the maximum benefit limitations specified in this ***policy***;
4. Any services requested by a third party;
5. Any treatment, service or supply not specifically listed as a covered benefit and all associated and related charges, including items or services to prepare for non-covered procedures;
6. Any items or services provided out of network not prior authorized or approved in writing by ***us***, except for ***emergency care***. ***Members*** should always bring their ***Quartz*** ID Card when travelling inside or outside the United States;
7. ***Foreign claims*** (except for ***emergency care***). See the "Emergency Services" section;
8. Any treatment or services rendered by a person residing in ***your*** household, or a ***member*** of ***your immediate family***. However, if one of the persons described above is a licensed medical ***provider*** and ***you*** receive urgent or ***emergency services*** from that person in an ***urgent care*** facility or ***hospital***, this ***exclusion*** does not apply;
9. Any treatment or services ordered or rendered by ***you***, for ***you***;
10. Any treatment or services rendered by or at the direction of a ***provider*** of health care services who is not licensed to provide the services, or who is not operating within the scope of that license;

11. Charges for drugs filled at out-of-network pharmacies;
12. Charges for services that were not rendered;
13. Charges for ***out-of-network provider*** services which exceed the ***usual and customary*** charge;
14. Charges for the addition of robotic assistance in a surgical setting. Robotic-assisted surgeries will be paid at the same contracted rate as surgeries performed without robotic assistance;
15. Charges for the services of a blood donor;
16. Charges related to surrogate mother services when the surrogate is not a ***member*** under this ***plan***;
17. Chelation therapy (coverage is limited to lead/heavy metal poisoning from a qualified ***in-network provider***);
18. Coma stimulation programs;
19. Communications, lodging accommodations, transportation and travel time unless otherwise indicated as being a ***covered service***;
20. ***Custodial care***;
21. Customization of vehicles and/or lifts for wheelchairs and/or scooters;
22. Dermabrasion;
23. Donor charges related to transplant services when the transplant recipient is not a ***Quartz member*** (even if the donor is a ***Quartz member***);
24. Expenses for medical reports, including preparation and presentation;
25. Hair removal, unless authorized by ***Quartz*** as part of covered ***gender-affirming care***;
26. Hair transplantation;
27. 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);
28. Long term acute care (LTAC) facility;
29. Massage therapy when provided by a masseuse;
30. The clinically-administered medications eteplirsen (Exondys 51) and golodirsen (Vyvondys 53), casimersen (Amondys 45), and vitolarsen (Viltepso);

31. 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;
32. Platelet-rich plasma treatment;
33. Removal of excess skin resulting from weight loss, other than panniculectomy;
34. Procedures to correct obesity or treat the complications or co-morbidities of obesity (e.g., bariatric surgery), including treatment of complications arising from such procedures;
35. Prolotherapy. However, prolotherapy is covered when provided for the treatment of lateral epicondylosis, symptomatic knee osteoarthritis, or sacroiliac (SI) joint pain. Prolotherapy is <u>not</u> covered for the treatment of any other conditions as it is considered to be experimental for other uses;
36. Psychological or neuropsychological testing for educational purposes;
37. Rental or purchase of hospital-grade breast pumps;
38. Services provided under another plan for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include medical payment coverage under no-fault or underinsured automobile insurance, or coverage required under similar legislation. If coverage under this legislation is optional, benefits will not be paid for any **injury** or ***sickness*** covered if ***you*** elected the optional coverage;
39. Services and supplies for which no charge is made or for which ***you*** would not have to pay without this coverage;
40. The amount of any ***co-payment***, ***co-insurance***, and/or ***deductible***;
41. Treatment, services and supplies furnished by the United States Veterans Administration, except for which ***we*** are the primary payer under applicable federal law;
42. Work hardening programs, health spas, health clubs, aerobic and strength conditioning, exercise equipment and all related material and products for these programs; and

43. Fitness or health tracking devices and related application memberships, unless provided as part of a ***Quartz***-sponsored clinical, ***care management*** or disease management program, or when items are provided through ***care management***.

SECTION 7 – CLAIM INFORMATION

Time Limit on Filing a Claim

A ***claim*** for benefits should be submitted to ***us*** within 90 days after the services are received, or as soon as possible. If ***we*** do not receive the ***claim*** within 12 months after the date it was otherwise required, ***we*** may deny coverage of the ***claim***.

How to File a Claim for Medical Services

When obtaining treatment at a ***provider's*** office, ***hospital***, or pharmacy, present ***your health plan*** ID card. ***We*** will be billed directly and will notify ***you*** of any applicable costs (***deductible***, ***co-payments*** or ***co-insurance***) or non-covered charges. If ***you*** receive medical services from an ***out-of-network provider*** or ***in-network pharmacy*** and are required to make payment, please obtain a claim form from ***our*** website or provide ***us*** with the following information when requesting payment from us:

- ***Subscriber's*** name and address;
- Patient's name and date of birth;
- Number from ***your*** ID card;
- Name and address of the ***provider*** of the service(s);
- Name and address of any ordering ***physician***;
- A diagnosis from the ***physician***;
- An itemized bill that includes applicable procedure codes or a description of each charge;
- The date of ***injury*** or ***sickness***;
- If ***you*** have other coverage, please include the name of the other insurance carrier(s); and,
- Proof of payment.

Submit this information to the following address:

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

You agree to provide ***us*** with any additional information regarding ***your claim*** that ***we*** may require to process the ***claim***. In order to be reimbursed, the service(s) or product(s) ***you*** received must not be used for employment reasons, will not be used for resale, and are intended for ***your*** own personal use. If ***you*** submit false receipts or fraudulently altered documents, ***you*** may be disenrolled by the plan and/or subject to civil or criminal penalties.

How to File a Pharmacy Claim

When obtaining prescriptions, ***you*** must present ***your health plan*** ID card. It is ***your*** responsibility to use participating, ***in-network pharmacies***. If ***you*** receive prescriptions and are required to make full payment, ***you*** may submit an itemized receipt to us. ***You*** will receive reimbursement for covered ***prescription drug*** services outlined in Section 5 of this document, minus the applicable ***co-payment***. Reimbursement will be at the current contracted rates, and any difference between this rate and the amount ***you*** paid will be ***your*** responsibility. Send ***us your*** itemized receipt, including the following information:

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

Address the information to:

Quartz Pharmacy Program
2650 Novation Pkwy.
Fitchburg, WI 53713

You agree to provide ***us*** with any additional information regarding ***your claim*** that ***we*** may require to process the ***claim***. In order to be reimbursed, the service(s) or product(s) ***you*** received must not be used for non-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.

Physician and Hospital Records

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

Care Management/Alternative Treatment

Care management is a collaborative process that assesses ***member*** needs, establishes goals and care plans, helps to coordinate care, and connects ***members*** to resources with the aim of improving ***member*** health and well-living. ***Quartz*** offers ***care management*** to ***members*** of this ***plan*** at no additional cost. These services are provided by a staff of health care professionals, including Registered Nurses, Certified Social Workers, and Health Coaches, or by other organizations contracted with ***Quartz***. Examples of these services are clinical programs that address hypertension/blood

pressure, diabetes, mental resiliency, and prenatal care coordination. If ***you*** feel that ***you*** would benefit from ***care management***, ***you*** can fill out a request form at ***QuartzBenefits.com*** or call Customer Success. Someone from the Care Management Team will reach out to ***you***. As part of ***care management***, ***Quartz*** reserves the right to direct treatment to the most appropriate and cost-effective option available.

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

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

SECTION 8 – COMPLAINT, APPEAL & EXTERNAL REVIEW PROCEDURES

Clinical Review Process

Standard Review

A decision on all standard requests for ***utilization review*** will be communicated to the ***provider*** and ***enrollee*** within five business days of the request, provided that all information reasonably necessary to make a decision has been submitted to ***us***.

When a decision is made to prior authorize services, notification will be provided promptly to the ***provider*** by telephone, written notification, or facsimile to a verified number or secure email. ***We*** maintain documentation regarding ***prior authorization*** and notifications provided in accordance with *Minnesota Statute 62M.05*.

When an ***adverse determination*** is made, notification will be provided to the attending health care professional and ***hospital*** or physician office (as applicable) within five business days after making the decision. The notification may be made by telephone, facsimile to a verified number or secure email. Written notification will be sent to the ***provider*** if the notification was provided by phone.

Upon request, ***we*** will provide the ***provider*** or ***enrollee*** with the criteria used to determine the necessity, appropriateness and efficacy of the health care service and identify the database, professional treatment parameter or other basis for the criteria. Reasons for an ***adverse determination*** may include a lack of adequate information to authorize after a reasonable attempt has been made to contact the ***provider*** or ***enrollee***.

When an ***adverse determination*** is made, ***you*** and the attending health care professional will receive written notification of the right to submit an ***appeal***

through the internal ***appeal*** process as well as the procedure for initiating the internal ***appeal***.

Expedited Review
If ***your*** attending health care professional believes that an expedited decision on a clinical review is warranted, ***we*** will notify ***you***, the ***hospital***, and the attending health care professional of ***our*** decision within 48 hours. For an ***adverse determination*** of an expedited review, ***we*** will also notify ***you*** and the attending health care professional of the right to submit an ***expedited appeal*** as well as the procedure for initiating an expedited internal appeal.

Complaint Procedure

Quartz has a ***complaint*** procedure to resolve ***complaints*** and disputes. The ***complaint*** process seeks to resolve a dispute which arose during the time of ***your*** coverage or at application of coverage.

A ***complaint*** is defined as *any grievance against* **us** *relating to an expression of dissatisfaction submitted orally or writing to* **us** *which is not under litigation regarding the provision of health care services including but not limited to the scope of coverage for health care services; retrospective denials or limitations of payment for services; eligibility issues; denials, cancellations or nonrenewal of coverage; administrative operations; and the quality, timeliness and appropriateness of health care services rendered.* It is ***our*** policy to make reasonable efforts to resolve ***your complaint***.

Complaint & Medical Review Process

Informal/Verbal Complaints (*Minnesota Statute 62Q.69*)

You may orally submit a ***complaint*** by calling the Customer Success Department at the telephone number provided in the Important Phone Numbers section of this ***COC***. Customer Success will make every effort to resolve ***your complaint***. The Customer Success Department will investigate ***your*** verbal ***complaint*** and will provide ***you*** with a verbal

resolution within ten business days of receipt of ***your complaint***. If the verbal ***complaint*** is not resolved to ***your*** satisfaction, Customer Success will inform ***you*** of ***your*** right to file ***your complaint*** in writing and will provide ***you*** with a Complaint Form, which must be completed and returned to the Customer Success Department for further consideration. Customer Success is available to assist ***you*** in completing the Complaint Form or will complete the form and mail it to ***you*** for a signature. ***Quartz*** uses the same form for both ***complaints*** and ***appeals***.

At any time, ***you*** may file a ***complaint*** with the Minnesota Department of Health (MDH), a state agency that enforces Minnesota's Health Maintenance Organization laws, either in writing or by calling (800) 657-3916. ***You*** may also visit their website at health.state.mn.us/facilities/insurance/managedcare/complaint.

Formal/Written Complaint Process (*Minnesota Statute 62Q.69*)

You can seek further review of a ***complaint*** not resolved through the informal ***complaint*** process. The steps in this ***complaint*** process are outlined below.

You or ***your authorized representative*** may utilize the Complaint Form to send ***your*** written request for review, including comments, documents, records and other information relating to ***your complaint***, the reasons why ***you*** believe ***you*** are entitled to benefits and any other supporting documentation. The Complaint Form should be sent to:

Quartz
Attn: Appeals Specialist
2650 Novation Pkwy.
Fitchburg, WI 53713
AppealsSpecialists@QuartzBenefits.com

To obtain a Complaint Form, or to request help in completing and/or submitting a written ***complaint***, please call the Customer Success

Department at the telephone number provided in the Important Phone Numbers section of this ***COC***.

An Appeals Specialist will notify ***you*** within ten business days that ***we*** received ***your*** written ***complaint***, unless the ***complaint*** has been resolved to ***your*** satisfaction within those ten business days.
Upon request and at no charge to ***you***, ***you*** will be given reasonable access to and copies of all documents, records, and other information relevant to ***your complaint***.

An Appeals Specialist will review ***your*** written ***complaint*** and will advise ***you***, ***your*** practitioner, and those ***providers*** involved in the provision of service the disposition of the written ***complaint*** and the action taken within thirty calendar days of the date of receipt of the written ***complaint***. If a decision cannot be made within thirty calendar days due to circumstances outside of ***our*** control, ***we*** may take an additional fourteen calendar days to notify ***you*** of ***our*** decision on ***your complaint***. If ***we*** take any additional days beyond the initial thirty calendar day time frame, ***we*** will inform ***you***, in advance, of the extension and the reasons for the extension. If the decision is partially or wholly adverse, a complete description of ***your appeal*** rights and the ***appeal*** process will be included with ***our*** written response. Notification will also include ***your*** right to submit a ***complaint*** to the Minnesota Department of Health (MDH), a state agency that enforces Minnesota's Health Maintenance Organization laws, either in writing or by calling (800) 657-3916 or visit their website at health.state.mn.us/facilities/insurance/managedcare/complaint.

Appeals Procedure

We encourage ***you*** to contact Customer Success if ***you*** have an inquiry, a concern or a ***complaint*** against ***us***, or one of ***our in-network providers***. The Customer Success Representative acts as an intermediary for ***us*** to resolve any of ***your*** issues. If a Customer Representative is unable to resolve the issue to ***your*** satisfaction, they will advise ***you*** of ***your*** right to ***appeal*** an ***adverse***

determination in writing or verbally with the Appeals Specialist. ***You*** have the right to review the claim file and present evidence and testimony as part of the internal ***appeals*** process. The Appeals Specialist is a person who is employed by ***us*** who specializes in the ***appeals*** process. The Appeals Specialist will receive and record ***your*** written ***appeal***. They will investigate ***your appeal*** and assist ***you*** through the ***appeals*** process. They will also advise ***you*** or ***your authorized representative*** of the disposition of the ***appeal*** and the action taken.

Time Limit on Filing an Appeal

An ***appeal*** must be submitted within 180 days following written notice of ***our*** initial decision. If ***you*** fail to submit ***your*** oral or written ***appeal*** within the 180-calendar-day time frame, ***you*** lose ***your*** right to ***appeal***.

Authorized Representative

You may designate an ***authorized representative*** or ***your attending physician*** to act on ***your*** behalf. Written designation of an ***authorized representative*** should accompany ***your*** written ***appeal***. **Your *authorized representative*** may (1) obtain information about ***your claims*** to the same extent that ***you*** are able to, (2) submit evidence, (3) make statements about fact or law, and (4) make any request or give any notice about the ***appeal*** proceedings.

If ***you*** appoint ***your authorized representative*** to file an ***appeal*** on ***your*** behalf, ***you*** and ***your authorized representative*** may but are not required to use ***our*** Personal Representative Appointment and Authorization to Release Protected Health Information form. ***We*** will accept any authorization form that confirms ***your*** request for representation during the ***appeal*** procedure.

Appeal

The definition of an ***appeal*** *is a request to change any previous* ***adverse determination*** *made by* ***Quartz****. An* ***appeal*** *can be for a pre-service or post-service request.*

Grievance and Appeals Committee and Goals

We have established a Grievance & Appeals Committee to review and act upon all ***member appeals***. The Grievance & Appeals Committee reviews all written ***appeals*** made by ***you*** and makes a final decision based on ***your benefit plan*** and all documentation present upon review.

We are committed to giving ***you*** an opportunity to exercise ***your*** right to a fair and expeditious resolution to any and all ***appeals***. ***Our appeal*** procedure has been developed to meet the following goals:

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

The ***appeal*** procedure(s) as described in this section will demonstrate ***our*** ability to meet the goals stated above.

Appeal Process

Pre-Service Appeal (Clinical decision for utilization review)

Minnesota Statute 62M.06

If after an ***adverse determination*** requiring a medical review is made for a pre-service request, ***you***, ***your authorized representative*** or ***your attending physician*** may submit an ***appeal*** request to the Appeals Specialist either in writing or by telephone. Written requests should include any relevant documents, issues, comments and additional information as appropriate and should be sent to:

Quartz
Attn: Appeals Specialists
2650 Novation Pkwy.
Fitchburg, WI 53713
Telephone: (608)644-3416 or Toll Free (866)569-3426
Fax Number: (608) 644-3500
Email: AppealsSpecialists@quartzbenefits.com

Written reconsideration will include the receipt of testimony, correspondence, explanations, or other information from ***you***, staff persons, administrators, practitioners, ***providers*** or other persons as deemed necessary for a fair review and resolution of the ***appeal***. During ***your appeal***, upon ***your*** request, ***we*** will provide ***you*** reasonable access to all documents, records and other information relevant to ***your appeal*** at no charge.

A full and fair investigation of the substance of ***your appeal***, including any aspects of clinical care, will be coordinated by the Appeals Specialist. A person who was not involved in the initial decision, or the subordinate of any person involved in the initial decision will review ***your appeal***. For medical necessity reviews only, a practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure or provides the treatment will review ***your***

appeal. ***Appeals*** concerning non-clinical issues will be reviewed by the appropriate Plan Director and/or manager, or designee, in accordance with ***our*** policies. ***We*** will document the substance of the ***appeal*** and any actions taken.

If ***your appeal*** request concerns clinical services, a written decision of ***your appeal*** will be made to ***you*** and ***your*** practitioner and/or ***provider*** involved in the ***appeal*** within 15 calendar days from the date ***we*** receive ***your*** request. In certain circumstances, this time period may be extended four additional days. In this case, ***we*** will notify ***you*** in advance of the reasons for the extension. ***You*** must voluntarily agree to this extension.

Written notification of ***our*** final ***appeal*** decision will include (1) a complete summary of the review findings, (2) the titles and qualifications, including specialty of person or person(s) participating in the review, (3) specific reasons for the decision in easily understandable language, (4) reference to the evidence, benefit provision, guideline and/or protocol used as the basis for the decision and notification of ***your*** right to request a copy of the actual benefit provisions, guidelines and protocols at no charge, (5) notification to ***you***, upon request and free of charge, reasonable access and copies of all documents, records and other information relevant to ***your*** benefit request, (6) notice of ***your*** right to contact the Minnesota Department of Health (MDH) either in writing or by telephone, and (7) notice of ***your*** right to initiate the external ***appeals*** process (when applicable) and the procedures for initiating the external ***appeal*** process. The final denial letter will also contain information on the circumstances in which ***appeals*** are eligible for ***external review***, and how ***you*** can seek further information about these rights. If the ***adverse determination*** is completely overturned, the written decision to ***you*** will state the decision and the date.

Non-Clinical Appeal

Minnesota Statute 62Q.70

If ***your*** request was denied following the initial pre-service review conducted by Customer Success of a non-clinical issue, ***you*** or ***your authorized representative*** may submit an ***appeal*** request to the Appeals Specialist either in writing or by telephone. Written requests should include any relevant documents, issues, comments and additional information as appropriate and should be sent to:

Quartz
Attn: Appeals Specialist
2650 Novation Pkwy.
Fitchburg, WI 53713
Telephone: (608)644-3416 or Toll Free (866)569-3426
Fax Number: (608) 644-3500
Email: AppealsSpecialists@QuartzBenefits.com

The Appeals Specialist will provide ***you*** or ***your authorized representative*** with the option of either a written reconsideration or a hearing before the Grievance and Appeals Committee either in person or over the telephone. Hearings or written reconsideration will include the receipt of testimony, correspondence, explanations or other information from ***you***, staff persons, administrators, practitioners, ***providers*** or other persons as deemed necessary for a fair review and resolution of the ***appeal***. During ***your appeal***, upon ***your*** request, ***we*** will provide ***you*** reasonable access to all documents, records and other information relevant to ***your appeal*** at no charge.

A full and fair investigation of the substance of ***your appeal***, including any aspects of clinical care, will be coordinated by the Appeals Specialist. A person who was not involved in the initial decision, or the subordinate of any person involved in the initial decision will review ***your appeal***. For ***medical necessity*** reviews only, a practitioner in the

same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment will review ***your appeal***. ***Appeals*** concerning non-clinical issues will be reviewed the by the appropriate Plan Director and/or manager, or designee, in accordance with ***our*** policies. ***We*** will document the substance of the ***appeal*** and any actions taken.

We will review ***your appeal*** and provide ***you*** or ***your authorized representative*** with written notice of ***our*** final decision and all key findings within thirty calendar days of ***our*** receipt of ***your*** written ***appeal*** request. If ***you appeal*** by hearing, written notice of ***our*** final decision and all key findings will be given to ***you*** or ***your authorized representative*** within forty-five days of ***our*** receipt of ***your*** written ***appeal***.

In certain circumstances, this time period may be extended fourteen additional days. In such case, ***we*** will notify ***you*** in advance of the reasons for the extension. ***You*** must voluntarily agree to this extension.

Written notification of ***our*** final ***appeal*** decision will include: (1) a complete summary of the review findings, (2) the titles and qualifications, including specialty of person or person(s) participating in the review, (3) specific reasons for the decision in easily understandable language, (4) reference to the evidence, benefit provision, guideline, and/or protocol used as the basis for the decision and notification of ***your*** right to request a copy of the actual benefit provisions, guidelines, and protocols, free of charge, (5) notification to ***you***, upon request and free of charge, reasonable access and copies of all documents, records and other information relevant to ***your*** benefit request, (6) notice of ***your*** right to contact the Minnesota Department of Health (MDH) either in writing or by telephone, (7) notice of ***our*** right to initiate the external ***appeals*** process (when applicable) and the procedures for initiating the external ***appeal*** process. The final denial letter will also contain information on the circumstances in which ***appeals*** are eligible for ***external review***, and how ***you*** can seek further information about these rights. If the ***adverse determination*** is

completely overturned, the written decision to ***you*** will state the decision and the date.

Please be aware that non-clinical ***appeals*** do not qualify for the ***expedited appeals*** process listed below.

Expedited Appeal Process

Minnesota Statute 62M.06 Subd.2

An ***expedited appeal*** process is used only for pre-service ***appeals*** when the condition is emergent or urgent in nature.

An **expedited appeal** is defined as *an appeal where the standard appeal procedure (1) could seriously jeopardize **your** life or health or **your** ability to regain maximum function, (2) in the opinion of a **physician** with knowledge of **your** medical condition, would subject **you** to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal, or (3) it is determined to be an **expedited appeal** when requested by **your** attending provider.*

An ***expedited appeal*** of a ***prior authorization*** (pre-service) denial must be utilized if ***you*** or a practitioner acting on ***your*** behalf believe the request is warranted. ***Expedited appeals*** may be submitted orally or in writing to the Appeals Specialist.

Your expedited appeal will be reviewed by one of ***our medical directors*** who will be available upon request to discuss the case with the practitioner. The ***appeal*** will be reviewed by persons who were not involved in the initial ***complaint*** or ***adverse determination***. For medical necessity reviews only, a practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment, will review the case.

The Appeals Specialist will:

- Notify ***you***, ***your authorized representative*** or ***your physician*** by telephone of ***our*** decision as expeditiously as ***your*** condition requires but by no later than 72 hours of ***our*** receipt of the ***expedited appeal***; and,
- Follow-up in writing within three days of ***our*** telephone notification.

If the ***expedited review*** is a ***concurrent review*** decision, the service will be continued without liability to ***you*** until ***you*** or ***your authorized representative*** has been notified of the decision.

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

If the ***adverse determination*** is not reversed, ***you*** will have the right to submit an appeal to the ***external review*** process.

Submission and Receipt of Information

At any time during the standard or ***expedited appeal*** process, ***you*** or ***your authorized representative*** may provide ***us*** with written comments, documents, records or any other information regarding ***your*** issue. ***You*** or ***your authorized representative*** can present such evidence in person, in writing, via teleconference or by fax.

Upon ***your*** request, ***we*** will provide ***you*** or ***your authorized representative*** with copies of all documents, records and other information relevant to ***your appeal*** issue(s). This information will be provided to ***you*** free of charge.

Voluntary Option Appeal

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

Minnesota Department of Health (MDH)

You may contact the MDH, a state agency that enforces Minnesota's Health Maintenance Organization laws, and file a ***complaint***. ***You*** can contact the MDH by writing to:

Minnesota Department of Health
Managed Care Systems Section
P.O. Box 64975
St. Paul, MN 55164-0975
Phone: (800) 657-3916

External Review

In addition to the internal ***appeals*** process, ***we*** are required to provide ***you*** with an ***external review*** procedure for review of certain decisions. ***External review*** provides ***you*** with an opportunity to have medical professionals who have no connection with ***us*** review ***your*** dispute.

For the purposes of this section regarding ***external review***, an ***adverse determination*** is defined as *(1)* a ***complaint*** *decision relating to a health care service or* ***claim*** *that has been appealed in accordance with Minnesota Statute 62Q.70, where the* ***appeal*** *decision is partially or wholly adverse to the* ***you****, (2) any initial decision related to an admission, extension of stay, or health care service that is partially or wholly adverse to* ***you*** *(including denial as not* ***medically necessary*** *or* ***authorization*** *of a less intensive service) that*

has been appealed in accordance with Minnesota Statute 62M.06, and the ***appeal*** *did not reverse the initial decision, (3) a decision relating to a health care service made by a health company licensed under Ch. 60A, Minnesota Statute, that denies the service on the basis that the service was not* ***medically necessary****, or is* ***experimental or investigative****, or 4) a decision relating to coverage* of ***out-of-network provider*** *services when* ***balance billing*** *is prohibited under the No Surprises Act*. A ***rescission*** is considered an ***adverse determination***, as is a determination that ***Quartz's*** application of non-quantitative treatment limitations is compliant with federal mental health parity law. ***External review*** rights may also apply if ***Quartz*** determines 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.

An ***adverse determination*** does not include ***complaints*** relating to fraudulent marketing practices or agent misrepresentation.

You or ***your authorized representative*** has the right to request an expedited ***external review*** with respect to an urgent matter. An urgent matter would be considered services that are received in a relatively short period of time. ***You*** or ***your authorized representative*** may make an expedited request by calling the Minnesota Department of Health at (800) 657-3916. An ***expedited review*** is also available if requested by ***your*** attending ***provider***.

We require that ***you*** exhaust ***our*** internal ***appeal*** procedure before ***you*** or ***your authorized representative*** request an ***external review***. ***We*** will not require ***you*** to exhaust ***our*** internal ***appeal*** procedure if (1) ***we*** agree with ***you*** or ***your authorized representative*** that the matter should proceed directly to ***external review*** or when the ***Independent Review Organization (IRO)***

determines that an ***expedited review*** is appropriate upon receiving ***you*** or ***your authorized representative's*** request, (2) ***we*** fail to comply with any requirements including but not limited to time limits for internal ***complaints*** or ***appeals***, or (3) ***you*** have submitted a request for an ***expedited external review*** at the same time ***you*** have applied for an internal review of the same ***adverse determination***.

You or ***your authorized representative*** must submit ***your*** request in writing within six months of the date of the ***adverse determination***. ***Your*** request must be submitted after ***you*** receive ***our*** notice of the disposition of ***your appeal***, unless exhaustion of the internal process is not required. The request for ***external review*** must contain the following information:

1. ***Your*** name;
2. ***Your*** address;
3. ***Your*** telephone number;
4. An explanation of why ***you*** or ***your authorized representative*** believe that treatment should be covered;
5. Any additional information or documentation that supports ***your*** position; and,
6. If someone else is filing an ***external review*** on ***your*** behalf, a statement signed by ***you*** authorizing that person to be ***your authorized representative***.

Please forward ***your*** written ***external review*** request to the following address:

Minnesota Department of Health
Managed Care Systems Section
P.O. Box 64975
St. Paul, MN 55164-0975

Quartz will participate in the ***external review*** process as directed by MDH, and will bear the cost of the review. If ***you*** have questions on how this process applies to ***your*** situation, please contact the MDH. The MDH oversees the independent review process. For more information please contact the MDH at (800) 657-3916, or e-mail health.mcs@state.mn.us.

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: (608)644-3416 or 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 prescriber ***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.

Legal Actions

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

SECTION 9 – COORDINATION OF BENEFITS

Applicability

For purposes of this COB section only, a plan means any of the following which provide benefits or services for, or because of, medical or dental care or treatment:

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

The ***policy*** means the ***health plan*** offered by ***Quartz*** and described in this individual ***policy***.

Coordinating Medical Benefits

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

1. Have other ***health insurance***;
2. Are enrolled in Part A and Part B of ***Medicare***;

3. Are eligible for governmental programs or coverages required or provided by statute unless the law requires that the ***policy*** is primary; or,
4. Have liability coverage (e.g., automobile, home, or other liability) that has provided benefits for any healthcare costs related to the accident or ***injury***. The liability carrier must provide any benefits for services related to the accident or ***injury*** first.

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

Coordinating Pharmacy Benefits

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

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

Any current limitation on the medication submitted for coordination will apply, such as step therapy, quantity level limit and any other ***formulary*** restrictions. Pharmacy benefit coordination will be consistent with this COB section and will follow all provisions in relation to medical claim ***coordination of benefits***.

Order of Benefit Determination Rules

The order of benefit determination rules decide whether the benefits of the ***policy*** apply before or after those of the other insurance 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.

General

When there is a basis for a ***claim*** under the ***policy*** and another plan:

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

plans and the benefits of any other insurance plan, which has its benefits determined before those of that secondary plan.

Noncomplying Other Insurance Plans

Except for services covered by workers' compensation, employer's liability insurance, ***Medicare***, medical assistance or traditional automobile "fault" contracts, ***we*** may coordinate the benefits of the ***policy*** with a noncomplying other insurance plan.

Benefits are coordinated as follows:

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

Determination of Primary Coverage

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

1. **Non-Dependent/Dependent**
   The benefits of the ***policy*** that cover the person as a ***subscriber*** are determined before those of the ***policy*** that covers the person as a ***dependent***;
2. **Dependent Child/Parents Not Separated or Divorced**
   The benefits of the plan of the parent whose birth day and month occur first during the calendar year are primary. If both parents have the same birthday, the benefits of the plan that covered the parent longer is primary;
3. **Dependent Child/Separated or Divorced Parents**
   Custodial parent is defined as *either the parent awarded custody of a **child** by a court decree, or in the absence of a court decree, the parent with whom the **child** resides more than one half of the calendar year*.
   - If the parents are divorced, separated, or not living together, whether or not they have ever been married:
     - If a court decree states that one parent is responsible for the ***dependent child's*** benefits then that plan is primary;
     - If the parent with responsibility for health coverage does not have benefits for the ***dependent child***, but the spouse of that parent does, then the plan of that parent's spouse is the primary plan;
     - If the court decree states both parents will be responsible for the ***dependent child***, benefits should be coordinated according to item 2 above; or,
     - If the court decree states the parents have joint custody without specifying that one parent is responsible for the ***dependent child***, benefits should be coordinated according to item 2 above;

- If there is no court decree, responsibility of benefits is as follows:
  - The plan covering the ***custodial parent***;
  - The plan covering the spouse of the ***custodial parent***;
  - The plan covering the non-custodial parent; and,
  - The plan covering the spouse of the non-custodial parent;
- If the ***dependent child*** is covered under a plan of an individual other than the parents, the order of benefits is determined as if those individuals were the parents of the ***child***. The custody rule is applicable to anyone who has legal custody of the ***dependent child***.

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

When a ***member*** is covered under a group health plan and this individual ***plan***, the group health plan pays primary and this ***plan*** pays secondary.

Effect on the Benefits of Plan

Definition of Allowable Expense
Allowable expense is defined as *any necessary, reasonable and customary item of expense for health care, at least a portion of which is covered under one or more Plans covering the person for whom the* ***claim*** *is made*.

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

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

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

Benefits provided under this ***plan*** during a ***claim determination period*** for ***allowable expenses*** incurred will be determined as follows:

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

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

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

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

Reduction in Plan's Benefits
The benefits of the ***policy*** will be reduced when the sum of the benefits exceeds the ***covered services*** in a ***claim determination period***. The definition of ***claim determination period*** is *a* **benefit year**. It does not include any part of a year during which a person was not covered under the ***policy***.

The sum of the benefits includes:

1. The benefits that would be payable for the ***covered services*** under the ***policy*** in the absence of this ***coordination of benefits*** provision; and,
2. The benefits that would be payable for the ***covered services*** under the other insurance plan(s), in the absence of a ***coordination of benefits*** provision, whether or not a ***claim*** is made.

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

Payment as a Secondary Plan
The amount by which a secondary plan's benefits are reduced shall be used by the secondary plan to pay ***covered services*** not otherwise paid which were incurred during the ***claim determination period***. As each ***claim*** is submitted, the secondary plan determines its obligation to pay for ***covered***

services based on all ***claims*** that were submitted up to that point in time during the ***claim determination period***.

Right to Receive and Release Information

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

Coordination of Benefits with Medicare

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

If ***you*** are eligible for ***Medicare*** on a primary basis, ***you*** should enroll in and maintain coverage under both ***Medicare*** Part A and ***Medicare*** Part B.

Facility of Payment

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

Subrogation Recovery Rights

Minnesota Statute 62A.095

At times, ***Quartz*** pays treatment expenses when another insurance company is actually responsible for payment. For example, when ***Quartz*** pays treatment expenses following an auto accident and an auto insurance company is actually responsible for covering the expenses. When ***Quartz*** pays first, ***we*** seek reimbursement from the auto insurer in a process called subrogation. ***Quartz*** may pursue subrogation against any person, company, or insurer ("Third Party") who was responsible for payment of treatment expenses that ***Quartz*** paid.

Notice. ***You*** must promptly notify ***Quartz*** in writing whenever ***you*** make an ***injury***-related claim against a Third Party. (MN Stat 62A.096) By accepting ***Quartz*** insurance, ***you*** agree to cooperate in protecting ***Quartz's*** interest in the claim and to provide necessary information to **Quartz** upon request.

Quartz's Subrogation Rights. Quartz may enforce its subrogation rights by asserting a claim to any ***injury***-related coverage to which a ***member*** may be entitled, including but not limited to, auto insurance liability coverage, uninsured and underinsured motorist coverage and homeowner's coverage. This right extends to fault and no-fault insurance coverage. ***Members*** must not do anything to prejudice ***Quartz's*** right of recovery. The subrogation claim is the amount actually paid by ***Quartz*** and the reasonable cash value of the services paid on a capitated basis. Reasonable cash value is determined by utilizing actuarial methodologies.

This subrogation clause applies only after the ***member*** has received a full recovery from another source. ***Quartz's*** subrogation right is also subject to subtraction for actual monies paid to account for the pro rata share of the covered person's costs, disbursements, and reasonable attorney fees, and other expenses incurred in obtaining the recovery from another source unless ***Quartz*** is separately represented by an attorney. (MN Stat 62A.095)

If ***Quartz*** is separately represented by an attorney, ***Quartz*** and the ***member***, by their attorneys, may enter into an agreement regarding allocation of the ***member's*** costs, disbursements, and reasonable attorney fees and other expenses. If ***Quartz*** and the ***member*** cannot reach agreement on allocation, ***Quartz*** and the ***member*** shall submit the matter to binding arbitration. Nothing in this section shall limit ***Quartz's*** right to recovery from another source which may otherwise exist at law.

For the purposes of this subrogation section, full recovery does not include payments made by ***Quartz*** to or for the benefit of the ***member***. (MN Stat 62A.095)

If ***Quartz*** is separately represented by an attorney in the ***member's*** civil action against a third party, ***Quartz*** and the ***member***, by their attorneys, may enter into an agreement regarding allocation of the covered person's costs, disbursements, and reasonable attorney fees and other expenses. If ***Quartz*** and the ***member*** cannot reach agreement on allocation, ***Quartz*** and the ***member*** will submit the matter to binding arbitration. (MN Stat 62A.095)

Reimbursement Rights. Whenever a ***member*** has been made whole through a settlement distributed directly to the ***member***, ***Quartz*** is entitled to excess recoveries obtained by or on behalf of a ***member*** from any Third Party. A ***member's*** obligation to reimburse ***Quartz*** exists, regardless of whether the settlement, compromise or judgment designates payment proceeds from a Third Party as including or excluding medical expenses.

Right of Recovery

We are entitled to:

1. Determine whether and to what extent another insurance plan provides benefits or services;
2. Determine which plan is primary;
3. Require that services or benefits be covered by the primary insurance plan. In the event ***we*** covered such services or benefits and ***we*** were

not primary, ***we*** will recover the reasonable value of services or benefits covered by ***us*** from the other insurance plan or the ***member***; and,

4. Process ***claims*** as the secondary payer.

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

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

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

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

You consent to the release of medical and/or legal information to ***us*** for ***you*** and ***your dependents*** when the ***enrollment form*** is signed. ***We*** have the right to deny any health care services or refuse to pay for the health services of any ***member*** who will not consent to release medical information to us.

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

submit any and all records concerning health care services rendered to ***you*** to appropriate medical review personnel.

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

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 10 – PREMIUMS

Policy Term and Renewal

This ***policy*** is issued for a term of 12 months and renews annually on January 1. ***You*** renew this ***policy*** by paying ***your premium*** before the renewal date. Coverage begins and ends at 12:01 a.m. Central Time.

Premium Rates

Quartz sets the ***premium*** rates for this ***policy*** before accepting ***your*** application. ***We*** will notify ***you*** of a ***premium*** change at least 60 days before any renewal period.

Changes in Premium

We will not change ***premium*** base rates unless ***we*** change the ***premium*** base rate of every ***member*** that ***we*** have issued this type of ***policy*** to with the same policy form number. The ***premium*** will increase if the ***subscriber*** or ***member*** changes age brackets. If there is a ***premium*** change, it will occur on the renewal date. In the event of a misrepresentation, ***we*** reserve the right to retroactively adjust ***premiums***. Please note that ***premium*** rates are subject to change the first of the month following a change in ***subscriber's*** residential address. ***Quartz*** also has the right to change renewal ***premium*** rates on an annual basis.

You may end this ***policy*** by notifying ***us***. Or, if the ***policy*** was purchased though the Health Insurance Marketplace, ***you*** must notify MNsure. See Section 3 - Eligibility and Effective Date of Coverage for additional information regarding voluntary disenrollment.

Premium Notices

We will only bill ***you*** once before ***your premium*** is due.

Premium Due Date

Your premium is due by the first day of the month. This ***policy*** will be in force and will renew for future periods of coverage, as long as ***you*** pay ***your premiums*** on time.

Grace Period

If ***you*** do not pay ***your premium*** and are not receiving ***APTC***, ***you*** have a 31-day grace period to pay ***your premium*** in full. If ***you*** do not pay ***your premium*** in full, the ***policy*** will terminate automatically at the end of the 31-day grace period.

If ***you*** do not pay ***your premium*** and are receiving ***APTC***, ***you*** have a three-month grace period for paying ***premium***. If after the three-month grace period ***you*** do not pay ***your premium*** in full, the ***policy*** will terminate automatically on the last day of the first month in the three-month grace period. ***You*** will be responsible for charges from ***providers*** for medical services ***you*** receive during the second and third months of the grace period.

If ***your policy*** terminates due to non-payment of ***premium*** and ***you*** are not enrolled in a Qualified Health Plan through MNSure, ***Quartz*** will offer a one-time reinstatement of the ***policy*** if ***you*** (1) request one within 60 days from the date coverage was terminated, and (2) pay all ***premiums*** due. Reinstatement will not be offered after this 60-day period expires, or more frequently than once per ***subscriber***.

Renewal Terms

Subject to Section 4 - Eligibility and Effective Date of Coverage above, ***Quartz*** will renew this ***policy*** unless ***we*** discontinue offering all ***policies*** under this ***Certificate***. If ***Quartz*** declines to renew all ***policies*** on this ***Certificate***, ***we*** will give ***you*** at least 90 days' advanced notice before the termination date. ***Quartz*** will offer ***you*** the option to purchase any other type of individual ***health insurance*** coverage that ***we*** offer and for which ***you*** are eligible.

Quartz reserves the right to discontinue a particular type of individual health plan. If ***we*** do so, ***we*** will notify ***you*** at least 90 days before the ***plan*** is discontinued and will offer ***you*** the option to purchase on a guaranteed issue basis any other individual ***plan Quartz*** offers in the individual market for which ***you*** are eligible.

SECTION 11 – GENERAL INFORMATION

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***.

Consent to Release Information

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

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

Advance Directives

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

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

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

Conformity with State Statutes

Any provisions, which on the ***policy effective date*** are in conflict with the laws of the state in which the ***policy*** is issued, will be amended to conform to the minimum requirements of those laws.

Incontestability

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

Rescission

Minnesota Statutes 62Q.186 and 62A.04(2)

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

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

We have the right to ***rescind*** coverage if a material misrepresentation was made on ***your*** application for insurance. A material misrepresentation is an

untrue statement that leads ***us*** to insure ***you*** when ***we*** would not have done so under the terms, conditions and limitations of the ***policy*** if ***we*** had known the truth. ***We*** will provide 30 days' written notice to each individual affected by the retroactive termination of coverage.

Quartz may investigate information provided by ***you*** in applying for coverage for two years after the original ***effective date*** of coverage. After this two-year period expires, no misstatements may be used to void coverage or to deny a ***claim*** that arises after the two-year period expires. This time limit does not apply to fraudulent misstatements made in the application for coverage under this ***plan***. This ***plan*** was issued on the basis that the statements, representations and warranties made at application are correct and complete.

Quartz may ***rescind*** coverage if information is received that indicates a fraudulent or intentional misrepresentation was made by ***you*** or anyone acting on ***your*** behalf, if ***you*** or the person acting on ***your*** behalf knew that the representation was false and the misrepresentation (1) was material or was made with intent to deceive, or (2) contributed to a loss under the ***plan***.

Assignment

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

Clerical Error or Misstatement

If it is determined that information about ***you*** or ***your dependents*** was omitted or misstated in error, ***claims*** will be adjusted accordingly and a ***premium*** adjustment will be made. This provision applies equally to ***you*** and

to ***us***. If the error was determined after six months from the ***effective date*** of ***your*** coverage, no adjustment will be made.

Quartz-Sponsored Wellness Programs

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