Offered by Quartz Health Plan MN Corporation

Health Maintenance Organization (HMO)

Individual Certificate of Coverage

State of Minnesota

2650 Novation Parkway
Fitchburg, WI 53713

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 2 of 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 referral. 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.

TABLE OF CONTENTS

Important Enrollee Information and Enrollee Bill of Rights 2

10-Day Right to Return Policy 5
Guaranteed Issue & Renewability 5

Table of Contents 6

IMPORTANT PHONE NUMBERS 11

IMPORTANT NOTICES 12

Concerning General Provider Payment Methods 12
Usual and Customary Charges 12
Statements in the Application for Insurance 14
Your Rights Under Newborns' and Mothers' Health Protection Act 14
Changes in Eligibility 15
Women's Health and Cancer Rights Act Of 1998 15
Availability of Language Services 16
Consumer Protections Against Balance Billing 17
Out-of-Pocket Limit 18
Non-Discrimination Rule 19

Plan Description Information 21

Section 1 – Introduction 22

Section 2 – Access to Covered Health Care 23

Provider Network 23
Your Rights Under Continuity of Care Statutes 24
Prior Authorization 26
Medical Prior Authorization 27
Drug Prior Authorization 27
Obtaining Prior Authorization 29
Referral Authorizations 30
Standing Referrals to an Out-of-Network Specialty Provider 31
Emergency Care 32
New Technology 32

Section 3 – Eligibility and Effective Date OF COVERAGE 34

Eligibility 34
Subscriber Coverage 34
Dependent Coverage 34
Effective Dates 35
Enrollment and Effective Date 35
Open Enrollment Period 35
Special Enrollment Periods 36
Domestic Partners 37
Definitions 37
Eligibility Criteria 38
Enrollment Criteria 40
Termination of Domestic Partner Coverage 40
When Coverage Ends 41
Extension of Coverage for Children 43
Benefit Changes 44

Section 4 – Benefits: Covered and Non-Covered Services 45

Acupuncture 46
Allergy Services 47
Ambulance Services 47
Behavioral Health and Substance Use Disorders 48
Biofeedback 52
Cancer Treatment 52
Cardiac Rehabilitation 54
Chiropractic Services 55
Chronic Diseases 55
Clinical Trials 56
Dental and Oral Surgery 57
Diabetes Services 61
Drugs and Biologicals 62
Dietary Counseling and Supplements 63
Disposable Medical Supplies 64
Durable Medical Equipment 64
Emergency Services 67

Experimental, Investigative and Emerging Technology 69
Gender-Affirming (Transgender) Services 70
Genetic Testing 70
Hearing Services 72
Home Care 73
Hospice Services 75
Hospital Services 76
Immunizations 77
Intermittent Catheters 77
Kidney Disease Treatment 78
Lyme Disease Treatment 78
Maternity/Newborn 78
Orthotic and Prosthetic Devices 80
Ovarian Cancer Screening 82
PANDAS/PANS 83
Phenylketonuria (PKU) and Elemental-Based Infant Formulas 84
Pharmacist Services 84
Physician/Clinician Services 84
Podiatric Services 85
Prescription Drug Benefit 86
Preventive Services 105
Rare Diseases or Conditions 112
Reconstructive Surgery or Procedures 114
Reproductive Health 115
Scalp Hair Prosthesis 118
Skilled Nursing Facility Care 119
Swing Bed Care 121
Telehealth Visits 122
Telemonitoring 123
Therapy (Physical, Speech & Occupational) 124
Tobacco/Smoking Cessation 126
Transplants 126
Urgent Care 127
Virtual Visits 127
Vision Care 128
X-Ray & Laboratory Tests 130

Section 5 – General Exclusions 131

Section 6 – Claim Information 135

Time Limit on Filing a Claim 135
How to File a Claim for Medical Services 135
How to File a Pharmacy Claim 136
Physician and Hospital Records 137
Care Management/Alternative Treatment 137

Section 7 – Complaint, Appeal & External Review Procedures .. 139

Clinical Review Process 139
Complaint Procedure 140
Appeals Procedure 142
Voluntary Option Appeal 151
External Review 151
External Review – Formulary Exceptions 154
Legal Actions 155

Section 8 – Coordination of Benefits 156

Applicability 156
Coordinating Medical Benefits 156
Coordinating Pharmacy Benefits 157
Order of Benefit Determination Rules 158
Effect on the Benefits of Plan 162
Right to Receive and Release Information 164
Coordination of Benefits with Medicare 164
Facility of Payment 164
Subrogation Recovery Rights 165
Right of Recovery 166
Right to Require Exhaustion of Primary Plan Appeal Process 168

Section 9 – Premiums 169

Policy Term and Renewal 169
Premium Rates 169
Changes in Premium 169
Premium Notices 170

Premium Due Date....170
Grace Period....170
Renewal Terms....171

Section 10 – General Information....172

Consent to Release Information....172
Advance Directives....172
Conformity with State Statutes....173
Incontestability....173
Rescission....173
Assignment....174
Clerical Error or Misstatement....175
Quartz-Sponsored Wellness Programs....175

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-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 not balance bill you for covered services.

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

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

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

You may contact us before a procedure is performed to determine if the provider's estimated charge will be within the usual and customary charge. You will need to provide us with the provider's estimated charge, the CPT or HCPCS code and the estimated date of service. 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 dependent 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, coinsurance and copayments, 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 copayments, deductibles, coinsurance, 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 copayments, deductibles, and coinsurance, 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 copayments, deductibles, coinsurance 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 – 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 2 – ACCESS TO COVERED HEALTH CARE

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

Provider Network

The definition of **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 4; 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 4 - 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 expenses when they are (1) incurred while your coverage is in force, (2) received from an in-network provider, (3) received from an out-of-network provider, but only with a prior approved written referral, (4) received from an out-of-network provider in an emergency, (5) listed as a covered expense under this 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.

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

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

The Member's Attending Physician or service provider makes decisions regarding service and treatment. 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. The definition of a **referral form** is *the form prepared in writing by an in-network provider for you in order for you to receive coverage for medical treatment, services, or supplies from an out-of-network provider.* Medical care, treatment, services or supplies that are received through a referral are subject to the exclusions and limitations of this 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

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

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

Please contact our Customer Success Department at the telephone number provided in the Important Phone Numbers section of this Policy to initiate the prior authorization process. See Section 4 – 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/investigational, as defined in Section 4 – Benefits – Experimental, Investigative and Emerging Technology;
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 3 – 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 <u>at least two</u> 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;
  - Advanced Premium Tax Credits (APTC) are those 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 the Health Insurance Marketplace;
  - 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 4 – BENEFITS: COVERED AND NON-COVERED SERVICES

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

Medical and pharmacy services, supplies or treatments are covered expenses when they are (1) incurred while your coverage is in force, (2) received from an in-network provider, (3) received from an out-of-network provider, but only with a prior approved written referral, (4) received from an out-of-network provider in an emergency, (5) listed as a covered expense under this 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.

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

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

The 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 2 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 expense 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.

Covered with Prior Authorization

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

Non-Covered Services

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

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 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;
- 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*)).

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;

5. Services provided in intensive outpatient programs by in-network providers who are certified by the appropriate credentialing body in their state; and,
6. 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; and,
8. 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

Copayments or coinsurance for prescription drugs prescribed to treat a chronic condition 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” means diabetes, asthma, and allergies requiring use of epinephrine auto-injectors.

"Related medical supplies" 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 coinsurance 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 coinsurance 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 sound natural teeth (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 investigational 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 sound natural teeth 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 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. **Foreign claims** are defined as 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.

Non-Covered Services

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

Experimental, Investigative and Emerging Technology

Minn. Rule 4685.0100

Non-Covered Services

1. Experimental, investigative, or unproven services (emerging technology) are not covered. **Experimental, Investigative and Emerging Technology** 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 of experimental, investigative, or unproven (emerging technology) 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 investigational even if the provider has performed, prescribed, recommended, ordered or approved it, or if it is the only available procedure or treatment for the condition. Quartz considers all services, procedures, and treatment with Category III codes to be experimental, investigational and/or emerging technology.

Gender-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 with Prior Authorization

1. Medically necessary gender-affirming health care services for the treatment of gender dysphoria are covered and may require prior authorization. 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*.

Non-Covered Services

1. Gender dysphoria-related treatment that is <u>not</u> 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 <u>not</u> on Quartz's list of covered hearing aid models, including over-the-counter models, coverage will be limited to $1,500 per hearing aid, per ear, every three years; 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 Care

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

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

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

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 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; and,
5. Medical supplies, drugs and laboratory services covered to the same extent they would have been covered if you were confined in a hospital.

Non-Covered Services

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

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;
- 48 hours of inpatient hospital care following vaginal delivery and 96 hours of inpatient hospital care following a caesarean section delivery. The length of stay coverage begins is when a delivery occurs in a hospital (at the time of delivery). For deliveries outside the hospital, the stay begins at the time the mother and/or newborn are admitted. The decision of whether an admission is in connection with childbirth is a medical decision to be made by your attending provider, not us. Coverage will be provided for a shorter length of stay if the attending provider, in consultation with the mother, decides on an earlier discharge. Coverage will be provided for a longer length of stay if medically necessary. We are prohibited from requiring precertification for the minimum stay; however, we may impose continued stay approval for the portion of stay after the 48 or 96 hours;

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. **Congenital** means *a condition that exists at birth*;
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 and Emerging Technology; 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 expense, such as diagnosis and treatment of ulcers, wound, or infections;
   - Routine hygiene and maintenance care such as trimming corns, calluses, and nails; or,
   - Cutting, trimming, or other non-operative partial removal of toenails;

Non-Covered Services

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

Prescription Drug Benefit

DEFINITIONS

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 Drug 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 visitQuartzbenefits.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.

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

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

Restricted Drug or Restricted Medication
A drug that is covered only when specific clinical criteria are met and Quartz issues a Prior Authorization for coverage of the drug. The clinical criteria for some Restricted Drugs require the failure of prerequisite therapies. 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 copayment published in the 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 not payable for Prescription Drugs obtained from an out-of-network pharmacy. Out-of-pocket payments for drugs obtained from an out-of-network pharmacy in the United States may be reimbursed on an exception basis. Your out-of-pocket costs are only eligible for reimbursement in cases of acute need when an exception request is submitted to Quartz with a completed Direct Member Reimbursement Form and an itemized paid prescription receipt. Amounts in excess of the Usual, Customary and Reasonable Charge are not covered benefits and are the responsibility of the member.

If Quartz determines you may be using Prescription Drugs in a questionable, harmful, abusive manner or frequency, we may require you to select a single in-network pharmacy to provide and coordinate all future pharmacy services. Benefit coverage will only be paid if the assigned single in-network pharmacy is used. If you do not make a pharmacy selection within 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 Prescription Drug formulary. Covered oral chemotherapy drugs are available on Tiers 1, 2 and 4. See your 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 a $100 Co-payment 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 7 of this COC.

Step Therapy override requests will be granted if you provide sufficient documentation that <u>any</u> 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 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.

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. Non-medical devices or substances unless listed on the formulary;
4. Any drug or medication that is administered or delivered to you by or in the presence of a health care provider (other than Prescription Drugs dispensed from a community pharmacy to be self-administered) unless listed on the formulary;
5. Any drug or medication that is to be taken by or administered to you while you are a patient at a healthcare facility, including a licensed hospital, rest home, extended care facility, convalescent hospital, skilled nursing home, emergency room or urgent care center, ambulatory clinic, infusion center, or similar institution;
6. Any drug labeled "Caution: limited by Federal Law to investigational use" or other wording with similar intent, experimental drugs, or FDA approved drugs being used in an experimental manner (non-evidence based indication, dosage regimen, etc.) even though a charge is made to you, except that coverage will be provided for any Prescription Drug that meets the following criteria:
    - Is prescribed for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection; and,
    - Is approved by the federal Food and Drug Administration for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection, including each investigational new drug that is approved under 21 C. F. R. 312.34 to 312.36, and that is in or has completed a phase-3 clinical investigation; and,
    - If the drug is an investigational new drug described in the second bullet above, is prescribed and administered in

accordance with the treatment protocol approved for the investigational new drug under 21 C. F. R. 312.34 to 312.36;

7. Any refill of a Prescription Drug that is in excess of what is prescribed, or any refill dispensed beyond the legally-allowed time limits;
8. Anabolic Steroids and athletic performance enhancing medications;
9. Anti-obesity drugs, anorexients and any drug for which weight modification is the primary mechanism by which indicated results are achieved or is the primary purpose the medication is prescribed;
10. Medications used to prevent hair loss (e.g., topical minoxidil and finasteride);
11. Medications used to enhance or facilitate fertility;
12. Any Prescription Drug for a procedure not covered by your medical health insurance Certificate of Coverage;
13. Any Prescription Drug for an Illness or Injury not covered by your medical health insurance Certificate of Coverage;
14. Over-the-Counter Medications, with or without a Prescription Order, unless the medication has been approved by Quartz. Any such approved medication is listed on Quartz's Formulary List as a Formulary Drug;
15. Prescription Drugs that are covered, or the member is entitled to receive, from any Workers' Compensation law or any municipal state or federal program. This includes Prescription Drugs the member is entitled to receive without charge;
16. Nutritional products and special food or feedings. 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 not 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, coinsurance and copay amounts).

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

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

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

Annual wellness exams commonly include screenings for blood pressure, obesity, alcohol and drug misuse, and other tests based on your risk profile (in absence of symptoms). 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 (i.e., pap smear) and relevant patient navigation services	One per benefit year
Sexually Transmitted Disease testing ▪ Chlamydia ▪ Syphilis ▪ Gonorrhea ▪ HIV	One of each per benefit year

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
Human papillomavirus testing	One every three benefit years for ages 30 or older
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.

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.14*).

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 not, 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. Treatment of Autism Spectrum Disorder (ASD) which includes autism disorder and pervasive developmental disorder not otherwise specified. Coverage is provided 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, music, or animal-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 and investigational 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 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 4 – Benefits: Covered and Non-Covered Services).

Virtual Visits

A **Virtual Visit** is *an on-demand consultation with a provide**r** 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 5 – GENERAL EXCLUSIONS

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

The following are General Exclusions of your Plan:

1. Any and all types of modifications to the home and the items associated with the modifications (e.g., ramps, grab bars, stair lifts, elevators);
2. Any loss 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. **Immediate family** is defined as *spouse, mother, father, grandparents, children, grandchildren, brothers, sisters, mother-in-law, father-in-law, brothers-in-law, sisters-in-law, daughters-in-law, and sons-in-law. Adopted and step relationships are also included in immediate family.* However, if one of the persons described above is a licensed medical provider and you receive urgent or emergency services from

that person in an urgent care facility or hospital, this exclusion does not apply;

9. Any treatment or services ordered or rendered by you, for you;
10. Any treatment or services rendered by or at the direction of a provider of health care services who is not licensed to provide the services, or who is not operating within the scope of that license;
11. Charges for drugs filled at out-of-network pharmacies;
12. Charges for services that were not rendered;
13. Charges for out-of-network provider services which exceed 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 expense;
20. Custodial care;
21. Customization of vehicles and/or lifts for wheelchairs and/or scooters;
22. Dermabrasion;
23. Donor charges related to transplant services when the 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;
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. The cell and gene therapies nadofaragene firadenovec-vcng (Adstiladrin), lifileucel (Amtagvi), fidanacogene elaparvovec-dzkt (Beqvez), delandistrogene moxeparvovec-rokl (Elevidys), talimogene laherparepvec (Imlygic), etranacogene dezaparvovec-drlb (Hemgenix), sipuleucel-T (Provenge), valoctocogene roxaparvovec-rvox (Roctavian), elivaldogene autotemcel (Skysona), afamitresegene autoleucel (Tecelra), eladocagene exuparvovec (Kebilidi), and remestemcel-L-rknd (Ryoncil);
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, 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 copayment, coinsurance, and/or deductible:

- **Copayment** is defined as *a specific dollar amount that you are responsible for before we assume any liability for the remaining part of the charges for that service;*
- **Coinsurance** is defined as *a percentage of the allowed charge for covered expenses that you are required to pay.* You are responsible for the payment to the provider for any coinsurance amount;
- **Deductible** is defined as *an amount of money that you must pay before benefits are payable by us.* The deductible applies to each member each benefit year. Only allowable charges that qualify as covered expenses may be used to satisfy the deductible. The amount of the deductible, if any, is stated on the Summary of Benefits and Coverage;

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 6 – 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, copayments or coinsurance) 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 4 of this document, minus the applicable copayment. 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 (Quartz InControl), diabetes, mental resiliency, and prenatal care coordination. If you feel that you would benefit from care management, you can fill out a request form at QuartzBenefits.com or call Customer Success. Someone from the Care Management Team will reach out to you. As part of care management, Quartz reserves the right to direct treatment to the most appropriate and cost-effective option available.

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

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

SECTION 7 – 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 decision is made, notification will be provided to the attending health care professional and hospital or physical 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 decision 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 decision 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.

For the purpose of this section, an adverse decision includes 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.

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 decision 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.

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/divs/hpsc/mcs/complaint.htm.

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/divs/hpsc/mcs/complaint.htm.

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 decision 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. The definition of **authorized representative** is *an individual authorized by you to act on your behalf in pursuing payment of a claim, obtaining a referral/prior authorization or in dealing with any of the levels of the appeal process. 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 decision 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 decision 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 decision 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 decision. 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 decision 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 Section
P.O. Box 64882
St. Paul, MN 55164-0882
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** is defined as *a request for independent, external review of the final decision made by Quartz through its internal appeal process.* External review provides you with an opportunity to have medical professionals who have no connection with us review your dispute.

An **adverse benefit 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 investigational, 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 benefit 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 benefit 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 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.

You or your authorized representative must submit your request in writing within six months of the date of the adverse benefit determination. Your request must be submitted after you receive our notice of the disposition of your appeal. 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 Section
P.O. Box 64882
St. Paul, MN 55164-0882

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 8 – COORDINATION OF BENEFITS

Applicability

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

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

- Group insurance or group-type coverage, whether insured or uninsured (self-insured), that includes continuous 24-hour coverage. This includes pre-payment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage;
- 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. The definition of **allowable expense** is *a necessary, reasonable and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.* Reductions will be made to the extent required to prevent benefits from exceeding the allowable expense.

Coordinating Pharmacy Benefits

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

Prescription claims submitted for coordination of benefits (COB) by you will be processed and 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 9 – 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, 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 3 - 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.

SECTION 10 – GENERAL INFORMATION

Consent to Release Information

You consent to release to us medical and/or legal information for yourself and your dependents when you sign the Enrollment Form. We have the right to deny any health care services or 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.

Notice of Non-Discrimination and Availability of Language Assistance Services and Auxiliary Aids and Services

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

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

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

We provide reasonable modifications and free appropriate auxiliary aids and services to people with disabilities to communicate effectively with us and to participate in health programs or activities, such as -

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

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

- Qualified interpreters
- Information written in other languages.

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

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

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

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

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

Complaint forms are available at hhs.gov/ocr/office/file/index.html. Quartz is a Qualified Health Plan issuer in the Health Insurance Marketplace® in certain states. To learn more, visit the Health Insurance Marketplace® at HealthCare.gov.

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call (800) 362-3310, TTY: 711 / (800) 877-8973.

Spanish - ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al (800) 362-3310. TTY: 711 / (800) 877-8973 o hable con su proveedor.
Chinese -**注意**：**如果您**说[**中文**]，**我**们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 (800) 362-3310. TTY: 711 / (800) 877-8973 **或咨**询您的服务提供商。
Hmong - LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau (800) 362-3310. TTY: 711 / (800) 877-8973 los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.
Russian - ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону (800) 362-3310. TTY: 711 / (800) 877-8973 или обратитесь к своему поставщику услуг.
Vietnamese - LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số (800) 362-3310. TTY: 711 / (800) 877-8973 hoặc trao đổi với người cung cấp dịch vụ của bạn.
Laotian - ຊືນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ (800) 362-3310. TTY: 711 / (800) 877-8973 ຫຼື ລົມກັບໝູ່ໃຫ້ບໍລິການຂອງທ່ານ.
German - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie (800) 362-3310. TTY: 711 / (800) 877-8973 an oder sprechen Sie mit Ihrem Provider.

Pennsylvania Dutch - LET OP: als je Nederlands spreekt, zijn er gratis taalhulpdiensten voor je beschikbaar. Passende hulpmiddelen en diensten om informatie in toegankelijke formaten te verstrekken, zijn ook gratis beschikbaar. Bel (800) 362-3310. TTY: 711 / (800) 877-8973 of spreek met je provider."

Arabic - تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1(800) 362-3310 .TTY: 711 / (800) 877-8973 أو تحدث إلى مقدم الخدمة".

Polish - UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer (800) 362-3310. TTY: 711 / (800) 877-8973 lub porozmawiaj ze swoim dostawcą.

French - ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le (800) 362-3310. TTY: 711 / (800) 877-8973 ou parlez à votre fournisseur.

Hindi - ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। I (800) 362-3310. TTY / TDD: 711 / (800) 877-8973 पर कॉल करें या अपने प्रदाता से बात करें।

Korean -주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. (800) 362-3310. TTY: 711 / (800) 877-8973 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Albanian - VINI RE: Nëse flisni [shqip], shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi (800) 362-3310. TTY: 711 / (800) 877-8973 ose bisedoni me ofruesin tuaj të shërbimit.

Tagalog - PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa (800) 362-3310. TTY: 711 / (800) 877-8973 o makipag-usap sa iyong provider.

Somali - FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac (800) 362-3310. TTY: 711 / (800) 877-8973 ama la hadal bixiyahaaga. Gargaarsi gargaaraa fi tajaajilli sirrii ta'ee fi odeeffannoo bifa dhaqqabamaa ta'een kennuunis bilisaan ni argama.

Cushite (Oromo) - XIYYEEFFANNOO: Afaan Kushii yoo dubbattan tajaajilli gargaarsa afaanii bilisaan isiniif ni kennama. Gargaarsi gargaaraa fi tajaajilli sirrii ta'ee fi odeeffannoo bifa dhaqqabamaa ta'een kennuunis bilisaan ni argama. (800) 362-3310 bilbili. TTY: 711 / (800) 877-8973 ykn dhiyeessaa keessan waliin haasa'aa.

Amharic - ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር (800) 362-3310. TTY: 711 / (800) 877-8973 ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።

Karen - ဆူ- နမ့်ကတိၤ ထါနၣ်လီၤဖဲအံၤ အဃိ, တၢ်အိၣ်ဒီး ကိုၣ်တၢ်ဆီၣ်ထွဲမၤစၢၤ လၢတလၢာ် ဘူၣ်လာ်စ့ၤလၢနဂီၢ်လီၤ. တၢ်အိၣ်ဒီး တၢ်မၤစၢၤတၢ်နၢ်ဟူပီးလီဒီး တၢ်မၤစၢၤတၢ်မၤ လၢအ ကြၢးအဘၣ် လၢကဟ့ၣ်တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢတၢ်မၤန့ၢ်အီၤသ့တဖၣ် လၢတလၢာ်ဘူၣ်လာ်စ့ၤ လၢနဂီၢ်လီၤ. ကိး (800) 362-3310. TTY: 711 / (800) 877-8973 မ့တမ့ၢ် ကတိၤတၢ်ဒီး နပှၤလၢဟ့ၣ် နၤတၢ်ကွၢ်ထွဲမၤစၢၤတက့ၢ်.

Mon-Khmer, Cambodian (Khmer) - សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃផងដែរ។ ហៅទូរសព្ទទៅ (800) 362-3310. TTY: 711 / (800) 877-8973 ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។

Serbo-croatian (Serbian) - ПАЖЊА: Ако говорите српскохрватски, доступне су вам бесплатне језичке услуге. Бесплатна су и одговарајућа помоћна помагала и услуге за пружање информација у приступачним форматима. Позовите (800) 362-3 ТТИ: 711 / (800) 877-8973 или разговарајте са својим провајдером.

Thai - หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ (800) 362-3310. TTY: 711 / (800) 877-8973 หรือปรึกษาผู้ให้บริการของคุณ"

Gujarati - ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે મફત ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટે યોગ્ય સહાયક સહાય અને સેવાઓ પણ મફતમાં ઉપલબ્ધ છે. કૉલ કરો (800) 362-3310. TTY: / (800) 877-8973 અથવા તમારા પ્રદાતા સાથે વાત કરો.

Urdu - توجہ: اگر آپ اردو بولتے ہیں، تو آپ کے لیے مفت زبان کی مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ (800) 362-3310 پر کال کریں۔ TTY: 711 / (800) 877-8973 یا اپنے فراہم کنندہ سے بات کریں۔

Italian - ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'(800) 362-3310. TTY: 711 / (800) 877-8973 o parla con il tuo fornitore.

Greek - ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το (800) 362-3310. TTY: 711 / (800) 877-8973 ή απευθυνθείτε στον πάροχό σας.

Nepali - ध्यान दिनुहोस्: यदि तपाइँ नेपाली बोल्नुहुन्छ भने, तपाइँलाई निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक सहायताहरू र सेवाहरू पनि निःशुल्क उपलब्ध छन्। कल (800) 362-3310। TTY: 711 / (800) 877-8973 वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

Ukrainian - УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером (800) 362-3310. TTY: 711 / (800) 877-8973 або зверніться до свого постачальника.

Tibetan - དོ་སྣང་། གལ་ཏེ་ཁྱེད་རང་གིས་བོད་སྐད་ཤེས་ན། ཁྱེད་རང་ལ་རིན་མེད་སྐད་ཡིག་རོགས་སྐྱོར་གྱི་ཞབས་ཞུ་ཡོད། འོས་འཚམ་གྱི་རོགས་རམ་དང་ཞབས་ཞུ་དེ་དག་གིས་གནས་ཚུལ་ཐོབ་ཐུབ་པའི་རྣམ་པ་ནང་དུ་སྤྲོད་ཐུབ་པ་དེ་དག་ཀྱང་རིན་མེད་དུ་སྤྲོད་ཐུབ་ཀྱི་ཡོད། ཁ་པར་(༨༠༠)༣༦༢-༣༣༡༠ TTY: 711 / (800) 877-8973 ཡང་ན་ཁྱེད་ཀྱི་མཁོ་སྤྲོད་བྱེད་མཁན་ལ་སྐད་ཆ་བཤད་རོགས།

Wolof - FÀTTAL: Sooy wax Wolof, ay serwiis yu lay jàppale ci làkk wi doo fay. Ay ndimbal ak ay serwiis yu war ngir joxe leeral ci formaa yu yomb am nañu ci te doo fay. Woowal (800) 362-3310. TTY: 711 / (800) 877-8973 wala nga waxtaan ak sa joxekat.