



## Prescription Drug Benefit Rider

Offered by Quartz Health Benefit Plans Corporation

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QuartzBenefits.com

This **Prescription Drug Benefit Rider** amends the **policy** issued by Quartz Health Benefits Plans Corporation, referred throughout this **rider** as "**Quartz**," to provide prescription drug benefits as specified below. Benefits under this **rider** are subject to the terms and conditions of the **policy**, except as amended by this **rider**.

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## DEFINITIONS

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### **Biologic Reference**

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

### **Biosimilar**

A type of biologic product that is approved by the FDA as a **biosimilar** because it is highly similar to an already FDA-approved biological product for which the patent is expired (known as the **biologic reference**) and has been shown to have no clinically meaningful differences from the **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, glucometers and continuous glucose monitors on **Quartz's formulary list** as **formulary drugs** or items;
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; 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 & Therapeutics Committee 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 & Therapeutics Committee and listed on **Quartz's drug formulary list** with a status other than "Non-formulary."

### **Formulary List**

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

### **Generic Drug**

A medication determined to be a generic by **Quartz**. A **generic drug** is typically a medication that has been approved by the FDA through an Abbreviated New Drug Application (ANDA) as equivalent to a FDA-approved

innovator product (**brand drug**). Authorized generics approved by the FDA through a New Drug Application (NDA) when there are no generic competitors of the same medication approved through an ANDA may be considered to be **brand drugs** by **Quartz**.

### **HDHP \$0 Drug**

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

### **HIV**

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

### **In-Network Pharmacy**

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

### **Medical Food**

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

### **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 & Therapeutics Committee as a **formulary drug**, (2) is listed on **Quartz's drug formulary list** with a status of "Non-formulary (but is not specifically listed as an exclusion on this rider), or (3) is not listed on the **formulary list**.

Medications new to the market are **non-formulary drugs** until reviewed by **Quartz's** Pharmacy & Therapeutics Committee, at which point a formulary decision will be made.

### **Non-Preferred Drug**

A **brand** or **generic** medication that (1) is designated by **Quartz's** Pharmacy & Therapeutics Committee as a **formulary drug**, (2) is listed on **Quartz's drug formulary list** with a status other than "Non-formulary," and (3) has been designated 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 & Therapeutics Committee as a **formulary drug**, (2) is listed on **Quartz's drug formulary list** with a status other than "Non-formulary," and (3) has been designated as a **preferred drug**.

### **Prescription Drug**

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

### **Prescription Order**

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

### **Preventive Medication**

A medication, including both prescription and **over-the-counter drugs**, determined by CMS to be a **preventive health service** as defined in 45 C. F. R. § 147.130.

### **Prior Authorization**

The process by which **Quartz** gives prior written approval for coverage of specific covered services, treatment, **prescription drugs, durable medical equipment ("DME")** and supplies. The purpose of **prior authorization** is to determine and authorize payment for the following:

1. The specific type and extent of service, treatment, **prescription drug, DME** or supply that is necessary;
2. The number of visits or the period of time during which care will be provided; and,
3. 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 medication(s) 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 **Quartz's Pharmacy and Therapeutics Committee** as being a **specialty pharmaceutical**. Drugs designated as **specialty pharmaceuticals** will be listed as such on **Quartz's formulary list** at **QuartzBenefits.com** 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.

### **Value Tier Drug**

A **preferred generic** or **preferred brand** medication on **Quartz's formulary** that has been designated by **Quartz** as a **value tier drug**.



## BENEFITS

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**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** for the approved **non-formulary drug** will be at the highest **formulary** tier cost-sharing as allowed under state or federal law.

*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 exception to step therapy requirements will be reviewed based on s. 632.866, Wis. Stat. Continuation of therapy criteria may apply to **members** who were previously approved for coverage. Persons who were not previously approved for coverage but who instead initiated therapy using a manufacturer-sponsored free drug program, provider samples or vouchers will not be considered to have met continuation of therapy criteria for coverage.

**Prescription claims** may be subject to **co-payment, deductible, or co-insurance**. **Members** with **co-payment** plans are subject to one **co-payment** for each claim dispensed up to a 30-day supply (i.e., 1-30 day supply = 1 **co-payment**, 31-60 day supply = 2 **co-payments**, 61-90 day supply = 3 **co-payments**). Some medications are packaged such that they cannot reasonably be dispensed in a 30-day quantity. For these medications, **members** are charged one **co-payment** for each 30-day claim covered by the medication (i.e., an inhaler is dispensed as a 60-day supply and can't reasonably be reduced to a 30-day supply; two **co-payments** would apply). In cases where the pharmacy dispenses a claim for less than a 30-day supply of a maintenance medication, as determined by **Quartz**, for the purposes of synchronizing refills for the member, a prorated **co-payment** will apply based on the percentage of a 30-day supply dispensed.

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

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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 co-pay assistance programs. However, in no case will true **out-of-pocket** costs to the participant be greater than the maximum co-payment published in the Summary of Benefits and Coverage (SBC). Finally, manufacturer-funded co-pay assistance received will not be credited to **your** annual **deductible** or maximum **out-of-pocket** requirement.]

When prescribed by a **physician** or other health care **provider**, **formulary drugs** listed on **Quartz's formulary list** as **preventive medications** are covered without member cost-sharing. 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.

Orally-administered chemotherapy drugs are subject to a maximum \$100 **co-payment** for a 30-day supply after any applicable deductibles are met.

[There is no **prescription drug** benefit available to members age 65 or older.]

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 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**, or you may contact **Quartz** Customer Success.

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

**Brand drugs** for which there is an available equivalent **generic drug** are non-formulary and require an approved formulary exception for coverage immediately upon market availability of the **generic** equivalent. As a cost-saving measure, **Quartz** may opt to cover a **brand drug** as the preferred option instead of the equivalent **generic drug**. In those select situations, the **brand drug** will be covered at the co-pay tier level that the **generic drug** would have been covered at, and the **generic drug** will be non-formulary.

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

Per s. 632.861 (4)(d), Wis. Stat., **Quartz** will cover an additional 30-day fill of a drug substituted at the pharmacy as described above if the patient has had an adverse reaction to the replacement drug or to a drug in the same pharmacological class or with the same mechanism of action as the replacement drug. This 30-day supply will be subject to the cost-sharing tier that applied to the substituted drug immediately preceding the substitution.

## LIMITATIONS

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### 1. **Supply Quantity Limits**

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

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

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

### ***Prescription Eye Drops Early Refill [s. 632.895 (16t), Wis. Stat.]***

*Per s. 632.895 (16t), Wis. Stat., Quartz will not deny coverage of a member's request for reasons of an early refill of prescription eye drops if all of the following are satisfied:*

- *The refill is requested by the **member** when 75% or more of the days have elapsed from the later of (1) the original date the prescription was filled, or (2) the date on which the most recent refill was distributed to the **member**; and,*

- *The prescription allows for a refill of the prescription eye drops; and,*
- *The requested refill does not exceed the number of refills allowed by the **prescription order**.*

## 2. **Specialty Pharmaceuticals**

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

## **EXCLUSIONS**

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Drugs are **not** covered under this **Prescription Drug Benefit Rider** 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 (e.g., Step Therapy not completed, Prior Authorization not approved, or **specialty pharmaceuticals** obtained outside **Quartz's** Specialty Pharmacy Network, among others). See **Quartz's formulary list** on our web site for the requirements applicable to our **formulary drugs**;
3. Non-medical devices or substances such as therapeutic devices or substances, hypodermic needles, syringes (except insulin syringes and needles), support garments;
4. Any drug or medication that is administered or delivered to you by or in the presence of a health care provider (other than prescription drugs dispensed from a community pharmacy to be self-administered);

5. Any drug or medication that is to be taken by or administered to you while you are a patient at a healthcare facility, including a licensed hospital, rest home, extended care facility, convalescent hospital, skilled nursing home, emergency room or urgent care center, ambulatory clinic, infusion center, or similar institution;
6. Any drug labeled "Caution: limited by Federal Law to investigational use" or other wording with similar intent, experimental drugs, or FDA-approved drugs being used in an experimental manner (non-evidence based indication, dosage regimen, etc.), even though a charge is made to you, except that coverage will be provided for any **Prescription drug** that meets the following criteria:
  - Is prescribed for the treatment of HIV infection or an **illness** or medical condition arising from or related to HIV infection; and,
  - Is approved by the FDA 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 (ii) 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, anorexiant 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 drugs**, with or without a **prescription order**, unless

- the medication has been approved by **Quartz**. Any such approved medication is listed on **Quartz's formulary list** as a **formulary drug**;
15. **Prescription drugs** that are covered, or the **member** is entitled to receive, from any Workers' Compensation law or any municipal state or federal program. This includes prescription drugs the **member** is entitled to receive without charge;
  16. Nutritional products and special food or feedings;
  17. Any **prescription drug** dispensed to a **member** prior to the **member's** effective date of coverage under the **plan** or after the **member's** termination date;
  18. **Prescription drugs** used for cosmetic treatment, including but not limited to Tretinoic Acid (Retin A);
  19. Irrigation solutions and supplies;
  20. Early refills. *This exclusion does not apply to Prescription Eye Drops per s. 632.895 (16t), Wis. Stat.;*
  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 when (1) endogenous production of the growth hormone is inadequate or (2) for a diagnosis of Turner Syndrome. With the exception of Turner Syndrome, coverage is not extended for short stature syndrome or other related growth abnormalities;
  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; and,
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 P&T for inclusion on the formulary. These drugs were approved by the FDA before it was required to evaluate effectiveness for approval (pre-1963). Drugs with open DESI proceedings have yet to be approved by the FDA as effective despite still being available on the market.



## 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](mailto: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](http://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](http://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](http://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.**

<b>Spanish</b> – 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.
<b>Chinese</b> – 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。
<b>Hmong</b> – 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.
<b>Russian</b> – 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.
<b>Vietnamese</b> – 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.
<b>Laotian</b> – ຄຳມອບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາໂດຍ (800) 362-3310. TTY: 711 / (800) 877-8973 ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.
<b>German</b> – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste 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.

<b>Pennsylvania Dutch</b> – 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."
<b>Arabic</b> – 3310-362 (800) ١٠٠٠٠٠٠٠. اتصل على الرقم المجاني. اتحدث إلى مقدم الخدمة 877-8973 (800) / ٧١١. تنبيه: إذا كنت تتحدث اللغة العربية، فستوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتسويات يمكن الوصول إليها مجانًا. "أو تحدث إلى مقدم الخدمة 877-8973 (800) / ٧١١.
<b>Polish</b> – 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.
<b>French</b> – 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.
<b>Hindi</b> – ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए नि:शुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएं भी नि:शुल्क उपलब्ध हैं।। (800) 362-3310. TTY / TDD: 711 / (800) 877-8973 पर कॉल करें या अपने प्रदाता से बात करें।
<b>Korean</b> – 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.
<b>Albanian</b> – VINI RE: Nëse flisni [shqip], shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shitesë 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.
<b>Tagalog</b> – PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyon 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.
<b>Somali</b> – 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.
<b>Cushite (Oromo)</b> – XIYYEEFFANNOO: Afaan Kushi 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.
<b>Amharic</b> – ማሳሰቢያ፡ አማርኛ የሚናገሩ ከሆኑ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርባል። መረጃን በተደራሽ ቅርጾች ለማቅረብ ተገቢ የሆኑ ተጨማሪ አገዛዞች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር (800) 362-3310. TTY: 711 / (800) 877-8973 ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።
<b>Karen</b> – ဆူး-နမ့်ကတိဝါ ထာန့်လီဝဲအံ၊ အယိ၊ တာအိန်ဒီး ကျိတ်တိအိန်ထွဲမစာ၊ လာတလတ် ဘူဂ်လတ်စုလောနီဂီလီ၊ တာအိန်ဒီး တာမီစာတန်ဂီဟူဝီးလီဒီး တာမီစာတန်မာ လာအကြားအဘဉ် လာကဟဉ်တန်ဂီတန်ဂျါ၊ လာတန်မနီအီသုတဖဉ် လာတလတ်ဘူဂ်လတ်စု လာနီဂီလီ၊ ကီး (800) 362-3310. TTY: 711 / (800) 877-8973 မုတမုာ် ကတိတော်ဒီး နုလလဟဉ် နုတော်ကွာ်ထွဲမစာတကွာ်.
<b>Mon-Khmer, Cambodian (Khmer)</b> – សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ សេវាកម្មជំនួយភាសាភក្តិភាសាខ្មែរសម្រាប់អ្នក។ ជំនួយនិងសេវាកម្មដែលជាការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយភក្តិភាសាខ្មែរផងដែរ។ ហៅទូរសព្ទទៅ (800) 362-3310. TTY: 711 / (800) 877-8973 ឬនិយាយទៅភាសាខ្មែរកម្ពុជាសម្រាប់អ្នក។
<b>Serbo-croatian (Serbian)</b> – 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.
<b>Thai</b> – หมายถึง: หากคุณใช้ภาษาไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าใจได้โดยไมเสียค่าใช้จ่าย โปรดโทรติดต่อ (800) 362-3310. TTY: 711 / (800) 877-8973 หรือปรึกษาผู้ให้บริการของคุณ”
<b>Gujarati</b> – 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.
<b>Urdu</b> – 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۔ یا اپنے فراہم کنندہ سے بات کریں۔ TTY: 711 / (800) 877-8973
<b>Italian</b> – 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.
<b>Greek</b> – 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.
<b>Nepali</b> – ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंलाई नि:शुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक सहायताहरू र सेवाहरू पनि नि:शुल्क उपलब्ध छन्। कल (800) 362-3310। TTY: 711 / (800) 877-8973 वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।
<b>Ukrainian</b> – УВАГА: Якщо ви розмовляєте українською мовою, 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.
<b>Tibetan</b> – ཇོ་མཆོག་གི་ཁྱེད་རང་གིས་བོད་སྐད་ཀྱི་ཁྱེད་རང་ལ་ཟིན་མེད་སྐད་ཡིག་རོགས་སྐྱོར་གྱི་ཞབས་ཀྱི་ཡོད། འོས་འཛམ་གྱི་རོགས་མཁའ་ནང་ཁགས་ཀྱི་དེ་དག་གིས་གནས་སྡོད་མེད་ཐབས་ལེན་མཁའ་ནང་དུ་སྒྲིན་ཐབས་ལ་དེ་དག་གྱུང་ཟིན་མེད་དུ་སྒྲིན་ཐབས་ཀྱི་ཡོད། ལ་པར་(༧༠༠) ༩༦༩- ༩༦༩༠ TTY: 711 / (800) 877-8973 ལང་ན་ཁྱེད་ཀྱི་མགོ་སྐྱོད་ཀྱི་ཁྱེད་མགས་ལ་སྐད་ཆ་བཤད་རོགས།
<b>Wolof</b> – FATTAL: 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.