Quartz Medicare Supplement [2022] Enrollment Application

Offered by Quartz Health Plan Corporation
840 Carolina Street, Sauk City, WI 53583
Phone: (800) 362-3310 • Fax: (608) 643-2564
QuartzBenefits.com

Section A: Applicant Information

Last Name	First Name	Middle Initial

Date of Birth (mm/dd/yyyy) _____/_____/_____	Age	Gender ☐ Male ☐ Female

Social Security Number: _____ - _____ - _____

Street Address			Apt #

City	State	County	ZIP Code

Home Phone Number ( ) -	Alternate Phone Number ( ) -

Email Address (Optional)

Preferred Language (spoken and written)

☐ English
☐ Spanish
☐ Hmong
☐ German
☐ Chinese
☐ American Sign Language
☐ Other (please specify):

_____

Race: Defined as a person's identification with one or more social groups.

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Declines to Answer
☐ Unavailable

Ethnicity: Refers to shared cultural characteristics such as language, ancestry, practices, and beliefs. For this application, Ethnicity is broken out into two categories: Hispanic or Latino and Not Hispanic or Latino.

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Declines to Answer
☐ Unavailable

Section B: Effective Date

Your effective date will be the 1st of the month after we receive your completed application. Upon approval, your effective date cannot be changed.

If you are requesting a future effective date or an effective date other than the 1st of the month, it cannot be more than 90 days after the date we receive your completed application. After the initial effective date, your policy will move to a 1st of the month anniversary date.

Requested effective date: ___ ___ / ___ ___ / ___ ___ ___ ___

Section C: Medicare Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

-OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare Number: _____

Is entitled to: Effective Date:

HOSPITAL (Part A): _____

MEDICAL (Part B): _____

You must have Medicare Parts A and B.

Section D: Benefits

Basic Plan Optional Riders

☐ Part A Deductible Rider 100% coverage **OR** ☐ Part A Deductible Rider 50% coverage

☐ Part B Deductible Coverage* **OR** ☐ Part B Copay / Coinsurance Coverage

☐ Excess Medicare Part B Charges Rider

☐ Home Health Care Visit Rider

☐ Foreign Travel Emergency Rider

**Must be eligible for Medicare before Jan. 1, 2020, for this option.*

Section E: Premium Payment

You will receive a mailed paper invoice. If you would prefer to receive your invoice electronically, please visit QuartzMyChart.com. You can also arrange one-time or recurring Automated Clearing House (ACH) payments through MyChart. Other acceptable methods of payment include paper checks, cashier's checks, money orders, ACH, credit cards and all general-purpose pre-paid debit cards.

Section F: Information About Other Insurance You May Have

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you are eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one of more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS BELOW. Please mark YES or NO below with an "X."

To the best of your knowledge:

1. Did you turn age 65 in the last six months? ☐ Yes ☐ No
   a. Did you enroll in Medicare Part B in the last six months? ☐ Yes ☐ No
   b. If yes, what is the effective date? _____/_____/_____

2. Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No

   Note to Applicant: *If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.*
   If you answered YES to this question:

   a. If yes, will Medicaid pay your premiums for this policy? ☐ Yes ☐ No
   b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ☐ Yes ☐ No

3. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or preferred provider plan), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

   START: _____/_____/_____ END: _____/_____/_____

   a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new policy? ☐ Yes ☐ No
   b. Was this your first time in this type of Medicare plan? ☐ Yes ☐ No
   c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐ Yes ☐ No

4. Do you have another Medicare Supplement policy in force? ☐ Yes ☐ No
   a. If so, with what company, and what plan do you have? _____
   b. If so, do you intend to replace your current Medicare Supplement policy with this policy? ☐ Yes ☐ No

5. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union or individual plan)? ☐ Yes ☐ No
   a. If so, with what company and what kind of policy? _____
   b. What are your dates of coverage under the other policy?
      (If you are still covered under the other policy, leave END blank.)

      START: _____/_____/_____ END: _____/_____/_____

6. Are you currently covered by another Quartz policy? ☐ Yes ☐ No
   a. If yes, please provide your Quartz member number: _____

Section G: Eligibility

Please indicate if any of the following apply to you:

☐ Your coverage will start when you are age 65 or older and within six months of your Medicare Part B coverage effective date.

☐ You are under age 65 and eligible for Medicare due to disability and applying when first eligible.

☐ You qualify for guaranteed-issue coverage for another reason.

You are eligible for open enrollment or guaranteed issue if you have checked any of the above. If you are eligible for open enrollment or guaranteed issue do not complete Section H.

Section H: Health Questionnaire

NOTE: If you are applying within six months of enrolling in Medicare Part B or within six months of turning 65 and you were already enrolled in Medicare before turning 65 or if you are applying under guaranteed issue, do not complete this section.

Have you used tobacco products, including cigarettes, cigars, pipes, chewing tobacco, or any form of tobacco within the past 12 months?	☐ Yes	☐ No

Please answer the following questions. If you answer "yes" to any, you are not eligible for Quartz Medicare Supplement coverage.

1. Are you currently hospitalized, bedridden, confined to a wheelchair or skilled nursing facility?	☐ Yes	☐ No
2. Within the past year, have you:		
a. Been scheduled to have surgery for any condition, but not had such surgery?	☐ Yes	☐ No
b. Been diagnosed or treated for any type of internal cancer or malignant melanoma?	☐ Yes	☐ No
c. Received Medicare-approved home health care more than once?	☐ Yes	☐ No
3. Within the past two years, have you been diagnosed, treated for, or taking prescription drugs for any of the following:		
a. Heart disease, heart condition or pacemaker?	☐ Yes	☐ No
b. Alzheimer's disease, senile dementia, or other senility disorder?	☐ Yes	☐ No
c. Chronic kidney disease (including end-stage renal disease), kidney/renal failure, or kidney/renal dialysis?	☐ Yes	☐ No
d. Cirrhosis of the liver, Hepatitis B, or Hepatitis C?	☐ Yes	☐ No
e. Any respiratory condition, including but not limited to, Chronic Obstructive Pulmonary Disease (COPD) or emphysema (excluding allergies and asthma)?	☐ Yes	☐ No
f. Crohn's, Colitis, Multiple Sclerosis, Rheumatoid Arthritis?	☐ Yes	☐ No
g. Been treated for, or diagnosed with, diabetes requiring insulin?	☐ Yes	☐ No
h. Had a stroke or seizure disorder?	☐ Yes	☐ No
i. Hemophilia, Sickle Cell Anemia, or chronic blood disorder?	☐ Yes	☐ No
4. Have you had an organ transplant, or been told you may need a transplant operation in the future?	☐ Yes	☐ No

Section I: Medical Assistance Entitlement Notice

MEDICARE NOTICE
SAVE A COPY OF THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

1. You do not need more than one Medicare Supplement, Medicare Cost or Medicare Select policy.
2. If you purchase this policy you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement, Medicare Cost or Medicare Select policy.
4. If after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement, Medicare Cost or Medicare Select policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement, Medicare Cost or Medicare Select policy, or, if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement, Medicare Cost or Medicare Select policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
5. If you are eligible for and have enrolled in a Medicare Supplement or Medicare Cost policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement or Medicare Cost policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement or Medicare Cost policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement or Medicare Cost policy or, if that is no longer available, a substantially equivalent policy will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement or Medicare Cost policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement or Medicare Cost insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). See the booklet "Wisconsin Guide to Health Insurance for People with Medicare", which you received at the time you were solicited to purchase this policy.

Section J: Authorizations and Agreements

I HEREBY AUTHORIZE THE USER OR DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW:

1. Person(s) or group(s) of persons authorized to use or disclose the information: Any licensed physicians, medical practitioners, hospitals, clinics, laboratories, long-term care facilities, medical or medically related facilities, pharmacies, the Department of Health and Human Services (Medicare), reinsurance and insurance companies including Quartz Health Plan Corporation ("Quartz").
2. Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information: Quartz, Quartz's authorized representatives, and the Department of Health and Human Services (Medicare).
3. Description of the information that may be used or disclosed: This authorization includes the disclosure of information related to my health and insurance claims, including but not limited to those containing diagnosis, treatments, prescription drug information, alcohol or drug abuse treatment, mental health

(except psychotherapy notes), or information regarding communicable or infectious conditions (but excludes genetic information, HIV test results or AIDS diagnosis). To facilitate the rapid submission of such information, the undersigned authorizes all such sources to give such records and information to any authorized representative of Quartz.

4. The information will be used or disclosed only for the following purpose(s): For the purpose of processing my application, billing, collecting and paying claims, conducting management and financial audits, monitoring and evaluating programs, reviewing health care services, quality improvement, medical management, quality management activities, utilization review, subrogation investigation and recoveries, and compliant resolution.

STATEMENTS OF UNDERSTANDING AND ACKNOWLEDGEMENT:

I understand that health information about me provided to Quartz Health Plan Corporation ("Quartz") is protected by federal and state privacy regulations. Quartz will only use and disclose such information in connection with a claim for benefits under an insurance policy. The authorization may not exceed the policy term or the pendency of a claim for benefits under the policy, whichever is longer.

I understand that information that is used or disclosed to an entity that is not covered under the federal privacy laws may be subject to re-disclosure and is no longer protected.

I understand that I may revoke this authorization in writing at any time, prior to the disclosure of this information. Requests to revoke this authorization can be sent to: Quartz, Attn.: Privacy Officer, 840 Carolina Street, Sauk City, WI 53583. I also understand that the revocation of this authorization will not affect the uses and disclosures of my health information for purposes of treatment, payment and business operations. However, failure to sign this authorization may prohibit the release of records, which could result in nonpayment of claims. Upon request, I understand that I am entitled to receive a copy of this signed authorization. I understand that for purposes of processing my application, this authorization shall be valid for 30 months from the date of this application. For all other purposes, this authorization shall be valid during the entire time I am covered under health insurance coverage issued by Quartz.

A copy of this authorization shall be as valid as the original.

I acknowledge receipt of the *Wisconsin Guide to Health Insurance for People with Medicare* and *The Quartz Medicare Supplement Outline of Coverage*.

I understand that the selling agent has no authority to promise coverage or to modify Quartz's underwriting policy or terms of any company coverage.

I have responsibility for accurately completing this application. I understand that I am not eligible for any benefits if any information requested on this application, even information about my Medicare coverage, is false, incomplete or omitted. I understand that Quartz may void all coverage from the original effective date of the policy only in the event that I failed to accurately respond to questions regarding my past or present health conditiins.

▶ _____ ▶ _____

(Applicant's Signature) **(Date)**

Continue to next page

Section K: Agents Only

(Print Name of Agent / Broker) _____

▶ _____ ▶ _____

(Agent / Broker Signature) **(Date)**

I have read and understand the application. I additionally certify that I have given the applicant the booklet *Wisconsin Guide to Health Insurance for People with Medicare* and *The Quartz Medicare Supplement Outline of Coverage* for the policy applied for, and that the applicant has both Parts A and B of Medicare. The policy applied for will not duplicate any health insurance coverage.

Please provide us with a supplementary list of all health insurance policies you have sold to the applicant that are still in force, and any other health insurance policies sold in the past five years that are no longer in force. Submit this information along with the application as required under Wis. Adm. Code Ins. Section 3.39. Include the policy and certificate number and the date of issuance.

_____

_____

_____

_____

Section L: Complaint

You may contact the Officer of the Commissioner of Insurance (OCI), a state agency that enforces Wisconsin's insurance laws, and file a complaint. You can contact the OCI by writing to:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, Wisconsin 53707-7873

Or call to request a complaint form: **(800) 236-8517 outside of Madison** or **(608) 266-0103 in Madison**

PLEASE REVIEW BEFORE YOU MAIL

1. **BE SURE TO SIGN AND DATE THE APPLICATION.**
2. Be sure to complete all sections of the application.
3. Be sure to complete the Health Questionnaire section. (If you are applying for coverage during an open enrollment period, you do NOT need to complete the Health Questionnaire section on your application. Please refer to "The Time to Enroll" section in the Outline of Medicare Supplement insurance you received with this enrollment application.)
4. If you are canceling other coverage, be sure to fill out the replacement form. DO NOT cancel the coverage until you have actually received a Quartz policy and you are sure you want to keep it.

Please mail your completed application to us at:

Quartz Medicare Supplement
Attn.: Sales
840 Carolina Street
Sauk City, WI 53583

Or email your application to us at: **QuartzMedicareSupplement@QuartzBenefits.com**

If you have additional questions, please contact your agent or sales team.

Quartz

Non-Discrimination & Language Access

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

For assistance understanding these materials in a language other than English, call (800) 362-3310, and a Customer Service 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.

We provide free aids and services to people with disabilities to communicate effectively with us, such as –

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

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

- Qualified interpreter
- Information written in other languages

If you need these services, contact Customer Service 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 –

Kristie Meier, Compliance Officer
840 Carolina Street
Sauk City, WI 53583
Phone: (800) 362-3310
TTY: 711 or toll-free (800) 877-8973
Fax: (608) 644-3500
Email: AppealsSpecialists@quartzbenefits.com

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

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

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

Quartz is a Qualified Health Plan issuer in the Health Insurance Marketplace in certain states. To learn more, visit the Health Insurance Marketplace at HealthCare.gov.

For help to translate or understand this, please call (800) 362-3310, TTY: 711 / (800) 877-8973.

Spanish – Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Quartz. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Hmong – Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm Quartz. Saib cov caij nyoog los yog tej hnub tseem ceeb uas sau rau hauv daim ntawv no kom zoo. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Vietnamese – Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình Quartz. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Chinese – 本通知含有重要的訊息 本通知對於您透過 Quartz 所提 出的申請或保險有重要的訊息 請在本通知中查看重要的日期 您可能要在特定的截止日期之 前採取行動，以保留您的健康保險或有助於省錢 您有權利免費以您的母語得到幫助和訊息 請致電 (800) 362-3310：711 / (800) 877-8973.

Russian – Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Quartz. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Laotian – ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນທີ່ສຳຄັນ.
ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບໃບສະໝັກ ຫຼື ການຄຸ້ມຄອງຂອງທ່ານຜ່ານ Quartz. ຊອກຫາວັນທີສຳຄັນ ໃນໜັງສືແຈ້ງການສະບັບນີ້.ທ່ານອາດຈຳເປັນຕ້ອງປະຕິບັດຕາມເວລາ ທີ່ກຳນົດໄວ້ທີ່ແນ່ນອນເພື່ອຮັກສາໄວ້ການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານ ຫຼື ຊ່ວຍເຫຼືອດ້ານຄ່າໃຊ້ຈ່າຍ.ທ່ານມີສິດທີ່ຈະໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີ (800) 362 3310. TTY / TDD: 711 / (800) 877 8973.

German – Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Quartz. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Arabic – يحتوي هذا الإشعار على معلومات مهمة. يتضمن هذا الإشعار معلومات هامة حول طلبك أو تغطيتك عبر Quartz. ابحث عن التواريخ الرئيسية في هذا الإشعار. قد تحتاج إلى إجراء تدابير معيّنة وفقاً لمواعيد معيّنة من أجل الحفاظ على تغطيتك الصحية أو المساعدة في التكاليف. لديك الحق في الحصول على هذه المعلومات وعلى المساعدة في لغتك دون أي تكلفة. اتصل على TTY / TDD: 711 / (800) 877-8973 / (800) 362-3310.

French – Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Quartz. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Korean – 본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Quartz을 통한 커버리지 에 관한 정보를 포함하고 있습니다.본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가있습니다. (800) 362-3310 로 전화하십시오. TTY / TDD: 711 / (800) 877-8973.

Tagalog – Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Quartz. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Pennsylvanian Dutch – Die Bekanntmaching gebt wichdichi Auskunft. Die Bekanntmaching gebt wichdichi Auskunft baut dei Application oder Coverage mit Quartz. Geb Acht fer wichdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimmde Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix. Kannscht du (800) 362-3310 uffrufe. TTY / TDD: 711 / (800) 877-8973.

Polish – To ogłoszenie zawiera ważne informacje. To ogłoszenie zawiera ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez Quartz.Prosimy zwrócic uwagę na kluczowe daty zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Hindi – इस सूचना में महत्वपूर्ण जानकारी शामिल है। इस सूचना में Quartz से जुड़े आपके आवेदन या कवरेज के बारे में महत्वपूर्ण जानकारी शामिल है। इस सूचना में महत्वपूर्ण तारीखों को देखना न भूलें। स्वास्थ्य कवरेज जारी रखने या खर्चे में मदद के लिए आपको कुछ तय तारीखों तक कार्रवाई करनी ज़रूरी है। आपके पास अपनी भाषा में, बिना किसी शुल्क के इस जानकारी और सहायता को पाने का अधिकार है। (800) 362-3310. TTY / TDD: 711 / (800) 877-8973 पर कॉल करें।

Albanian – Ky njoftim përmban informacion të rëndësishëm. Ky njoftim përmban informacion të rëndësishëm për aplikimin ose mbulimin tuaj nëpërmjet Quartz. Kontrolloni për data të rëndësishme në këtë njoftim. Mund t'ju duhet të ndërmerrni veprim brenda afatave të caktuara për të mbajtur mbulimin tuaj shëndetësor ose për ndihmën me koston. Keni të drejtë ta merrni këtë informacion dhe ndihmë falas në gjuhën tuaj. Telefononi numrin (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Somali – FIIRO GAAR AH: Haddii aad ku hadashid af Soomaali, adeegyada caawimada luuqada, ayaa waxaa laguugu siinayaa bilaash, waa laguu heli karaa. 1-800-362-3310 (TTY: 1-800-877-8973) bilbilaa.

Cushite – Oroomiffa XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Amharic – ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል: ወደ ሚከተለው ቁጥር ይደውሉ (800) 362-3310. (መስማት ለተሳናቸው: 711 / (800) 877-8973).

Karen – ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤနှ် ကျိာ်အတ်မၤစၢၤလၢ တလၫ်ဘူဉ်လၫ်စု့ၤ နီတမံၤဘဉ်သ့နှဉ်လိၤ. ကိး: (800) 362-3310.TTY / TDD: 711 / (800) 877-8973.

Mon-Khmer, Cambodian – ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Serbocroatian – OBAVJEŠTENJE: Ako govorite srpskohrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite (800) 362-3310 TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711 / (800) 877-8973.

Thai – เรียน: ถา้ คุณพดู ภาษาไทยคุณสามารถใชบ้ ริการช่วยเหลือทางภาษาไดฟ้ รี โทร (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Gujarati – સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Urdu – خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Italian – ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Greek – ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.