

Offered by Quartz Health Plan Corporation



Quartz Medicare Supplement

This health insurance policy is offered by Quartz Health Plan Corporation, referred to throughout this policy as “Quartz,” “we” or “our.” For questions about this policy, feel free to contact Quartz Customer Service:

Address: **Quartz, 840 Carolina St, Sauk City, WI 53583**

Phone: **(800) 362-3310**

For people who are deaf, hard of hearing or speech-impaired, please call **(800) 877-8973** or **TTY 711**.

The Wisconsin Insurance Commissioner has set standards for Medicare supplement insurance. This policy meets these standards. It, along with Medicare, may not cover all your medical costs. You should carefully review all policy limitations. For an explanation of these standards and other important information, see the “Wisconsin Guide to Health Insurance for People with Medicare” given to you when you applied for this policy.

Do not buy this policy if you did not receive the Wisconsin Guide to Health Insurance for People with Medicare.

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IMPORTANT NOTICES

PAYMENT SYSTEM

For services covered by Medicare, we pay our portion of the Medicare-approved amounts. For services not covered by Medicare but explicitly covered under this policy, we pay the usual, customary and reasonable amount. The usual, customary, and reasonable amount may be less than the actual charge for the health care service or supplies.

YOUR RIGHT TO RETURN THIS POLICY

Please read this policy right away. If you are not satisfied with it for any reason, you can return this policy to your insurance agent. You may also return it to us at the address above within 30 days. Upon return, this policy becomes invalid. We will refund all payments you have made on it.

GUARANTEED RENEWABLE FOR LIFE

As a member you will never be cancelled or non-renewed because of a decline in health. As long as you continue to make your premium payments on time, your policy is guaranteed renewable for life. We will neither cancel nor non-renew your policy for any reason other than nonpayment of premium or intentional material misrepresentation. Your policy may be revised to comply with federal or state law. You can end your policy at any time by writing to us. No refusal of renewal will affect an existing claim for Medicare-approved expenses covered under this policy and incurred prior to the date on which this policy ends.

STATEMENTS IN THE APPLICATION FOR INSURANCE

Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Write to us within 10 days if any information is not correct. Write to us if the medical history is not complete. The application is part of the insurance contract. The insurance contract was issued on the basis that the answers to all questions and any other material information shown on the application are correct and complete.

PREMIUM RATES CAN BE CHANGED AT OUR OPTION

We may change the premium rates under this policy (1) on the first day of the renewal period on or after each 12-month anniversary of the effective date of this policy, (2) on any date the benefits under this policy change as required by law, (3) on any date this policy is amended, and

(4) if you move into a new rating area. We can only change the renewal premium if we also change it for all policyholders in the same class as you. No change in premium will be made because of the amount of claims you file. No change in premium will be made due to a change in your health or type of work.

SERVICE LOCATIONS

With Quartz Medicare Supplement, you are able to keep the same doctor you currently see. You can also change doctors at any time. As long as you are a Wisconsin resident at the time your policy takes effect, you can see any health care provider, anywhere in the U.S. If you move, your policy can move with you.

| CONTACT US | |
|--|---|
| Customer Service | (800) 362-3310 |
| For people who are deaf, hard of hearing, or speech-impaired | (800) 877-8973 or 711 You may also call through a video relay service company of your choice. |
| Free of Charge Language Assistance | (800) 362-3310 |
| Website | QuartzBenefits.com |

If you are calling outside of our normal office hours, you can leave a private voicemail message. Your call will be returned on the next business day.

Upon your payment of premium and the issue of this policy and a Quartz ID card, we agree to provide the benefits described in this policy.

ELIGIBILITY AND ENROLLMENT

To enroll in Quartz Medicare Supplement, you need to meet the following criteria:

- ✓ You must be at least 65 years of age or under 65 with certain disabilities (for example, End-Stage Renal Disease).
- ✓ You must reside in Wisconsin on the effective date of the policy.
- ✓ You must have been enrolled in Medicare Part A and Part B by the date your policy starts.
- ✓ You must not be covered by Medicaid (BadgerCare) or a Medicare Advantage plan.

To apply you must meet all eligibility requirements, fill out an application, and return it to your insurance agent.

If you join a Medicare Advantage (MA) plan, you cannot use Medicare supplement insurance (Medigap) to pay for out-of-pocket costs you have in an MA plan. If you already have an MA plan, you cannot be sold a Medigap policy. You can only use a Medigap policy if you disenroll from your MA plan and return to original Medicare.

If you are not enrolled in Medicare Part B or discontinue or lapse your Medicare Part B medical insurance, and you incur charges allowable by Medicare, we will pay Medicare-eligible expenses as if you had been insured under Medicare Part B. You will be responsible for the charges that Medicare Part B should have covered, had you been enrolled.

Open Enrollment Period

The Quartz Medicare Supplement open enrollment period is the six calendar months immediately following the month you enroll in Medicare Parts A and B.

Coverage begins the first of the month after we accept your application and premium. It could also begin on the effective date you requested on your application. The effective date you request can be up to three months from when you completed your application.

Enrollments made during the open enrollment period are guarantee issue.

Special Enrollment Period

If you have lost or are losing other health insurance coverage, you may be guaranteed acceptance in one or more of our Medicare supplement plans that we offer. You may have received a notice from your prior insurer saying that you had certain rights and were eligible for guaranteed issue or a Medicare supplement insurance policy. You must submit a copy of the notice from your prior insurer with your application to us. You must submit them to us no later than 63 days after your other coverage ends.

Coverage begins the first of the month after we accept your application and premium. It could also begin on the effective date you requested on your application. The effective date must be within 63 days from the termination of your previous policy.

Enrollments made during this period are guarantee issue.

Other Enrollment Periods

Enrollments made outside of the open enrollment period are subject to medical underwriting.

PREEXISTING CONDITIONS

This policy will cover expenses for a preexisting condition. We will not exclude any benefits based on a preexisting condition.

DEFINITIONS

Balance Billing

When a practitioner or hospital bills you more than the plan's cost-sharing amount for services. For services that Medicare covers, we do not allow providers to "balance bill" you. You only have to pay the plan's cost-sharing amounts.

For services not covered by Medicare but explicitly covered under this policy, we pay the usual, customary and reasonable amount, defined below. The usual, customary, and reasonable amount may be less than the actual charge for the health care service or supplies, so a provider may balance bill you for the difference. Balance billing may also occur when Quartz denies a claim that was coded improperly, and the provider bills you the unpaid amount.

Benefit Period

A benefit period starts with the first full day that you are in a hospital. It ends when you have not been in a hospital or a skilled nursing facility or rehabilitative facility for at least 60 consecutive days. There is no limit to the number of benefit periods you can have.

Calendar Year

The period that starts with the effective date of your policy and ends on December 31 of such year. Each following calendar year will start on January 1 of any year. Each calendar year will end on December 31 of that year.

Centers for Medicare & Medicaid Services (CMS)

The federal agency that administers Medicare.

Class

A grouping of persons based on one or more of the following:

- Age;
- Sex; or,
- Current geographic residence.

Coinsurance

An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (e.g., 20%).

Confinement

The period starting with your admission on an inpatient basis lasting more than 24 hours. Admission is to a hospital or other licensed health care facility for treatment of an illness or injury. A confinement ends with your discharge from the same hospital or other facility.

Copayment

An amount you may be required to pay as your share of the cost for a medical service or supply. This is like a doctor's visit or hospital outpatient visit. A copayment is usually a set amount, rather than a percentage. For example, you might pay a \$20 copayment for a doctor's visit or a \$50 copayment for emergency room visit.

Creditable Coverage

Previous health coverage that reduces the time you have to wait before preexisting health conditions are covered. This policy covers preexisting conditions. We do not need proof of your creditable coverage.

Custodial Care

Care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who do not have professional skills or training. This care includes help with walking, dressing, bathing, and eating. It also includes preparation of special diets, taking medication, and 24-hour supervision for potentially unsafe behavior. Medicare does not cover custodial care.

Deductible

The amount you must pay for health care before this policy begins to pay.

Durable Medical Equipment

Items needed for medical reasons that are sturdy enough to be used many times without wearing out. A person normally needs this kind of item only when ill or injured. It can be used in the home. Examples are wheelchairs, hospital beds, and equipment that supply a person with oxygen.

Effective Date

The earliest date in our records when this policy covers you. It is the date for which we first accepted premium and issued this policy.

Emergency Care

Covered services that are rendered by a provider qualified to furnish emergency services. These services are needed to evaluate or stabilize an emergency medical condition.

Experimental or Investigative Treatments and Services

Drugs, procedures, surgeries, equipment and devices that do not meet the following criteria as determined by Quartz:

- Must have federal Food and Drug Administration (FDA) approval;
- Scientific evidence must permit conclusions concerning the effect on health outcome; and,
- Research and experimental stage of development must be completed.

Quartz considers all services, procedures, and treatments with Category III codes to be experimental, investigational, and/or emerging technology.

Home Health Care

Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. It can include services from a home health aide. The services must be a part of the home health plan of care for your illness or injury. They are not covered unless you are also getting a covered skilled service. Home health services do not include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice Care

A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling. It is given by a team of people who are part of a Medicare-certified public agency or private company.

Hospital Inpatient Stay

A hospital stay when you have been formally admitted to a Medicare-approved hospital for skilled medical services. "Hospital" does not include an institution that is mainly for transitional care or sub-acute care, rest, nursing, long-term, extended or custodial care. It does not include an institution for convalescence, care of the aged, treatment for substance use disorders, or rehabilitation. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Lifetime Reserve Days

These are added days that Medicare will pay for when you are in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime.

Maintenance Care

Maintenance care is health care services delivered after the acute phase of an illness has passed and the maximum therapeutic benefit has occurred. Such care promotes optimal function in the absence of significant symptoms.

Medically Necessary

Medical treatment, services or supplies that are required to identify or treat a sickness or injury. The member's attending physician makes decisions regarding service and treatment. The plan, through its Medical Director(s), using criteria developed by Medical Management and other recognized sources, has the authority to determine whether a service, treatment, procedure, prescription drug, device or supply is medically necessary and eligible for coverage under the plan. Medically necessary treatments, services or supplies are the following:

- Consistent with the symptoms, diagnosis or treatment of your medical condition;
- Appropriate with regard to standards of good medical practice;
- Not primarily for your convenience or your immediate family, or that of your practitioner or another provider;
- The most appropriate and cost-effective level of medical service or supplies that can

be safely provided. When applied to inpatient care, it further means that the medical symptoms or conditions require that the medical services or supplies cannot be safely provided as an outpatient;

- Of proven value or usefulness; and,
- Compliant with your provider's treatment plan.

Medicare

The federal health insurance program for people 65 years of age or older. It is also for some people under age 65 with certain disabilities. People with End-Stage Renal Disease (ESRD) also qualify for Medicare. ESRD is generally those with permanent kidney failure who need dialysis or a kidney transplant. People with Medicare can get their Medicare health coverage through original Medicare or a Medicare Advantage plan.

Medicare Advantage Plan

Sometimes called Medicare Part C. It is a plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan.

When you are enrolled in a Medicare Advantage plan, Medicare services are covered through the plan. They are not paid for under original Medicare. In most cases, Medicare Advantage plans also offer Medicare Part D (prescription drug coverage).

Medicare-Eligible Expenses

Health care expenses that are covered by Medicare Parts A and B. They are also recognized as medically necessary and reasonable by Medicare. They may or may not be fully paid by Medicare.

“Medigap” (Medicare Supplement Insurance) Policy

Medicare supplement insurance sold by private insurance companies to fill “gaps” in original Medicare. Medigap policies only work with original Medicare. A Medicare Advantage plan is not a Medigap policy.

Practitioner

A provider who is deemed payable by Medicare or by us.

Preexisting Condition

A condition for which medical advice was given or treatment was recommended by or received from a doctor within six months prior to your effective date. This policy covers preexisting conditions.

Prior Authorization

Approval in advance for services to monitor frequency, intensity and appropriateness of services.

Rescission/Rescind

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

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

Skilled Nursing Care

Health care services furnished on practitioner's orders which are medically necessary and require the skill of a registered nurse (RN).

Skilled Nursing Facility Care

s. 632.895(3), Wis. Stat.

An institution which is a licensed facility by the State of Wisconsin, or other applicable jurisdiction. It maintains and provides the following:

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

A skilled nursing facility is not a rest home or a home for care of the aged. It is also not a facility engaged in the care and treatment of persons with mental health or substance use disorders.

Supportive Care

Health care services provided to you when your recovery has slowed or ceased entirely. Only minimal gains can be shown with continuation of health care services.

Usual, Customary and Reasonable Charges

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

BENEFITS

We will pay for your care described in this section under the terms, conditions and provisions of this policy. The services you get must be reasonable and medically necessary for admission, diagnosis and treatment of an illness. This policy will not duplicate benefits provided by Medicare. This policy does not pay or reimburse you for services you administer to yourself, even if you are a provider.

The benefits of this policy will automatically change to coincide with any changes in applicable Medicare deductible amounts and coinsurance percentage factors. When benefits change, your premium may change.

HOSPITAL INDEMNITY BENEFITS

1. We will pay the Medicare Part A hospital daily coinsurance from the 61st to 90th day of your confinement.
2. After you have been in a hospital for 90 days, Medicare pays an extra 60 reserve days during your lifetime. We will pay the Medicare Part A hospital coinsurance for each reserve day you use.
3. You may still be in a hospital after the above benefits are paid. If so, we will pay the charges for all Medicare Part A expenses for hospitalization not covered by Medicare for an added 365 days. This is to the extent the hospital is permitted to charge by federal law and regulation. It is also subject to the Medicare repayment rate and a lifetime maximum benefit. The provider will accept our payment as payment in full. They may not balance bill you.
4. After Medicare pays its lifetime hospital inpatient psychiatric care benefits, we will pay the Medicare Part A eligible expenses. This is for inpatient psychiatric hospital care for each day you are confined. This applies to psychiatric care beyond the Medicare lifetime limit of 190 days. It is not to exceed a lifetime combined limit of 365 days confinement under this policy.
5. We will pay the Medicare Part A eligible expenses for blood to the extent not covered by Medicare.

SKILLED NURSING FACILITIES

s. 632.895(3), Wis. Stat.

1. Prior to your admittance into a skilled nursing facility, please notify us.

If you are unable to do so, have a family member, practitioner, skilled nursing facility or other health care provider notify for you. Mail or fax us using the information below:

Quartz
Customer Service Department
840 Carolina St.
Sauk City, WI 53583
Fax: (608) 643-2564

2. **Skilled Nursing Facility (Swing Bed) care that qualifies for Medicare coverage.** We will pay the Medicare coinsurance amount for the skilled nursing Medicare eligible expenses incurred per benefit period as shown in the Benefits Table of the Outline of Coverage. Once Medicare stops paying benefits, you may be eligible for the benefit listed in Section 3 below.
3. **Skilled Nursing Facility (Swing Bed) care that does not qualify for Medicare coverage.** If your stay in the skilled nursing facility does not qualify for Medicare coverage or if your benefits are exhausted under Section 2 above, we will pay skilled nursing facility charges up to 30 days per benefit period. The skilled nursing facility must be licensed. The care must meet our standards for medical necessity. No prior hospital stay is required and we will pay benefits at the maximum daily rate established for the State of Wisconsin Medical Assistance.

HOSPICE CARE

We will pay your coinsurance or copayments for all Medicare Part A-eligible expenses for hospice and respite care. Your care is eligible for payment under Part A of Medicare. To qualify for hospice care, your doctor must certify that you are terminally ill. If you are already getting hospice care, a hospice doctor or nurse practitioner will need to see you about six months after you enter hospice. This is to certify that you are still terminally ill. Coverage includes drugs for pain relief and symptom management, as well as medical, nursing, and social services. It also includes certain durable medical equipment and other covered services. It includes services Medicare usually does not cover. These include spiritual and grief counseling. A Medicare-approved hospice usually gives hospice care in your home. It can also be in another facility where you live such as a nursing home.

For more information on hospice care, visit medicare.gov. Under "Search Tools," choose "Find a Medicare Publication" to view. You can then search for and download the publication "Medicare Hospice Benefits." You may also call (800) MEDICARE (800) 633-4227. TTY users should call (877) 486-2048.

PROFESSIONAL AND OTHER SERVICES

We will pay all of the Medicare Part B eligible charges that are not paid by Medicare. This is subject to the Medicare Part B calendar year deductible that you have.

Hospital outpatient department charges are paid under a prospective payment system. We will pay the copayment amount for the following services that are rendered to you, including outpatient psychiatric care:

1. Medical services provided by a practitioner;
2. Surgical services, including pre- and post-operative care and services of surgical assistants;
3. X-ray and laboratory tests;
4. Anesthesia, when connected with a covered surgery;
5. Consultation ordered by your attending practitioner;
6. Outpatient hospital services in an emergency room or outpatient clinic;
7. Radiation therapy, including materials and services of a technician;
8. Drugs and injections that cannot be self-administered;
9. Medical supplies, like surgical dressings, splints and casts;
10. Rental and purchase of durable medical equipment, like hospital beds, wheelchairs and walkers;
11. Prosthetic devices including but not limited to the initial receipt of artificial limbs (arm or leg), eye prosthesis, or braces (excluding dental);
12. Ambulance services from a licensed ambulance service also receiving Medicare payments;
13. Dental care, only for surgery of the jaw or related structure or setting of fractures of the jaw or facial bone. This does not include the nonsurgical extraction of teeth due to dental disease. This is the case even when recommended prophylactically as part of a medical plan of treatment;
14. Blood transfusions;
15. First three pints of blood;
16. Physical, speech and occupational therapy, if given by a practitioner or registered physical, speech or occupational therapist;
17. Outpatient psychiatric care;
18. Immunosuppressive drugs following a covered transplant; and,
19. Preventive services as covered by Medicare.

PREVENTIVE HEALTH CARE SERVICES

We will pay benefits for the following preventive health care services not covered by Medicare. They must be determined to be medically appropriate by an attending practitioner. Payment will be for the actual charges up to 100% of the Medicare-approved amount for each service. This is calculated as if Medicare were to cover the service. This benefit will not include payment for any procedure covered by Medicare.

Routine Exams

We will pay up to \$1,000 total per calendar year. This includes:

- Routine eye exams;
- Eye refractions;
- Hearing exams;
- Hearing tests; and,
- Other preventive services not covered by Medicare.

This benefit does not include immunizations.

Per s. 632.87(5), Wis. Stat., we will pay for services and associated laboratory fees for preventive pelvic examinations or Pap tests under this benefit, whether they are received from a physician or from a licensed nurse practitioner acting within the scope of their license.

HOME CARE

Benefits

We will pay usual, customary and reasonable charges as determined by us for the following under the terms, conditions and provisions of this policy. You must receive these services after your policy takes effect. We will pay to the extent they are medically necessary for your treatment. They must not be covered elsewhere in this policy. Services must be provided or directed by a state-licensed or Medicare-certified home health agency or certified rehabilitation agency.

Per ss. 632.895 (1) and (2), Wis. Stat., every health insurance policy that provides coverage of expenses incurred for inpatient hospital care must provide coverage for no less than 40 home health care visits. This required benefit is covered 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 will be considered as one home care visit.

The following benefits are covered as home care:

1. Part-time or intermittent home nursing care by or under supervision of a registered nurse;
2. Part-time or intermittent home health aide services. These must be medically necessary as part of your home care plan. They must consist solely of care for you. A registered nurse or medical social worker must supervise them;
3. Physical, respiratory, occupational or speech therapy;
4. Medical supplies and laboratory services by or on behalf of a hospital. These must be necessary under your home care plan. We cover these supplies and services the same way we would if you had been hospitalized;
5. Nutrition counseling that a certified or registered dietitian gives or supervises. This must be necessary as part of your home care plan; and,

6. The assessment of your need for a home care plan. A registered nurse, practitioner extender or medical social worker must do this. Your attending practitioner must ask for or approve this assessment.

The maximum weekly benefit for such coverage will not be more than the maximum benefit under this policy. This is for the usual and customary weekly cost of care in a skilled nursing facility.

Limitations

We will not pay for home care unless your attending doctor certifies that:

- Without home care, you would need confinement in a hospital or skilled nursing facility;
- Your immediate family members or others living with you could not give you needed care and treatment without undue hardship; and,
- A state-licensed or Medicare-certified home health agency or certified rehabilitation agency will provide or coordinate the home care services.

CHIROPRACTIC SERVICES

s. 632.87(3), Wis. Stat.

We will pay benefits for usual, customary and reasonable charges for chiropractic services. These services must be provided by a licensed chiropractor or practitioner. Services must be within the scope of the practitioner's license. Benefits will be payable if covered by Medicare or as required by Wisconsin law.

EQUIPMENT AND SUPPLIES FOR TREATMENT OF DIABETES

s. 632.895(6), Wis. Stat.

We will pay benefits for usual, customary and reasonable charges incurred for the installation and use of an insulin infusion pump. We will also pay benefits for all other equipment and supplies used in the treatment of diabetes. This includes syringes, needles, alcohol swabs, and gauze. We will pay charges for diabetes self-management education programs. This benefit is limited to the purchase of one pump per calendar year. You must use the pump for at least 30 days before the pump is purchased.

The exceptions to this benefit are insulin and medical supplies for injection of insulin, which are not covered under this policy.

BENEFITS FOR KIDNEY DISEASE

s. 632.895(4), Wis. Stat.

We will pay benefits for inpatient, outpatient and home treatment of kidney disease. These services must be necessary for your diagnosis and treatment. This includes dialysis treatment and kidney transplantation expenses of both donor and recipient. There is a maximum of \$30,000 per calendar year for these benefits.

BREAST RECONSTRUCTION

s. 632.895(13), Wis. Stat.

We will pay benefits for usual, customary and reasonable charges for breast reconstruction of the affected tissue incident to a mastectomy.

HOSPITAL AMBULATORY SURGERY CENTER CHARGES AND ANESTHETICS FOR DENTAL CARE

s. 632.895(12), Wis. Stat.

Ambulatory Surgery Center has the meaning given in s. 49.45 (6r)(a)1., Wis. Stat.

Benefits

We will pay benefits for usual, customary and reasonable charges for hospital and ambulatory surgery center charges incurred. We will also pay benefits for anesthetics provided. This is in conjunction with dental care that is provided in a hospital or ambulatory surgery center, if any of the following applies:

- The person is a child under the age of five;
- The person has a chronic disability that meets all of the conditions under ss. 230.04(9r) (a) 2. a., b. and c., Wis. Stat.; or,
- The person has a medical condition that requires hospitalization or general anesthesia for dental care.

CANCER CLINICAL TRIAL

s. 632.87(6), Wis. Stat.

We will pay charges for services rendered as part of a cancer clinical trial. This is if the services are otherwise covered under this contract. We will also pay charges if the clinical trial meets all of the following criteria:

1. The purpose of the trial is to test whether the treatment improves the trial participant's health. It is not designed solely to test toxicity or disease pathophysiology;
2. 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;
3. The trial is approved by one of the following:
- The federal Food and Drug Administration (FDA);
 - The federal Department of Defense;
 - The federal Department of Veterans Affairs;
- 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

Routine patient care does not 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. These are not to be used in the direct clinical management of the patient. It also does not include an investigational drug or device that has not been approved for market by the FDA.

Transportation, lodging, food, or other expenses are not covered. This applies to the patient or a family member or companion of the patient. Transportation that is related to travel to or from a facility providing the cancer clinical trial is not covered.

Any services, items, or drugs provided by the cancer clinical trial sponsors free of charge for any patient are not covered.

Any services, items, or drugs which are eligible for payment by a person other than us are not covered. This includes the sponsor of the cancer clinical trial.

Experimental clinical trials for cancer treatment that do not meet the criteria for coverage in this section are not covered.

PRESCRIPTION EYE DROP REFILLS

s. 632.895(16t), Wis. Stat.

For prescription eye drops covered under Medicare Part A or B, 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.

EXCLUSIONS

The following are not covered benefits under this policy:

1. Medicare Part A deductible, unless the “Medicare Part A 100% Deductible Rider” or “Medicare Part A 50% Deductible Rider” accompany this policy. Please see the Benefit Table in the Outline of Coverage for more information;
2. If you choose not to maintain Medicare Part B coverage, expenses for what Medicare Part B would have covered if you had been insured under Medicare Part B;
3. Any treatment or services rendered by or at the direction of a person living 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;
4. Any treatment or services rendered by you, even if you are a provider;
5. Cosmetic surgery, except if for repair of accidental injury or for improving the functioning of a malformed body part;
6. Custodial care, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services;
7. Dental care, treatment, filling, cleaning, removal or replacement of teeth, dental x-rays, root canal therapy, or surgery for impacted teeth. Other surgical procedures involving the teeth or structures directly supporting them are also excluded;
8. Drugs that meet the definition of Part D drug. This includes drugs that may be self-administered in a hospital outpatient setting such as emergency room, observation unit, and surgery center or pain clinic. The drugs are not required for the medical condition being treated. This exclusion applies to drugs and medicines you buy with or without a practitioner’s prescription;
9. Pharmacy supply fees and dispensing fees on medical benefit drugs dispensed for self-administration at the patient’s home;
10. Eye glasses or the preparation or fitting of eyeglasses, except for those services covered by Medicare (such as after cataract surgery includes insertion of intraocular lens);
11. Health care services for confinement, surgery or care before your insurance becomes effective;
12. Health care services Medicare does not cover, unless this policy specifically provides for them;
13. Health care services received outside the U.S., except if shown in the Benefit Table in the Outline of Coverage as being applicable;
14. Health care services that are deemed unwarranted and nonessential by Medicare. This includes but is not limited to the following services:
 - Drugs or devices that have not been approved by the FDA;
 - Medical procedures and services performed using drugs or devices not approved by the FDA;
 - Services including drugs or devices not considered safe and effective because

they are experimental or investigational except for the HIV drugs described in s. 632.895(9), Wis. Stat., as amended. Quartz considers all services, procedures, and treatments with Category III codes to be experimental, investigational, and/or emerging technology;

15. 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 coverage by Workers' Compensation, medical payment coverage under no-fault or underinsured automobile insurance, or coverage required under similar legislation;
16. Health care services to the extent that they are paid for by Medicare, or they would have been paid for by Medicare if you were enrolled in Medicare Parts A and B. Health care services to the extent that they are paid for by another government entity or program, directly or indirectly, are also excluded. This does not apply to health benefits or insurance plans for employees of such entities;
17. Health care services which neither you nor a party in your behalf has a legal obligation to pay in the absence of insurance;
18. Health care services you need as a result of war, or an act of war, occurring on or after the effective date of this policy;
19. Hearing aids or fitting of hearing aids;
20. Home health care above the 40 visits mandated by s. 632.895(2), Wis. Stat., except if shown in Benefit Table in the Outline of Coverage as being applicable;
21. Immunizations, when covered under Part D following Medicare guidelines, including but not limited to Zostavax;
22. Maintenance care and supportive care;
23. Medicare Part A deductible, except if shown in the Benefit Table in the Outline of Coverage as being applicable;
24. Medicare Part A eligible expenses for hospitalization above 365 days;
25. Medicare Part B copayment or coinsurance, except if shown in the Benefit Table in the Outline of Coverage as being applicable;
26. Medicare Part B deductible, except if shown in the Benefit Table in the Outline of Coverage as being applicable;
27. Orthopedic and/or therapeutic shoes unless:
 - The shoes are part of a leg brace and are included in the cost of the brace; or,
 - The shoes are for a person with diabetes or peripheral vascular disease;
28. Personal comfort items such as telephone or television;
29. Practitioner charges exceeding the Medicare- eligible expense for health care services, except if shown in the Benefit Table in the Outline of Coverage as being applicable;
30. Professional services not provided by a Medicare-eligible practitioner;
31. Routine foot care, unless related to disease affecting the lower limbs, such as peripheral vascular disease or diabetes, as covered under Medicare guidelines;
32. Routine physical exams and any related diagnostic x-ray and laboratory tests covered by Medicare; and,
33. Treatment of service-related conditions for members or ex-members of the armed forces by any military or Veterans' hospital or soldier home. Services are also excluded

EXCLUSIONS

if received at any hospital contracted for or operated by a national government or agency.

RENEWAL TERMS, REINSTATEMENT, AND MID-TERM CANCELLATION BY INSURED

RENEWAL TERMS

This policy is guaranteed renewable for life subject to timely payment of premium. We will neither cancel nor non-renew your policy for any reason other than nonpayment of premium or material misrepresentation. Your policy may be revised to comply with federal or state law. This policy cannot be cancelled or nonrenewed solely on the grounds of a decline in health. This policy ends on the day you die. You can end your policy at any time by writing to us. No refusal of renewal will affect an existing valid claim for Medicare-eligible expenses covered under this policy and incurred prior to the date on which this policy ends.

CANCELLATION BY INSURED

You may cancel this policy at any time. Please send a written request to our office requesting cancellation, stating the requested cancellation date. Verbal requests will not be accepted. Cancellation dates will not be retroactive. The cancellation date can be the date your written request is received, if stated in your written request. It can also be a future date not to exceed three months from the date of your written request. This policy provides for mid-term cancellation at your request. If you cancel this policy mid-term or this policy terminates mid-term because of your death, we will issue a *pro rata* refund to you or to your estate. If a midterm cancellation is due to death and a refund is due, the refund will be issued to your estate.

PREMIUM AND COVERAGE

PREMIUM RATES

We determine the premium rates for this policy and all subsequent premiums due under this policy. Each premium, after the initial payment submitted with your application, must be paid directly to us. Premium must be paid by the due date in order to keep this policy in force, and it must be paid in full.

Full payment of the required premium by the due date will maintain your coverage. This policy will be in force for that period, subject to this policy's 31-day grace period. If you fail to pay the premium, we will end this policy at the end of the grace period. You remain responsible for the premium due during the grace period.

We may change the premium rates under this policy:

- On the first day of the initial renewal period on or after each 12-month anniversary of the effective date of this policy;
- On any date the benefits under this policy change as required by law;
- On any date this policy is amended; and,
- Upon your move into a new rating area.

We will send you written notice of a premium rate change. This will be at least 30 days before any change takes effect for this policy. If this policy's premium rate is increased 25% or more at renewal, we will send written notice of the new premium at least 60 days before any changes take effect. The rate change takes effect on the first day of the renewal period as described in the required notice.

The rate change may be on the date the policy or benefits change as required by law.

If you elect to submit premium payments in advance, we will not issue a refund unless your coverage is terminated. Refunds are only issued when a policy is cancelled, and an overpayment exists at that time.

PREMIUM DUE DATE

Premiums are due before the first day of the month prior to coverage. You have three options for making your premium payment:

- Check or money order;
- Automatic withdrawal from a checking or saving account (not available for your initial payment); or,
- Credit or debit card (not available for your initial payment).

GRACE PERIOD

Any premium not paid to us by the due date is in default. For each premium not paid when due, there is a 31-day grace period. If you do not pay your premium in full, the policy will terminate automatically at the end of the 31-day grace period. You may notify us in advance if you want to end the policy.

MISCELLANEOUS PROVISIONS

CONTRACT DOCUMENTS

Our contract consists of this policy. It also consists of your Quartz ID card and your application or supplemental application, if any. If you chose any riders, endorsements or attachments, they are included. No agent, broker or other person may change any term, condition, provision or limitation of this policy in any way. They may not extend the time for any premium payment. We may on our own accord make a change to this policy if we send written notice to you at least 60 days in advance of that change. Any change to this policy will be made by endorsement or rider. Any change will be binding on each member covered under this policy and us.

TIME LIMIT ON CERTAIN DEFENSES

We may investigate information you provided in applying for coverage for two years after the original effective date of your policy. 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.

HOW TO CLAIM BENEFITS

Notice of Claim

When you seek health care services from a provider, always show your Medicare ID card. You must also show your Quartz ID card.

Medicare Filing

Claims for services that are eligible for payment under Medicare must be sent to and processed by Medicare. This must happen before we can process a claim. Normally the provider of service will send the claim to Medicare first. We receive it next. If your provider does not submit the claim to Medicare and to us on your behalf, we will need the following information to process your claim:

- A copy of the Explanation of Medicare Benefits (EOMB); and,
- A copy of the provider's itemized bill on a standard claim form.

Please keep copies of these items for your records.

Proof of Loss and Time Limit on Filing a Claim

s. 631.81(1), Wis. Stat.

If you pay for services directly, please submit the itemized bill to Quartz within 90 days from the date the services were provided. Circumstances beyond your control might make this time limit unreasonable. If so, you must file the claim as soon as possible, and pursuant to sec. 631.81, Wis. Stats., we will still process your claim if you submit it within one year after the time required under this provision. A Member Claim Form is available in the Forms section of QuartzBenefits.com.

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

EXPLANATION OF BENEFITS

When a claim is submitted to Medicare, they determine payment. They will send you an explanation of your benefits called a Medicare Summary Notice. This document explains what Medicare paid and any balance due on the claim submitted. Your doctor’s office, hospital or facility will get a copy of the Medicare Summary Notice. They will submit the balance of the charges with a copy of the summary notice to us for you.

We will process the claim according to your benefits. If there is a balance due, we will send our Explanation of Benefits (EOB) to you.

CONFORMITY WITH STATE LAWS

Any provision that conflicts with the laws of the state in which we issue this policy will conform to the minimum requirements of such laws.

YOUR RELATIONSHIP WITH YOUR DOCTOR OR HOSPITAL

This contract will not alter the relationship you have with your doctor, hospital, service or facility. We do not contract with you to choose or provide a doctor, hospital, service or facilities. We do not assure their availability. We are not responsible to you for the acts of any health care provider or for any services or facilities. We are obliged only to provide the benefits stated in this policy.

PRACTITIONERS AND HOSPITAL REPORTS

Practitioners and hospitals must give us reports to help determine contract benefits due to you. You hereby clearly authorize practitioners, hospitals and other providers of service to release all records to us regarding services you received. This is a condition of our issuing this contract. It is also a condition of our paying benefits. All information must be furnished to the extent we deem it necessary in a particular situation and allowed by pertinent statutes.

DIRECT PAYMENTS OF BENEFITS

We can, if we choose, pay any benefit we owe to you. We can also pay directly to the practitioner, hospital or other provider that furnished the service, care, item or facility. Such payments discharge our liability for the amounts paid.

RECOVERY OF EXCESS PAYMENTS

We might pay more than we owe under this policy. If so, we can recover the excess from you, the hospital or the other provider of care. We can recover from another insurance company or service plan. We can also recover from any other person or entity that has received any excess payment from us.

LIMIT ON ASSIGNABILITY OF BENEFITS

This is your personal policy. You cannot assign a benefit to anyone other than a practitioner, hospital or other provider entitled to receive a specific benefit from you.

SEVERABILITY

If any part of this policy is ever prohibited by law, it will not apply any more. The rest of the policy will continue in full force.

SUSPENSION OF BENEFITS AND PREMIUMS FOR POLICYHOLDERS ENTITLED TO MEDICAID

Benefits and premiums under this policy will be suspended at your written request. This can be for a period of up to 24 months. During that time, you must have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must provide proof of entitlement to us within 90 days after the date you become entitled to assistance.

If suspension occurs and you lose entitlement to medical assistance, this policy will be automatically reinstated. This will be effective as of the date of termination of entitlement. You need to provide written proof of loss of entitlement within 90 days after the date of a loss. You must pay the premium attributable to the policy. This begins on the date you lost entitlement to medical assistance.

If notice is not given or premium paid according to the preceding paragraph, the suspended policy will be cancelled as of the end of the 24-month period.

SUSPENSION OF BENEFITS AND PREMIUM FOR POLICYHOLDERS ENTITLED TO BENEFITS UNDER A GROUP HEALTH PLAN

Benefits and premiums under this policy will be suspended at your written request. It will be for a period provided by federal regulation. During that time, you must have applied for and are determined to be entitled to benefits under section 226 (b) of the Social Security Act. You are also covered under a group health plan, as defined in section 1862 (b) (1) (A) (v) of the Social Security Act. You need to provide proof of entitlement to us within 90 days after the date you become entitled to group health benefits.

If suspension occurs and you lose entitlement to group health benefits, this policy will be automatically reinstated. This will be effective as of the date of loss of coverage. You need to provide written notice of loss of coverage within 90 days after the date of loss. You also need to pay the premium attributable to the policy. This begins on the date of loss of coverage. If the suspended policy provided coverage for outpatient prescription drugs, the reinstated policy will not. It will otherwise provide largely the same coverage as the coverage in effect before the date of suspension.

If notice is not given or premium paid according to the preceding paragraph, the suspended policy will be canceled. This will take effect as of the end of the period provided by federal regulation.

COORDINATION OF SERVICES AND BENEFITS

Applicability

This Coordination of Benefits ("COB") provision applies to This Plan when an employee or the employee's covered dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

- Shall not be reduced when, under the order of benefit determination rules, This Plan

- determines its benefits before another Plan; but,
- May be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described in the Effect on the Benefits of This Plan section, below.

Definitions

ALLOWABLE EXPENSE

Means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

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

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

CLAIM DETERMINATION PERIOD

Means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan or any part of a year before the date this COB provision or a similar provision takes effect.

PLAN

Means any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

- Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, 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.

Each contract or other arrangement for coverage under the bullets above is a separate Plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

PRIMARY PLAN/SECONDARY PLAN

The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.

THIS PLAN

Means the part of the group contract that provides benefits for health care expenses.

Order of Benefit Determination Rules

When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

- The other Plan has rules coordinating its benefits with those of This Plan; and,
- Both those rules and This Plan's rules described below, require that This Plan's benefits be determined before those of the other Plan.

This Plan determines its order of benefits using the first of the following rules which applies:

1. **Non-Dependent/Dependent**

The benefits of the Plan which covers the person as an employee, member or subscriber are determined before those of the Plan which covers the person as a dependent of an employee, member or subscriber.

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

Except as stated in paragraph 3 below, when This Plan and another Plan cover the same child as a dependent of different persons called “parents”:

- The benefits of the Plan of the parent whose birthday falls earlier in the calendar year are determined before those of the Plan of the parent whose birthday falls later in that calendar year; but,
- If both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described above but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall determine the order of benefits.

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

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

- First, the Plan of the parent with custody of the child;
- Then, the Plan of the spouse of the parent with the custody of the child; and,
- Finally, the Plan of the parent not having custody of the child.

Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to paragraph 2, above.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. **Active/Inactive Employee**

The benefits of a Plan which covers a person as an employee who is neither laid off nor retired or as that employee's dependent are determined before those of a Plan which covers that person as a laid-off or retired employee or as that employee's dependent. If the other 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. **Continuation Coverage**

If a person has continuation coverage under federal or state law and is also covered under another plan, the following shall determine the order of benefits:

- First, the benefits of a plan covering the person as an employee, member or subscriber or as a dependent of an employee, member or subscriber; and,
- Second, the benefits under the continuation coverage.

If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this paragraph 5 is ignored.

6. **Longer/Shorter Length of Coverage**

If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

Effect on the Benefits of This Plan

This section applies when, in accordance with the Order of Benefit Determination Rules section, this Plan is a Secondary Plan as to one or more other Plans. In that event, the benefits of this Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" below.

The benefits of This Plan will be reduced when the sum of the following exceeds the allowable expenses in a claim determination period:

- The benefits that would be payable for the allowable expenses under This Plan in the absence of this COB provision; and,
- The benefits that would be payable for the allowable expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made. Under this provision, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those allowable expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

Quartz has the right to decide which facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state law. Each person claiming benefits under This Plan must give Quartz any facts it needs to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, Quartz may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan.

Quartz will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Quartz is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- The persons it has paid or for whom it has paid;
- Insurance companies; or,
- Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Right to Request Final Benefit Determination

If This Plan is the secondary Plan, Quartz must be able to determine whether the Primary Plan will make payment prior to making our payment for an allowable expense under This Plan.

Quartz may require evidence of a final benefit determination prior to approving coverage.

SUBROGATION

The term “Benefit Amount,” as used in the Subrogation and Reimbursement Section below, means the Fee-for-Service Equivalent Value of health care services received by a member minus all out-of-pocket expenses for which a member is responsible for paying, including all deductibles, coinsurance, copayments, and other similar charges. “Benefit Amount” is the amount for which Quartz seeks subrogation and reimbursement.

Quartz retains both the right of subrogation against a third party and the right of reimbursement from members to the extent of benefits paid by Quartz, as defined hereinabove as “Benefit Amount” and as identified as Quartz Paid Provider in the member’s Explanation of Benefits (EOB). Quartz may enforce its subrogation rights, to the extent permitted by law, by asserting a claim to any injury-related coverage to which a member may be entitled, including but not limited to liability coverage, uninsured and underinsured motorist coverage and homeowner’s coverage. In addition to its subrogation rights, Quartz may enforce its reimbursements rights, to the extent permitted by law, by asserting a claim of reimbursement from any and all recoveries obtained by a member arising out of an injury for which Quartz has provided benefits. This means that whenever Quartz provides services or other benefits to any member, Quartz shall, to the extent a member has been “made whole” under applicable state law, be entitled to be reimbursed from all of the member’s rights of recovery and all actual recoveries obtained by or on behalf of a member from any other party, person or corporation (“Third Party”), including but not limited to any proceeds received by a Member under policies of liability coverage, uninsured or underinsured motorist coverage and homeowner’s coverage. A member’s obligation to reimburse Quartz exists, regardless of whether the settlement, compromise or judgment designates payment proceeds received from a Third Party as including or excluding medical expenses. Quartz is not required to help a Member pursue a claim for damages or personal injuries, and no amount of associated costs, including attorneys’ fees, shall be deducted from Quartz’s recovery without Quartz’s express written consent.

Any member who receives services or benefits from Quartz, and has any right of recovery against any Third Party, including a claim made pursuant to uninsured or underinsured motorist coverage, must, by or on behalf of Quartz, execute and sign all documents as may be required, deliver the same to Quartz or Quartz’s designee and perform whatever other acts, including an assignment of rights, that are necessary to secure Quartz’s rights. By participating in and accepting benefits from Quartz, members agree to assign to Quartz any benefits, claims or rights of recovery a member has under any automobile policy, including no-fault benefits, PIP benefits and/or medical payments coverage benefits, and all other coverages or against any Third Party, to the full extent of the benefits paid by Quartz, as defined hereinabove as “Benefit Amount” and as identified as Quartz Paid Provider in the member’s Explanation of Benefits (EOB).

Members must do nothing to prejudice Quartz's right of recovery. Members must promptly advise Quartz in writing whenever a claim against another party is made on behalf of the member and will further provide such additional information as is reasonably requested by Quartz or Quartz's designee. Quartz reserves the right to be provided notice of any claim against a Third Party. The member agrees to cooperate in protecting Quartz's interest and to provide necessary information to Quartz or Quartz's designee upon request.

WORKERS' COMPENSATION

This contract is separate from Workers' Compensation insurance. It does not satisfy any legal requirement for that insurance.

You will consent to our direct repayment in the event that you receive covered services under any Workers' Compensation or Employer Liability Law. This would be for any illness or injury for which you are or would have been eligible for an award, settlement or compromise, in whole or in part. Proceeds would have been available under such law to the extent of the value of the covered services you receive.

GRIEVANCE & EXTERNAL REVIEW PROCEDURES

COMPLAINT PROCESS

We encourage you to contact Customer Service if you have an inquiry, concern, or complaint against us. A customer service representative acts as a liaison to resolve any of your issues. They might be unable to resolve the issue to your satisfaction. If so, they will advise you of your right to submit a written grievance to the Appeals Specialist. The Appeals Specialist is a person employed by us who specializes in the grievance process. He or she will receive and record your written grievance. The Appeals Specialist will investigate your grievance and assist you through the grievance process. They will advise you or your authorized representative of the result of the grievance and the action taken.

GRIEVANCE PROCEDURE

A grievance is any dissatisfaction with the provision of services or claims practices of an insurer. The insurer offers a health benefit plan or administration of a health benefit plan. It can also be a determination to reform or rescind a policy. A grievance is expressed in writing to the insurer by or for you. There is no time limit in which to submit a written grievance.

If a person is acting as your authorized representative in the grievance process, we will require written evidence of the representative's authority to act for you.

Standard Grievance Procedure

You must submit your grievance in writing to the following address:

Quartz
Attn: Appeals Specialist
840 Carolina St.
Sauk City, WI 53583

We will provide a written notice letting you know we received your grievance. We will advise you of the date and place of the Grievance and Appeals Committee meeting. You will have the right to appear in person or via teleconference before the committee to present written or oral information. We will resolve your grievance within 30 calendar days of receipt.

Expedited Grievance Procedure

An expedited grievance is where any of the following applies:

- The time it takes to process a standard grievance will result in serious danger to your life or health. It could also affect your ability to regain maximum function;
- A practitioner familiar with your medical condition knows a standard grievance would

subject you to severe pain. That pain cannot be amply managed without the care or treatment that is the subject of the grievance; or,

- A practitioner who knows of your medical condition determines that the grievance will be treated as an expedited grievance.

If you have an expedited grievance, we will resolve it as promptly as your health condition requires. It will be no more than 72 hours after we receive the grievance. You or your doctor may verbally request an expedited grievance. This is done by contacting the Appeals Specialist at (800) 362-3310.

EXTERNAL REVIEW PROCESS

We are required to provide you with an external review procedure for review of certain decisions. An external review is a process that provides you with a chance to have medical professionals, who have no connection to us, review your dispute. These decisions include coverage denial determinations. In turn, these are preexisting condition exclusion denial determinations and rescissions of a policy or certificate.

You can request an external review with the member advocate. You will need to complete an External Review Request Form. You can get it from the Appeals Specialist in person, by phone or in writing.

A written request for external review must be submitted within four months (120 days) of our notice containing a final adverse determination.

OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

You may resolve your problem by taking the steps outlined above. You may also contact OCI, a state agency that enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with OCI at its website at <https://oci.wi.gov>, or by writing to:

Office of the Commissioner of Insurance
Complaints Department
125 South Webster Street, P.O. Box 7873
Madison, WI 53707-7873

You may also call (800) 236-8517 outside of Madison or (608) 266-0103 in Madison, and request a complaint form.



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 hnuv tseem ceeb uas sau rau hauv daim ntawv no kom zoo. Tej zaum koj kuj yuav tau ua qee yam uas pab 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 giúp 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, потребуются 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. ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນທີ່ສໍາຄັນກ່ຽວກັບໃບສະໜັກ ຫຼື ການຄຸ້ມຄອງຂອງທ່ານຜ່ານ Quartz. ຊອກຫາວັນທີ່ສໍາຄັນ ໃນໜັງສືແຈ້ງການສະບັບນີ້. ທ່ານອາດຈຳເປັນຕ້ອງປະຕິບັດຕາມເວລາ ທີ່ກຳນົດໄວ້ທີ່ແນ່ນອນເພື່ອຮັກສາໄວ້ການຄຸ້ມຄອງສະພາບຂອງທ່ານ 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 معينة وفقاً لمواعيد معينة من أجل الحفاظ على تغطيتك الصحية أو المساعدة في التكاليف. لديك الحق في الحصول على هذه المعلومات 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 devez 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 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. (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.

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 አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ (800) 362-3310. (መስማት ለተሳናቸው: 711 / (800) 877-8973).

Karen – ၵၢ်သ့ၵ်သး- န့ၵ်ကတိၢ် ကညိၢ် ကျိၵ်အသိၢ်, န့ၵ်န့ၵ် ကျိၵ်အတၢ်မၤတၢ်လၢ တလၢၵ်သ့ၵ်သးန့ၵ်လိၢ်. ကိး (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Mon-Khmer, Cambodian – ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ 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 – เร็ยณ: ถำ कुณพค ภาษำไทยคุณสำมำรถใช้ขำ รึการช่วยเหลือทางภาษาได้ฟรี โทร (800) 362-3310. TTY / TDD: 711 / (800) 877-8973.

Gujarati – સુચના: 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.

Pennsylvanian Dutch – Die Bekanntmachung gebt wıchdıchı Auskunft. Die Bekanntmachung gebt wıchdıchı Auskunft baut dei Application oder Coverage mit Quartz. Geb Acht fer wıchdıche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschımmde 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 nıx. 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 zwrócić 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 खर्च में मदद के लिए आपको कुछ तय तारीखों तक कार्रवाई करनी जरूरी 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 ndërmerri 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 lagu heli karaa. 1-800-362-3310 (TTY: 1-800-877-8973) bilbilaa.