Offered by Quartz Health Benefit Plans Corporation

Preferred Provider Organization (PPO)

Large Group Certificate of Coverage

State of Wisconsin

2650 Novation Parkway
Fitchburg, WI 53713

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IMPORTANT INFORMATION

Preferred Provider Organization (PPO)
Certificate of Coverage

Quartz is the shorthand name for the administrator of this ***policy*** and the insurance underwriting company, ***Quartz Health Benefit Plans Corporation***. ***Quartz*** has entered into an agreement with ***your*** employer to provide ***you*** with a Preferred Provider Organization (PPO) ***health insurance benefit plan***. ***Quartz*** has issued to ***your*** employer a ***Group Master Policy Agreement*** that outlines the duties and obligations of the parties. ***You*** and any ***dependents*** who are insured under the ***Group Master Policy Agreement*** are listed on an ***Enrollment Form*** that ***your*** employer has submitted to ***Quartz***.

This ***Certificate of Coverage*** is incorporated into and made part of the ***Group Master Policy Agreement***. If the terms of this ***Certificate of Coverage*** differ from the terms of the ***Group Master Policy Agreement***, the ***Group Master Policy*** will govern. This ***Certificate of Coverage*** replaces any previous ***certificate*** that ***Quartz*** may have issued to ***you***. ***You*** may contact ***your*** employer's benefits manager if ***you*** wish to review the ***Group Master Policy Agreement***.

Quartz insures and administers all of the benefits ***you*** receive under this ***plan***. This ***Certificate of Coverage*** explains the terms and conditions of ***your*** insurance coverage. Please read it carefully. If ***you*** have questions, contact ***your*** employer's benefit manager or ***Quartz*** Customer Success. Unless otherwise explicitly indicated, ***Quartz*** has full discretion and authority to make all determinations required to administer the ***policy***, including eligibility for benefits and interpretation of terms under the ***policy***.

NOTICE: LIMITED BENEFITS WILL BE PAID WHEN OUT-OF-NETWORK PROVIDERS ARE USED

You should be aware that when ***you*** elect to utilize the services of an ***out-of-network provider*** for a covered service, benefit payments to such ***out-of-network provider*** are not based upon the amount billed. The basis of ***your*** benefit payment will be determined according to ***your policy's*** fee schedule, ***usual and customary charge*** (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the ***policy***.

YOU RISK PAYING MORE THAN THE CO-INSURANCE, DEDUCTIBLE AND CO-PAYMENT AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION

Out-of-network providers may bill enrollees for any amount up to the billed charge after the plan has paid its portion of the bill. ***In-network providers*** have agreed to accept discounted payment for covered services with no additional billing to the enrollee other than the co-payment, co-insurance and deductible amounts.

You may obtain further information about the participating status of professional ***providers*** and information on out-of-pocket expenses by calling (800) 362-3310 or by visiting ***Quartz's*** website at ***QuartzBenefits.com***.

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ARTICLE I: DEFINITIONS

The following terms are used in this ***Certificate of Coverage***:

Activities of Daily Living (ADL)
The basic tasks of everyday life, such as eating, bathing, dressing, toileting, and transferring.

Allowed Amount
The maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If ***your provider*** charges more than the ***allowed amount***, ***you*** may have to pay the difference. See ***Balance Billing***.

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

Ancillary Provider
Anesthesiologist, radiologist, pathologist, emergency room ***physician*** and medical laboratory.

Appeal
A request for ***your*** health insurer or ***plan*** to review a decision or a ***grievance*** again.

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

Autism Spectrum Disorder
Includes any of the following:

1. Autism disorder; or,
2. Pervasive developmental disorder not otherwise specified.

Balance Billing
When a ***provider*** bills ***you*** for the difference between the ***provider's*** charge and the ***allowed amount***. For example, if the ***provider's*** charge is $100 and the ***allowed amount*** is $70, the ***provider*** may bill ***you*** for the remaining $30. ***Balance billing*** may also occur when ***Quartz*** denies a claim that was coded improperly, and the ***provider*** bills ***you*** the unpaid amount.

An ***in-network provider*** may not ***balance bill you*** for covered services. An ***out-of-network provider*** may not ***balance bill you*** for covered ***emergency services***. With ***your informed consent***, an ***out-of-network provider*** may ***balance bill you*** for non-emergent services received at an ***in-network*** facility.

Behavioral Health and Substance Use Disorder Services
The treatment of psychiatric ***illness*** or substance use disorders. This treatment is provided on an inpatient, outpatient, transitional and emergency care basis.

Benefit Period
The 12-month period during which ***deductibles***, ***out-of-pocket expenses*** and limitations accumulate. The ***benefit period*** may be based on the ***benefit year*** or the calendar year. Your ***Schedule of Benefits*** indicates whether ***deductibles*** and ***out-of-pocket expenses*** accumulate on a ***benefit year*** or calendar year basis. All benefit limits listed in the policy documents will accumulate on the same basis unless specified otherwise.

Benefit Year
The coverage period shown on ***your Schedule of Benefits.***

Benefit Rider
An amendment to the ***Group Master Policy Agreement*** that adds or modifies ***plan benefits*** outlined in this ***Certificate of Coverage***.

Care Management
The collaborative process that promotes quality health care in a cost-effective manner and which enhances the physical, psychological and social

health of individuals. The goal of ***care management*** is to assist patients and families in obtaining quality health care at an appropriate cost, in the appropriate setting, and to achieve positive outcomes through coordinated efforts with ***your*** health care ***providers***. ***Care management*** services are provided by a staff of health care professionals. ***Quartz*** reserves the right to use these services to optimize the clinical outcome, the standards of care and the cost-effectiveness of care, and to remove barriers to well-living.

Certificate of Coverage (or Certificate)
This document, including any ***benefit rider***, issued to ***you*** which sets forth the terms, conditions and limitations of ***your health plan***.

Change Form
The form that ***you*** must complete if ***you*** wish to add or delete ***dependents*** or change the information on ***your Enrollment Form***. ***You*** may submit some changes electronically by logging on to ***QuartzBenefits.com***.

Charge
The fee charged by the ***provider*** for the service or item provided.

Chemotherapy
Drugs and biologics that kill cancer cells directly, including antineoplastics, biologic response modifiers, hormone therapy, and monoclonal antibodies, and that are used to do any of the following:

1. Cure a specific cancer;
2. Control tumor growth when cure is not possible;
3. Shrink tumors before surgery or radiation therapy; or,
4. Destroy microscopic cancer cells that may be present after a tumor is removed by surgery to prevent a cancer recurrence.

Child
A ***subscriber's*** natural blood-related ***child***, stepchild, legally adopted ***child***, minor ***child*** placed in the custody of the ***subscriber*** for adoption, or a minor ***child*** for whom the ***subscriber*** or the ***subscriber's*** covered spouse has been appointed as legal guardian. Adopted children become ***dependents*** when the court order for adoption is signed or when the minor ***child*** is placed in the

custody of the ***subscriber*** who is to be the adoptive parent, whichever occurs first.

Claim

A demand for payment due in exchange for health care services provided. A ***claim*** must have this minimum information: patient name and address, ***provider*** name and address, description of services provided, date of service, reason for providing service and amount charged.

Co-insurance

Your share of the costs of a covered health care service, calculated as a percent of the ***allowed amount*** for the service. ***You*** pay ***co-insurance*** *plus* any ***deductibles you*** owe. For example, if the ***health insurance*** or ***plan's*** allowed amount for an office visit is $100 and ***you've*** met your ***deductible***, ***your co-insurance*** payment of 20% would be $20. The ***health insurance*** or ***plan*** pays the rest of the ***allowed amount***.

You are responsible for paying ***co-insurance*** directly to the ***provider***.

Complaint

Any expression of dissatisfaction to ***Quartz*** by ***you***, or a person acting on ***your*** behalf, about ***Quartz*** or ***Quartz's in-network providers***.

Complications of Pregnancy

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

Confidential Matter

Personal information concerning the medical, personal or financial affairs that ***Quartz*** may acquire about ***you*** in the course of administering ***plan benefits***. ***Confidential matters*** also include proprietary information and financial and other information relating to ***Quartz*** and its ***providers***.

Confinement (or Confined)

1. The period of time between the admission to an inpatient or outpatient health care facility through the time of discharge. The health care facility may be a ***hospital***, a substance use treatment center, a ***skilled nursing facility*** or a licensed ***ambulatory surgical center***; and,
2. The time spent receiving ***emergency services*** for ***illness*** or ***injury*** in a ***hospital***.

A ***hospital*** swing bed ***confinement*** is considered the same as ***confinement*** in a ***skilled nursing facility***. In the event a ***member*** is transferred from one facility to another for the continued treatment of the same or a related condition, it is considered one ***confinement***.

Congenital

A condition that exists at birth.

Contract Year

The 12-month period following the ***effective date*** of the ***Group Master Policy***.

Coordination of Benefits (COB)

A process that allows ***Quartz*** to determine its respective payment responsibility. Through ***COB***, ***Quartz*** determines which insurance plan has primary payment responsibility when an individual is covered by more than one plan.

Co-payment

A fixed amount ***you*** pay for a covered health care service, usually when ***you*** receive the service. The amount can vary by the type of covered health care. ***You*** are responsible for paying the ***co-payment*** directly to the ***provider***.

Covered Expense

A ***charge*** incurred for a ***covered service***.

Covered Service

A ***medically necessary*** treatment, service or supply that has been specified as a benefit in this ***Certificate of Coverage*** or the ***Schedule of Benefits***, for which any applicable ***prior authorization*** has been obtained.

Custodial Care

The provision of room and board, nursing care, personal care or other care that is designed to assist an individual in the ***activities of daily living*** (e.g., eating, dressing, assistance in walking and preparing meals). ***Custodial care*** is care and treatment that is generally received by an individual who has reached the maximum level of recovery in the opinion of the ***plan***. In the case of an institutionalized person, ***custodial care*** also includes room and board, nursing care or such other care provided to an individual for whom it cannot reasonably be expected, in the opinion of the ***attending physician***, that medical or surgical treatment will enable that person to live outside an institution. ***Custodial care*** includes rest care, respite care and home care provided by family members. Care may be considered ***custodial care*** as determined by the ***plan*** even if (1) the ***member*** is under the care of a ***physician***, (2) the ***physician*** prescribes services to support and maintain the ***member's*** condition, or (3) services and supplies are being provided by a registered nurse or licensed practical nurse.

Deductible

The amount ***you*** owe for health care services ***your health insurance*** or ***plan*** covers before ***your health insurance*** or ***plan*** begins to pay. For example, if ***your deductible*** is $1,000, ***your*** plan won't pay anything until ***you've*** met your $1,000 ***deductible*** for covered health care services subject to the ***deductible***. The ***deductible*** may not apply to all services. Only ***charges*** that qualify as ***covered expenses*** may be used to satisfy the ***deductible***. The amount of the ***deductible*** is stated on the ***Schedule of Benefits***.

For some family plans, services for an individual member may begin to pay when the single deductible is met. For other family plans, the entire family deductible must be met before ***your*** plan begins to pay. Refer to ***your Schedule of Benefits*** for details on how ***your deductible*** works.

Dependent

One or more of the following:

1. A ***subscriber's*** lawful spouse;
2. A ***child*** under the age of 26;
3. A ***subscriber's*** adult ***child*** who satisfies all of the following:
   - The ***child*** is a full-time student; and,
   - The ***child*** was under 27 years of age when he or she was called to federal active duty in the National Guard or in a reserve component of the U.S. Armed Forces while the ***child*** was attending, on a full-time basis, an institution of higher education, and applied to an institution of higher education as a full-time student within 12 months from the date the ***child*** has fulfilled his or her active duty obligation; and,
4. A ***subscriber's*** grandchild, if the parent of the grandchild is a covered ***dependent child*** under the age of 18. The ***dependent*** grandchild is covered until the end of the month in which the ***dependent child*** turns age 18.

If a ***member*** is the father of a ***child*** born outside of marriage, the ***child*** does not qualify as a ***dependent*** unless and until there is a court order declaring paternity, or on the date the acknowledgment of paternity is filed with the Wisconsin Department of Health Services, or its equivalent if the birth was outside the State of Wisconsin. Once a ***child*** becomes eligible for coverage, coverage will be effective according to the rules specified in the "Eligibility and Effective Date of Coverage" section of this ***certificate***.

Developmental or Learning Disability or Delay

A condition due to a ***congenital*** abnormality, trauma, deprivation or disease that interrupts or delays the sequence and rate of normal growth, development and maturation, but excluding ***Autism Spectrum Disorder***.

Disenrollment

Coverage under the ***plan*** has ended or has been revoked by ***Quartz***.

Drug Formulary
A set of generic and brand name drugs that ***physicians*** and pharmacists use to prescribe and fill prescriptions. ***Quartz's drug formulary*** is designed to provide the desired medical results while controlling the cost of pharmaceuticals. ***Quartz's drug formulary*** is reviewed and updated on a regular basis. Prescriptions covered by ***Quartz*** must adhere to the ***drug formulary***.

Dual Choice Enrollment Period
A period of time when ***members*** who are currently enrolled in any of the employer's other group ***health insurance benefit plans*** will be allowed to enroll for coverage under a ***Quartz health plan***. The establishment of such an enrollment period must be by the mutual agreement of the employer and ***Quartz***.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care ***provider*** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Effective Date
The date on which an ***employee*** becomes enrolled in a ***Quartz health plan*** and entitled to the benefits specified in the ***Certificate of Coverage***.

Eligible Employee
An ***employee*** who meets the requirements for eligibility as specified in the ***Group Master Policy Agreement*** and in the ***group application***. An ***eligible employee*** is one who works 30 or more hours per week or, if less than 30 hours**,** at least as many hours as specified by ***Quartz*** in the ***group application***. This term also includes a sole proprietor, a business owner, including the owner of a farm business, a partner of a partnership, a member of a limited liability company; if the sole proprietor, business owner, partner, or member is included as an ***employee*** under the health plan of an employer, as defined by state and federal law. The term does not include an ***employee*** who works on a temporary or substitute basis.

Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

It is a condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a lack of immediate medical attention will likely result in any of the following:

1. Serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn ***child***;
2. Serious impairment of the person's bodily functions; or,
3. Serious dysfunction of one or more of the person's body organs or parts.

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services

Evaluation of an ***emergency medical condition*** and treatment to keep the condition from getting worse. These include items or services furnished after ***your*** condition has been stabilized as part of outpatient observation or an inpatient or outpatient stay at a ***hospital***.

Emergent/Urgent Transportation

Ground or air ambulance services for an ***emergency medical condition***.

Employee

An individual whose employment or other status is the basis for their eligibility to enroll in this ***plan***.

Employer's Certification of Group Health Plan Coverage

A form that is provided to an individual following the termination of their coverage under the ***plan***. This form is evidence that the individual had coverage under the ***plan*** and the duration of such coverage. ***Quartz*** will issue the form directly to the individual following termination of coverage.

Enrollment Application Form (or Enrollment Form)

The form signed by an ***eligible employee*** to signify that they and any eligible ***dependents*** wish to become ***members*** of the ***plan***.

Essential Health Benefits

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

- Ambulatory patience services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and,
- Pediatric services, including oral and vision care.

Excluded Services (also referred to as Non-Covered Services)

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

Exclusion

Any service or supply listed in the section entitled "Exclusions and Limitations." Those services or supplies listed as ***exclusions*** are not covered by ***Quartz***, regardless of the ***medical necessity***.

Expedited Grievance

A ***grievance*** where the standard resolution process might lead to:

1. Serious jeopardy to the life or health of the ***member*** or the inability of the ***member*** to regain maximum function; or,

2. A situation where, in the opinion of the ***physician*** with knowledge of the ***member's*** medical condition, the ***member*** would be subjected to severe pain that could not be adequately managed without the care or treatment that is the subject of the ***grievance***.

It is determined to be an ***expedited grievance*** by a ***physician*** with knowledge of the ***member's*** medical condition.

Expedited Review

A review process used when the standard review process would jeopardize ***your*** life, health or ability to regain maximum function.

Expense

The ***charge*** for a ***covered service*** or supply that ***Quartz*** determines is the ***usual, customary and reasonable charge***. An ***expense*** is incurred on the date ***you*** receive the service or supply.

Experimental or Investigative Treatments and Services

Drugs, devices, equipment, treatment or procedures which do not meet one or more of the following criteria, as determined by ***Quartz***:

- Full and final approval has been granted by the U.S. Food and Drug Administration for the treatment of the patient's medical condition;
- The research and experimental stage of the development of the treatment or service have been completed; and,
- The scientific evidence must permit conclusions concerning the effect on health outcomes for the specific condition or indication it will be used for.

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

Explanation of Benefits (EOB)
An ***EOB*** is a statement sent by ***Quartz*** to a ***member*** explaining what medical treatments and/or services were paid on their behalf.

Extended Care Facility
A health care facility, or a distinct part of a health care facility, which has been accredited for that purpose by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Community Health Accreditation Program or ***Medicare*** as a ***skilled nursing facility***.

External Review
A review of ***Quartz's*** decision conducted by an ***independent review organization***.

Foreign Claims
Items or services obtained or provided outside of the 50 United States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

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

Grievance
A complaint that ***you*** communicate to ***your health insurer*** or ***plan***. It is any dissatisfaction with the provision of services or claims practices or the administration of a ***Quartz health plan*** that is expressed in writing to ***Quartz*** by or on behalf of a ***member***.

Group
The employer, union, trust or association to which ***Quartz*** has issued a ***Group Master Policy Agreement***. The ***group*** is the basis for ***eligible employees*** and their ***dependents*** to become entitled to coverage under the ***health plan*** described by this ***Certificate of Coverage***.

Group Application

The form that is completed by a ***group*** when it requests coverage from ***Quartz*** for individuals in the ***group***.

Group Master Policy Agreement (or Group Master Policy)

An agreement between ***Quartz*** and a ***group*** that entitles ***eligible employees*** of the employer to become ***subscribers*** of the ***plan*** according to the terms of such agreement.

Habilitative Services

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

Health Insurance

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

Health Insurance Benefit Plan

Any ***health benefit plan*** that is any ***hospital*** or medical policy or ***certificate***, as defined by ss. 632.745 and 632.746, Wis. Stat.

A ***health insurance benefit plan*** does not include any of the following:

1. Accident insurance or disability income insurance, or any combination of those two types;
2. Liability insurance or coverage issued as a supplement to liability insurance;
3. Workers' Compensation or similar insurance;
4. Automobile medical payment insurance;
5. Credit-only insurance;
6. Coverage for on-site medical clinics;

7. If provided under a separate policy, certificate or contract of insurance, or, if the following is not an integral part of a policy, certificate or other contract of insurance:
    - Limited-scope dental or vision benefits;
    - Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of those benefits; or,
    - Other similar, limited benefits as are specified in regulations issued by the federal Department of Health and Human Services under sec. 2791 of P.L. 104-191; or,
8. Other similar coverage as specified in s. 632.745(11)(b), Wis. Stat.

Health Plan (or Benefit Plan or Plan)

The overall program of health services insured and administered by ***Quartz***.

Health Questionnaire

The part of the ***Enrollment Form*** that requests information to develop the ***premium*** rate.

Home Health Care

Health care services a person receives at home.

Home Health Care Services

Services to treat an ***illness*** or ***injury*** for which a ***member*** was or could have been hospitalized or ***confined*** in a ***skilled nursing facility***. This term shall have the same meaning as defined by the more liberal of Title XVIII of the Social Security Act or s. 632.895 (1)(b), Wis. Stat.

Hospice Care

Palliative care services provided to a ***member*** whose ***attending physician*** certifies that they have a life-limiting condition. Care is available on an intermittent basis with on-call services available on a 24-hour basis. ***Hospice care*** services ease pain and make the ***member*** as comfortable as possible. ***Hospice care*** must be provided through a licensed ***provider*** approved by ***Quartz***.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal ***illness*** and their families.

Hospital
An acute care facility which:

1. Provides inpatient diagnostic and therapeutic services for surgical or medical diagnosis, treatment and care of injured and sick persons by or under the supervision of staff or duly licensed ***physicians***;
2. Provides continuous nursing service by or under the supervision of registered professional nurses;
3. Is not a federal hospital or, other than incidentally, a place for rest, a place for the aged or a nursing home; and,
4. Operates as an acute care general or psychiatric hospital under applicable state or local laws.

Hospitalization
Care in a ***hospital*** that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

Identification Card
The card that ***Quartz*** issues to ***members*** to indicate that they are entitled to receive ***covered services***.

Illness (or Sickness)
A condition or disease that causes the loss of, or affects, a normal body function, other than those conditions that result from an ***injury***.

Immediate Family
The spouse of the ***subscriber***; the ***dependents***, parents, grandparents, brothers and sisters of the ***subscriber*** and their spouses.

Independent Review Organization (IRO)
An entity certified under state or federal law to review ***Quartz's*** decisions. Please refer to the Complaint and Grievance article for a description of the independent review process.

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

Informed Consent
When an ***out-of-network provider*** operating at an ***in-network*** facility notifies ***you*** that their services are not considered ***in-network*** for ***your Quartz*** plan, and ***you*** agree that the ***provider*** may ***balance bill you*** for costs that ***Quartz*** does not cover.

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

In-Network Benefit Level
The level of reimbursement for services performed by ***your primary care provider*** or other ***in-network providers***, including specialists and ***hospitals***, and ordered by the ***primary care provider*** or other ***in-network provider*** specialists. See the ***Schedule of Benefits*** for details on ***in-network benefit level*** reimbursement.

In-Network Co-insurance
The percent ***you*** pay of the ***allowed amount*** for covered health care services to ***providers*** who contract with ***your health insurance*** or ***plan***. ***In-network co-insurance*** usually costs ***you*** less than ***out-of-network co-insurance***.

In-Network Co-payment

A fixed amount ***you*** pay for covered health care services to ***providers*** who contract with ***your health insurance*** or ***plan***. ***In-network co-payments*** usually are less than ***out-of-network co-payments.***

In-Network Provider

Any person or entity, public or private, that:

1. Has entered into a contract to provide or arrange for the provision of ***plan benefits*** to ***Quartz members***; or,
2. Provides services through and in accordance with the ***provider network*** associated with the ***member's benefit plan***; or,
3. Is an ***ancillary provider*** providing services through an ***in-network provider***.

Intensive-Level Services

Evidence-based behavioral therapy that is designed to help an individual with ***Autism Spectrum Disorder*** overcome the cognitive, social, and behavioral deficits associated with that disorder.

Long-term Therapy

Any therapy that does not meet ***Quartz's*** criteria for ***short-term therapy***.

Maintenance and Supportive Care and/or Therapy

These terms are often used interchangeably to refer to therapies that seek to prevent disease in the absence of significant symptoms or to prevent deterioration of a condition once maximum therapeutic benefit has been achieved, even if symptoms are still present. The determination of what constitutes ***maintenance and supportive care and/or therapy*** is made by ***Quartz's medical director*** after reviewing the ***member's*** case history and/or treatment plan.

Medicaid

A program instituted pursuant to the federal "Grants to States for Medical Assistance Program." This program is governed by Title XIX of the United States Social Security Act, as it is now or hereafter amended.

Medical Director

A ***physician*** appointed by ***Quartz*** to serve as the ***plan's*** final decision-maker for determining whether a service, device, treatment or supply is eligible for coverage under the ***plan***.

Medically Necessary

Health care services or supplies needed to prevent, diagnose or treat an ***illness***, ***injury***, condition, disease or its symptoms and that meet accepted standards of medicine.

Medically Necessary Services, Treatments or Supplies

A service, treatment, procedure, ***prescription drug***, device or supply provided by a ***hospital***, ***physician*** or other health care ***provider*** that is required to identify or treat a ***member's illness*** or ***injury*** and which is, as determined by the ***plan***:

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

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

Medicare
Title XVIII, Parts A, B, C and D of the United States Social Security Act, as it is now or hereafter amended.

Member
The ***subscriber*** and any ***dependents*** covered under a ***policy*** issued by ***Quartz***.

Open Enrollment Period
A period of time when all potential ***members*** are allowed to enroll for coverage, whether or not they are currently enrolled in any of the employer's other health benefit plans. The establishment of an enrollment period must be by mutual agreement of the employer and ***Quartz***.

Out-of-Network Benefit Level
The level of reimbursement for services performed by ***out-of-network providers***, regardless of whether the services are elective services or ***urgent care services***. See the ***Schedule of Benefits*** for details on ***out-of-network benefit level*** reimbursement.

Out-of-Network Co-insurance
The percent ***you*** pay of the ***allowed amount*** for covered health care services received from ***out-of-network providers***. ***Out-of-network co-insurance*** usually costs ***you*** more than ***in-network co-insurance.***

Out-of-Network Co-payment
A fixed amount ***you*** pay for covered health care services received from ***out-of-network providers***. ***Out-of-network co-payments*** usually are more than ***in-network co-payments***.

Out-of-Network Provider
A ***provider,*** supplier or facility that:

1. Does not have a signed contract to provide or arrange for the provision of ***plan benefits*** to ***Quartz members***; or,

2. Is an ***ancillary provider*** providing services through an ***out-of-network provider.***

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

Out-of-Pocket
A portion of a ***covered expense*** for which the ***member*** is responsible for making payment. The ***expense*** may be incurred because of applicable ***co-insurance***, ***co-payment*** or ***deductible*** amounts or because a ***charge*** exceeds the ***usual, customary and reasonable charge***.

Out-of-Pocket Limit
The most ***you*** pay during a policy period (usually a year) before ***your health insurance*** or ***plan*** begins to pay 100% of the ***allowed amount***. This limit never includes ***your premium***, ***balance-billed*** charges or health care ***your health insurance*** or ***plan*** doesn't cover. Some ***health insurance*** or ***plans*** do not count all of ***your co-payments, deductibles, co-insurance*** payments, out-of-network payments or other expenses toward this limit.

Physician
A person holding an active, unrestricted license to practice medicine and/or surgery under Wisconsin law or under the laws of the state in which he or she practices.

Physician Services
Health care services a licensed medical physician (M.D.- Medical Doctor or D.O. - Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit ***your*** employer, union or other group sponsor provides to ***you*** to pay for ***your*** health care services.

Plan Benefits
Medical, ***hospital***, ***behavioral health and substance use disorder***, Chiropractic, ***home health care***, ***skilled nursing facility***, Emergency Care and

other specified ***covered services*** as defined in the ***Group Master Policy Agreement***, ***Certificate of Coverage***, ***Schedule of Benefits*** and ***benefit riders*** to which a ***member*** is entitled by membership in the ***plan***.

Policy

An agreement between ***Quartz*** and an employer wherein ***Quartz*** agrees to provide a ***group health plan*** to the employer's ***eligible employees*** and their eligible ***dependents***. The ***policy*** sets forth all of the obligations, rights and responsibilities of the parties. The ***policy*** includes all of the following:

1. The **Group Master Policy Agreement**;
2. The **Certificate of Coverage**;
3. The **Schedule of Benefits**;
4. Any **Benefit Riders**;
5. The **Group Application**;
6. The **Enrollment Forms**; and,
7. The **Provider Network Directory**.

Post-Intensive-Level Services

Therapy for an individual with ***Autism Spectrum Disorder*** that occurs after the completion of treatment with ***intensive-level services*** and that is designed to sustain and maximize gains made during treatment with ***intensive-level services*** or, for an individual who has not and will not receive ***intensive-level services***, therapy that will improve the individual's condition.

Preauthorization (also referred to as Prior Authorization, Prior Approval, or Precertification)

A decision by ***your*** health insurer or ***plan*** that a health care service, treatment plan, ***prescription drug*** or ***durable medical equipment (DME)*** is ***medically necessary***; sometimes called prior authorization, prior approval or precertification. ***Your health insurance*** or ***plan*** may require ***preauthorization*** for certain services before ***you*** receive them, except in an emergency. ***Preauthorization*** isn't a promise ***your health insurance*** or ***plan*** will cover the cost.

Premium

The amount that must be paid for ***your health insurance*** or ***plan***. ***You*** and/or ***your*** employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or ***plan*** that helps pay for ***prescription drugs*** and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Preventive Health Services

1. Evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
4. Such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.

The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current.

Primary Care Provider (also PCP)
A ***physician*** (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), physician assistant (PA) or nurse practitioner who provides, coordinates, or

helps a patient access a range of health care services. ***PCPs*** are listed in ***Quartz's Provider Network Directory***.

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

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

Prior authorization does not guarantee that services will be fully covered. Coverage is determined by the terms and conditions of the ***policy***. Services and items requiring ***prior authorization*** are listed on ***Quartz's*** website at ***QuartzBenefits.com/PPOPAList***. Contact ***Quartz*** Customer Success for details on the ***prior authorization*** process.

Provider
A ***physician*** (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), health care professional or health care facility licensed, trained, certified or accredited as required by state law.

Provider Network (or Network)
The facilities, ***providers***, organizations and suppliers who have contracted with or on behalf of ***Quartz*** to provide ***plan benefits*** to ***members***. Visit Find A Doctor at ***QuartzBenefits.com/FindADoctor*** or contact ***Quartz*** Customer Success for assistance in navigating the ***provider network***.

Provider Network Directory
A listing of ***physicians*** and other ***providers*** who are available to provide health care services to ***members***. Printable directories can be found at https://quartzbenefits.com/ProviderDirectoryPDFs.

Qualifying Payment Amount

The amount that ***we*** use to calculate ***your*** cost-sharing for:

- ***Emergency services*** received ***out-of-network***;
- Some ancillary services received from an ***out-of-network provider*** at an ***in-network*** facility; and,
- Services received from an ***out-of-network provider*** at an ***in-network*** facility without ***your informed consent***.

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

Quartz

The marketing name for ***Quartz Health Benefit Plans Corporation***, its plan administrator, and the overall program of health benefits that are insured and administered pursuant to the ***policy***. ***Quartz Health Benefit Plans Corporation*** is a health maintenance organization that operates pursuant to Chs. 609 and 611, Wis. Stat., or any succeeding provisions of Wisconsin law.

QuartzBenefits.com

A comprehensive website resource to guide ***you*** through ***your*** health plan benefits and educate ***you*** about ***Quartz's*** health and wellness programs. The internet domain name for this site is ***QuartzBenefits.com***.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions. ***Reconstructive surgery*** includes breast reconstruction following a covered mastectomy.

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

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

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

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

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

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

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.

Rider

An amendment to the ***health plan*** that adds benefits to the ***covered services*** outlined in the ***policy***.

Schedule of Benefits

A summary of the ***covered services*** provided by the ***policy***. The ***Schedule of Benefits*** lists the ***co-payment***, ***co-insurance*** and ***deductible*** amounts that may apply to the ***covered services*** under the ***policy***.

Service Area

The geographic area within which ***Quartz*** and its affiliated entities are authorized to do business and where ***Quartz*** has determined that there are enough contracted ***providers*** to serve its ***members***.

Short-term Therapy

Physical, speech, occupational, manipulative or respiratory therapy that is likely to significantly improve a ***member's*** condition within 60 days from the date the therapy begins, as determined by ***Quartz***.

Skilled Nursing Care

Services from licensed nurses in ***your*** own home or in a nursing home. Skilled care services are from technicians and therapists in ***your*** own home or in a nursing home. Skilled care must be ***medically necessary*** as determined by ***Quartz***. Services to support ***activities of daily living (ADL)***, even if provided by a licensed, registered or practical nurse, are not ***skilled care***.

Skilled Nursing Facility

A facility that is licensed by the State of Wisconsin, or another state, that maintains and provides all of the following:

1. Permanent and full-time bed care facilities for resident patients;
2. ***Physician services*** available at all times;
3. A registered nurse or ***physician*** in charge and on full-time duty and one or more registered nurses or licensed vocational or practical nurses on full-time duty;
4. A daily record for each patient; and,

5. Continuous ***skilled nursing care*** for patients during convalescence from ***illness*** or ***injury***.

A ***skilled nursing facility*** is not, except by coincidence, any of the following:

1. A rest home;
2. A home for care of the aged; or,
3. A facility engaged in the care and treatment of persons with psychiatric or substance use disorders.

Skilled Nursing Facility Services

The health care services provided by a ***skilled nursing facility*** or ***extended care facility*** as part of its licensed operations. These services must be designated as ***covered services*** by ***Quartz***.

Small Employer

An employer that:

1. Employs an average of two to 50 ***employees*** on business days during the preceding calendar year; or,
2. Is reasonably expected to employ two to 50 ***employees*** on business days during the current calendar year if the employer was not in existence during the preceding calendar year, and that employs at least two ***employees*** on the first day of the ***plan*** year; or,
3. Meets the most current definition of "***small employer***" as defined by state or federal law.

Sound Natural Tooth

A tooth that would not have required restoration in the absence of trauma or ***injury***, or a tooth with restoration limited to composite or amalgam filling, but not a tooth with crowns or a tooth that has had root canal therapy.

Special Enrollment Period

A 31-day period of time during which an ***eligible employee*** is allowed to enroll in the ***health plan*** without having to serve a ***waiting period***. The ***special enrollment period*** begins on the date the ***employee***:

1. Loses coverage under a ***health insurance benefit plan*** or other health plan; or,

2. Gains a ***dependent*** through marriage, birth, legal guardianship, adoption or placement for adoption.

Specialist

A ***physician specialist*** focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-***physician specialist*** is a ***provider*** who has more training in a specific area of health care.

Subscriber

An ***eligible employee*** who is enrolled in a ***health plan*** issued by ***Quartz*** to his/her employer under a ***Group Master Policy Agreement***.

Telehealth

A remote scheduled appointment with ***your*** usual ***provider*** during clinic hours using a telephone call or video chat. Unless otherwise disclosed in ***your Schedule of Benefits***, cost-sharing for a ***telehealth visit*** is the same as an in-person visit.

Third Party Examinations, Services and/or Supplies

Services and/or supplies that are provided primarily at the request of, for the protection of, or to meet the requirements of, a party other than the ***member***. These services and supplies are not considered to be ***covered services*** unless:

1. The service and/or supply is otherwise ***medically necessary***; or,
2. The service and/or supply is mandated by state or federal law.

Total Disability (or Totally Disabled)

For a ***subscriber***, this term means that, because of an ***illness*** or ***injury***, he/she is at all times unable to perform the duties of the job or occupation for which he/she is reasonably qualified for wage or profit. ***Total disability*** also means that the ***subscriber*** cannot engage in any job or occupation for wage or profit.

For a ***dependent***, ***total disability*** means a disability that prevents a person from engaging in substantially all of the usual and customary activities of a person in good health and of the same age and gender.

Quartz's medical director makes the determination as to whether or not a ***member*** is ***totally disabled***.

Urgent Care

Care for an ***illness***, ***injury*** or condition serious enough that a reasonable person would seek care right away, but not so severe as to require ***emergency room care***.

Urgent Care Services

Those services that are warranted by ***illness***, ***injury*** or symptoms where delay in the receipt of the care or treatment would jeopardize the ***member's*** health or result in a disability. These services include treatment received from health care professionals and health care facilities.

Usual, Customary and Reasonable (UCR)

The amount paid for a medical service in a geographic area based on what ***providers*** in the area usually ***charge*** for the same or similar medical service. The ***UCR*** amount sometimes is used to determine the ***allowed amount***.

Usual, Customary and Reasonable Charge

The reasonable dollar amount ***charge*** for the services and supplies provided by a health care ***provider***. The ***usual, customary and reasonable charge*** is not more than the following:

1. The ***usual charge***, which is the fee ***charged*** by the ***provider*** for a service or item to the majority of their patients;
2. The ***customary charge***, which is the fee that falls within a range of the ***usual charges*** of most ***providers*** in a geographic area that will generate a statistically credible claims distribution for the same or similar service;
3. The ***reasonable charge***, as determined by ***Quartz***, which considers the complexity of a given treatment required for a particular case;

4. An amount developed by ***Quartz*** or its vendors using current publicly-available data reflecting fees typically reimbursed to ***providers*** or facilities for the same or similar services, adjusted for geographical differences where applicable; or,
5. A ***charge*** negotiated by ***Quartz*** with an ***in-network provider***. If a ***provider*** is not an ***in-network provider***, ***Quartz*** will pay based on the ***usual, customary and reasonable*** amount as determined by ***Quartz***.

You may request the amount that ***Quartz*** has determined to be the ***usual, customary and reasonable charge*** by completing a Determination of Benefits Worksheet available at ***QuartzBenefits.com/WIMaterials*** or by contacting ***Quartz*** Customer Success. ***You*** must furnish the ***provider's*** name, address, the actual ***charge***, the appropriate procedure code and the date of service. ***You*** may also be provided an advance ***Explanation of Benefits (EOB)*** if ***your provider*** notifies ***us*** that ***you*** are scheduled to receive services, as required under federal law.

Virtual Visit

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

We/Us/Our

Quartz Health Benefit Plans Corporation d/b/a ***Quartz***, and its plan administrator. These shorthand terms may also be used to refer to subcontractors performing administrative tasks on behalf of ***Quartz***.

You/Your

A ***member*** enrolled in a ***Quartz health plan***.

ARTICLE II: OBTAINING SERVICES

As a ***member*** of ***Quartz's Preferred Provider Organization (PPO) Benefit Plan***, ***you*** are entitled to benefits that are ***covered services*** in accordance with the guidelines set forth in this ***Certificate of Coverage***. ***You*** should obtain these services from a ***network (in-network) provider*** in order to receive the highest level of coverage. Services received from ***non-network (out-of-network) providers*** will be covered at the ***out-of-network benefit level***. Preventive care, as well as treatment for ***illness*** or ***injury***, is a ***covered service*** as shown in the ***Certificate of Coverage***. This ***policy*** does not pay or reimburse ***you*** for services ***you*** administer to ***yourself***, even if ***you*** are a ***provider***. Benefits that are ***covered services*** are described in the ***Schedule of Benefits*** and this ***certificate***.

This ***Certificate of Coverage*** provides benefits that are mandated by the State of Wisconsin. Other state-mandated benefits may apply; if so, the applicable state mandate is determined by the state in which the ***subscriber*** resides. Contact ***Quartz*** Customer Success if ***you*** have questions.

If ***your plan*** includes a ***deductible***, then the ***deductible*** must be paid in full before ***Quartz*** will make any payment for ***covered services*** subject to the deductible. Once the ***deductible*** has been satisfied, any ***co-payments*** or ***co-insurance*** required may apply toward satisfaction of the ***annual out-of-pocket expense*** limit. For specific information, refer to the ***Schedule of Benefits***.

Levels of Benefits

This ***PPO*** plan offers ***you*** two benefit levels:

1. The ***in-network benefit level*** applies when ***you*** obtain ***covered services*** from ***in-network providers***. Please visit ***QuartzBenefits.com/FindADoctor*** for assistance in locating ***providers***.

2. The ***out-of-network benefit level*** applies when ***you*** use ***out-of-network providers***. When ***you*** use ***out-of-network providers***, ***Quartz*** covers the ***usual, customer and reasonable charge***, and ***you*** pay a greater share of the cost of the health care services through higher annual ***deductible*** and ***co-insurance*** amounts. ***You*** will also be responsible for amounts in excess of the ***usual, customary and reasonable charge***. The ***out-of-network benefit level*** is described more fully in the "***Out of Network***" column of the ***Schedule of Benefits***.

Prior Authorization

The ***prior authorization*** program is an important part of this ***health plan***. It allows ***us*** to review ***your*** arrangements for elective (***non***-***emergency***) outpatient procedures and ***hospital*** stays so ***we*** may determine in advance whether benefits are available. Please read this section very carefully. The procedures outlined below apply whether ***covered services*** are obtained from ***in-network providers*** or ***out-of-network providers***. As an insured under ***Quartz's*** PPO plan, ***you*** are ultimately responsible for obtaining ***prior authorization*** when it is required.

If a ***prior authorization*** is not obtained when one is required, the service will not be considered a ***covered service***. ***Prior authorization*** does not guarantee that benefits will be fully covered. Coverage is determined by the terms and conditions of this ***policy***. If ***you*** receive ***prior authorization*** for services through an ***out-of-network provider***, ***you*** may be subject to ***balance billing***.

Prior Authorization for Elective Inpatient Admissions to Hospitals and Skilled Nursing Facilities

At least three business days *before* ***you*** are admitted to a ***hospital*** or a ***skilled nursing facility*** for elective (***non***-***emergency***) care, ***you*** or ***your provider*** must call (888) 829-5687. This starts the ***prior authorization*** process. ***We*** will authorize coverage for ***your*** admission if it is ***medically necessary*** or deny coverage if it is not ***medically necessary***. As an insured under ***Quartz's*** PPO plan, ***you*** are ultimately responsible for obtaining ***prior authorization*** when it is required.

Prior Authorization for Certain Covered Services

Prior authorization may be required in order for ***you*** to receive coverage for certain ***covered services.*** A request for ***prior authorization*** must be made before ***you*** obtain the services. A list of services requiring ***prior authorization*** is available at ***QuartzBenefits.com/PPOPAList***; choose the list that matches the name of the network and logo on ***your*** ID card (Cigna PPO or PHCS/MultiPlan PPO/HealthEOS). ***You*** or ***your provider*** may also contact ***Quartz*** Customer Success for information about ***prior authorization***. As an insured under ***Quartz's*** PPO plan, ***you*** are ultimately responsible for obtaining ***prior authorization*** when it is required.

Continued Stay Authorization

We will contact the ***hospital*** or ***skilled nursing facility*** on or before ***your*** expected discharge date. If ***you*** are to remain inpatient longer than originally authorized, ***we*** will request the medical reasons for the continued stay. After reviewing these reasons, if ***we*** determine that continued stay is not ***medically necessary***, ***we*** will notify ***you***, the ***hospital*** or ***skilled nursing facility*** and the ***physician***. ***Quartz*** will not cover ***charges*** for unauthorized days.

Behavioral Health Services

For assistance in accessing ***behavioral health services***, contact Behavioral Health Care Management at (800) 683-2300.

Non-Emergency Care

Elective (***non-emergency***) health care services must be obtained in accordance with any applicable ***referral*** and ***prior authorization*** requirements. Coverage is subject to all of the terms, conditions, limitations and ***exclusions*** stated in the ***Certificate of Coverage*** and ***Schedule of Benefits***.

Benefits for elective (***non-emergency***) health care services are paid at different levels depending on the ***provider you*** use:

1. If ***you*** receive services from an ***in-network provider***, claims will be processed at the ***in-network benefit level***; and,
2. If ***you*** receive services from an ***out-of-network provider***, claims will be processed at the ***out-of-network benefit level***.

Emergency Care

You do not need ***prior authorization*** to access ***emergency services***. If ***you*** experience an ***emergency medical condition***, seek immediate care from the nearest health care ***provider***. Follow-up care will not be covered as ***emergency services***. Medical treatment that ***you*** receive on an emergency basis for an ***illness*** or ***injury*** that is not an ***emergency medical condition*** will be covered at the appropriate benefit level, based on the ***provider*** used and ***medical necessity***.

Urgent Care

If you need ***urgent care services***, call ***your primary care provider*** for instructions if possible. Otherwise, seek treatment at the nearest urgent care facility.

If ***you*** receive ***urgent care services*** from an ***out-of-network provider***, ***you*** should notify ***Quartz*** within three business days of receiving the care or as soon as medically feasible. Contact ***Quartz*** Customer Success to provide this notice.

Special Provisions Relating to Full-Time Students on Medical Leave

If a ***dependent*** over age 26 who is a full-time student must take a ***medically necessary*** leave of absence from school due to ***illness*** or ***injury***, ***Quartz*** will continue to provide coverage for the ***dependent*** if the student, or an individual acting on their behalf, submits documentation and certification of ***medical necessity*** for the leave of absence from the ***dependent's attending physician***. The date on which the ***dependent*** ceases to be a full-time student due to the ***medically necessary*** leave of absence is the date on which continuation of coverage under this provision begins.
Quartz will continue to provide coverage to the ***dependent*** until any of the following events occurs:

- The ***dependent***, or an individual acting on their behalf, advises ***Quartz*** that the ***dependent*** does not intend to return to school full-time;
- The ***dependent*** becomes employed full-time;
- The ***dependent*** obtains other health insurance coverage;
- The ***dependent*** marries;
- Coverage of the person through whom the ***dependent*** has coverage under this ***plan*** is discontinued or not renewed; or,
- One year has elapsed since the ***dependent's*** coverage continuation began and the ***dependent*** has not returned to school on a full-time basis.

Full-time student status is defined by the school in which the student is enrolled. ***Quartz*** may require proof of attendance. Coverage begins on the day the student becomes a full-time student and ends on the day they are no longer a full-time student, or the last day of the month in which they attain the limiting age, whichever occurs sooner.

ARTICLE III: COVERED SERVICES

Members are entitled to ***covered services*** subject to the terms and conditions of the ***health plan***, as set forth in this ***Certificate of Coverage***, the ***Schedule of Benefits*** and any ***benefit riders*** attached to this ***certificate***.

Services and supplies are covered at the ***in-network benefit level*** only if they are (1) ***medically necessary***, (2) provided by or at the direction of an ***in-network provider***, and (3) provided in accordance with the guidelines set forth in the "Obtaining Services" article of this ***certificate***. ***Plan benefits*** are described in this ***Certificate of Coverage***, the ***in-network*** column of the ***Schedule of Benefits*** and any applicable ***benefit riders***. Treatment, services, and supplies that exceed any maximum benefit limit specified in this ***policy*** are not covered.

Medically necessary services and supplies that are obtained through an ***out-of-network provider*** are covered at the ***out-of-network benefit level***. ***Quartz*** provides coverage for ***out-of-network*** benefits up to the ***usual, customary and reasonable charge***. Please review the ***out-of-network*** column of the ***Schedule of Benefits*** for details on coverage.

Certain services received ***out-of-network*** require ***prior authorization*** to be eligible for coverage. See the section entitled "Out-of-Plan Services Requiring Prior Authorization" in this article. Contact ***Quartz*** Customer Success with questions.

Some or all ***covered services*** may be subject to ***co-payment, co-insurance*** and ***deductible*** amounts. For specific information, refer to the ***Schedule of Benefits***.

Important Notice

You may contact ***Quartz*** Customer Success before receiving services from an ***out-of-network provider*** to determine if a ***provider's charge*** will be within

Quartz's usual, customary and reasonable charge range. A Benefits Determination Worksheet may be completed at ***QuartzBenefits.com/WIMaterials***. If ***you*** call, ***you*** must provide ***Quartz*** with the following information:

1. The ***provider's*** estimated ***charge***;
2. The CPT code of the service(s) to be obtained;
3. The ***provider's*** name and zip code; and,
4. The anticipated date of service.

Benefits

Professional and Related Services

Professional and related services include medical, surgical and other services listed in this ***Certificate of Coverage***. Benefits are subject to (1) any ***deductible, co-payment, co-insurance*** and other limitations shown on the ***Schedule of Benefits***, and (2) all other terms and conditions outlined in this ***certificate***. Specific services require ***prior authorization***. If a ***prior authorization*** is not obtained when one is required, the service will not be considered a ***covered service***.

Ambulance Services

Quartz covers ***emergent/urgent transportation*** to the nearest ***hospital*** that can provide the required level of care when it is clear that ***emergency services*** are needed and medical care is required during transport. In non-emergent, non-urgent situations, transportation between ***hospitals*** requires ***prior authorization*** by ***Quartz***. ***Emergent/urgent transportation*** services are not covered when the ***member*** is not actually transported (e.g., if an ambulance is called but the ***member*** is transported to the ***hospital*** by a friend instead).

Anesthesia Services

General Anesthesia

Covered when connected with the medical and surgical benefits described in this ***certificate***.

Dental Anesthesia

Anesthesia services for dental care are covered under certain circumstances when rendered at a hospital or ambulatory surgery center, and may be subject to prior authorization requirements. These services are covered if any of the following applies, pursuant to s. 632.895(12), Wis. Stat.:

- The member is under the age of 5;

- The ***member*** has a chronic disability that meets all of the conditions under s. 230.04(9r)(a)2., Wis. Stat.; or,
- The ***member*** has a medical condition that requires hospitalization or general anesthesia for dental care.

Autism Spectrum Disorder

Treatment for the condition of ***Autism Spectrum Disorder***:

- Services to a ***member*** with a primary verified diagnosis of ***Autism Spectrum Disorder*** made by a ***provider*** skilled in testing and in the use of empirically validated tools specific for ***Autism Spectrum Disorder***. ***Quartz*** may require a second opinion from a ***provider*** that is mutually agreeable to the ***member*** or the ***member's*** parent and ***Quartz***. ***Quartz*** may require that the assessment include both a standardized parent interview as well as a direct structured observation of social and communicative behavior and play;
- The treatment is prescribed by a physician and provided by any of the following who are qualified to provide ***intensive-level services*** or ***post-intensive-level services***:
  - A psychiatrist;
  - A person who practices psychology;
  - A social worker who is certified or licensed to practice psychotherapy;
  - A paraprofessional working under the supervision of a ***provider*** listed under the prior three bulleted items;
  - A professional working under the supervision of a certified outpatient mental health clinic;
  - A speech-language pathologist;
  - An occupational therapist; or,

  - A behavior analyst who is licensed under s. 440.312, Wis. Stat.;
- For ***intensive-level services***, the maximum coverage provided per insured per ***benefit period*** for services:
  - Based on a treatment plan developed by a qualified ***provider*** that includes at least 20 hours per week over a six-month period of time of evidence-based behavioral intensive therapy, treatment and services;
  - The majority of services are provided to the ***member*** when the parent or legal guardian is present;
  - Does not exceed four cumulative years of ***intensive-level services***, measured from the date the ***intensive-level services*** first commenced; and,
  - Progress is assessed and documented throughout the course of treatment. Such documentation will be provided to ***Quartz*** at its request;
- For ***post-intensive-level services***, the maximum coverage provided per insured per ***benefit period*** for services:
  - Based upon a treatment plan that includes specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of ***Autism Spectrum Disorders***; and,
  - Progress is assessed and documented throughout the course of treatment. Such documentation will be provided to ***Quartz*** at its request;
- The duration required for treatment does not need to be met if it is determined by a supervising professional, in consultation with the insured's physician, that less treatment is medically appropriate;
- The ***member*** or the ***member's*** authorized representative must provide notice to ***Quartz*** if the ***member*** is unable to receive ***intensive-level services*** for an extended period of time. Such notice must indicate the reason or reasons the ***member***, the ***member's*** family or care giver are unable to comply with an ***intensive-level services*** treatment. ***Quartz*** may not deny ***intensive-level services*** to an insured for failing to maintain at least 20 hours per week of evidence-based behavioral therapy if notice is provided as specified in this section or if the ***member*** can document that the failure to

maintain at least 20 hours per week of evidence-based therapy was due to waiting for waiver program services.

Bariatric Surgery

Bariatric surgery is covered when ***Quartz's*** medical policy criteria are met and the service has been ***prior authorized***.

Recognized bariatric surgical procedures are covered, including but not limited to pre-operative and post-operative care and the services of ***physicians***, assistants and consultants that are necessary for the bariatric surgery.

Removal of excess skin resulting from weight loss is excluded from coverage, except that panniculectomy procedures may be covered following weight loss if determined to be ***medically necessary*** by ***Quartz***.

Behavioral Health and Substance Use Disorder Services

Covers ***medically necessary*** inpatient, outpatient, transitional treatment and ***emergency services*** for the treatment of psychiatric and nervous disorders and substance use disorders. A range of digital care options may also be available through ***in-network providers*** or a ***Quartz***-sponsored ***care management*** program.

Transitional treatment services are services for the treatment of mental ***illness*** and substance use disorders. These are:

- Services provided in day treatment programs certified by the appropriate credentialing body in their state;
- Services for persons with chronic mental ***illness*** provided through a community support program certified by the appropriate credentialing body in their state;
- Services provided in residential treatment programs certified by the appropriate credentialing body in their state;
- Services provided in partial hospitalization programs certified by the appropriate credentialing body in their state; and
- Services provided in intensive outpatient programs certified by the appropriate credentialing body in their state.

Transitional treatment services are subject to the same ***co-payment***, ***co-insurance***, ***deductibles*** and maximum amount limitations as ***hospital outpatient care***.

Emergency ***behavioral health services*** provided by an emergency room or crisis stabilization program certified by the appropriate credentialing body in their state are covered for persons who are experiencing a behavioral health crisis or who are in a situation likely to turn into a behavioral health crisis if emergency support is not provided.

Behavioral health (mental health) services coverage applies to nervous and mental disorders listed in the most current edition of the American Psychiatric Association Diagnostic and Statistical Manual. Coverage is excluded for relationship counseling.

Co-payments, ***co-insurance*** and ***deductibles*** may apply to ***behavioral health and substance use disorder services***. For specifics on the level of benefits and limitations for the ***contract year***, please refer to ***your Schedule of Benefits***.

For assistance in accessing ***behavioral health and substance use disorder services***, contact Behavioral Health Care Management at (800) 683-2300.

Biofeedback

With prior authorization, biofeedback is covered for the treatment of:

- Headaches;
- Spastic torticollis or spasmodic torticollis; and,
- Pediatric voiding dysfunction. Biofeedback coverage for the treatment of pediatric voiding dysfunction is limited to eight visits per lifetime.

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

Breast Reconstruction

Services include:

- Breast reconstruction to correct a functional impairment caused by a ***congenital*** condition;
- Mastectomy and reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and,
- Treatment of physical complications at all stages of the mastectomy, including lymphedema.

Chiropractic Services

Benefits are not available for care that is ***maintenance and supportive care*** or ***long-term therapy***. For specifics on the level of benefits covered, refer to the ***Schedule of Benefits***.

Clinical Trials

Definitions

Approved clinical trial means a phase I, phase II, phase III, or phase IV ***clinical trial*** that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.

Quartz:

- May not deny the qualified individual participation in an approved ***clinical trial*** with respect to the treatment of cancer or another life-threatening disease or condition;
- May not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and,
- May not discriminate against the individual on the basis of the individual's participation in the trial.

Life-threatening condition means any disease or condition from which the likelihood of death is probable, unless the course of the disease or condition is interrupted.

To be considered a ***qualifying clinical trial***, a ***clinical trial*** must be approved or funded by one or more of the following:

- Federally-funded trials:
  - The National Institutes of Health;
  - The Centers for Disease Control and Prevention;
  - The Agency for Health Care Research and Quality;
  - The Centers for Medicare & Medicaid Services;
  - Cooperative group or center of any of the entities listed above;
  - The Department of Defense;
  - The Department of Veterans Affairs;
  - The Department of Energy;
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or,
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or,
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The ***clinical trial*** must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. ***We*** may, at any time, request documentation about the trial to confirm that the ***clinical trial*** meets current standards for scientific merit and has the relevant IRB approvals.

The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a ***covered health service*** and is not otherwise excluded under the ***policy***.

Covered Benefits

Routine patient care costs incurred during participation in a ***qualifying clinical trial*** for the treatment of a ***life-threatening condition***. Benefits include the reasonable and necessary items and

services used to diagnose and treat complications arising from participation in a ***qualifying clinical trial***. Benefits are available only when the ***member*** is clinically eligible for participation in the ***clinical trial*** as defined by the researcher. Benefits are not available for preventive ***clinical trials***.

Routine patient care costs for ***clinical trials*** include:

- ***Covered health services*** for which ***benefits*** are typically provided absent a ***clinical trial***;
- ***Covered health services*** required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and,
- ***Covered health services*** needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Non-Covered Benefits

Routine costs for ***clinical trials*** do not include:

- The ***experimental or investigational service*** or item. The only exceptions to this are:
  - Certain *Category B* devices as defined by Center for Medicare and Medicaid Services;
  - Certain promising interventions for patients with terminal illnesses; and,
  - Other items and services that meet specified criteria in accordance with our medical policy guidelines;
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and,
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Diabetes Management Services

Certain diabetes management outpatient services may be covered with no cost-sharing when ***you*** are participating in a ***Quartz care management*** program and these personalized prevention plan services are received from select ***in-network*** pharmacists. Services may be provided in person or via ***telehealth***.

Diabetic Self-Management Education

A diabetic self-management education program is covered. See "If you visit a health care provider's office or clinic" on the ***Schedule of Benefits***.

Diagnostic Services

Radiology, laboratory and other diagnostic tests are covered when ordered as part of a physical examination or when authorized by ***Quartz***. Pap tests and pelvic examinations are ***covered services*** as deemed appropriate by a ***provider***, including Nurse Practitioners or Physician Assistants. Vision and hearing screenings are covered when performed to determine the need for correction. Dental x-rays are covered only when performed in conjunction with covered procedures. Services/tests for the diagnosis of infertility are covered and may be obtained ***in-network*** or ***out-of-network***.

Quartz covers blood tests to detect lead exposure.

Screening for the presence of breast cancer and examination by low-dose mammography is covered. Diagnostic mammograms are covered as ***medically necessary***.

Screening for colorectal cancer is covered for ***members*** 45 years of age or older and a ***member*** under 45 years of age at high risk for colorectal cancer.

Drugs and Biologicals

Prescription drugs are covered only when a ***Prescription Drug Benefit Rider*** has been made a part of this ***policy.*** Coverage for ***prescription***

drugs is subject to the terms and conditions of the ***benefit rider***. Coverage for ***prescription drugs*** is subject to the ***Quartz drug formulary*** available at ***QuartzBenefits.com/formulary***. Review the ***Schedule of Benefits*** for specific information on the extent of coverage for this benefit.

Disposable diabetic supplies include needles, syringes, alcohol swabs, lancets, lancing devices and blood and urine test strips. Disposable diabetic supplies, ***prescription drugs*** and insulin are covered and are subject to ***Quartz's drug formulary***. Certain covered continuous glucose monitors available from a pharmacy are also subject to ***Quartz's drug formulary. You*** can view the most current ***drug formulary*** by visiting ***QuartzBenefits.com***.

If a ***Prescription Drug Benefit Rider*** is part of this ***plan***, diabetic testing reagents, supplies, certain continuous glucose monitors, ***prescription drugs*** and insulin are covered subject to the terms and conditions of the ***Prescription Drug Benefit Rider***. If the ***Prescription Drug Benefit Rider*** is not part of this ***plan***, these items are covered as ***durable medical equipment*** (***DME***) on the ***Schedule of Benefits***.

Orally administered ***chemotherapy*** drugs are covered and are subject to ***Quartz's drug formulary***. If a ***Prescription Drug Benefit Rider*** is part of this ***plan***, orally administered ***chemotherapy*** drugs are covered subject to the terms and conditions of the ***Prescription Drug Benefit Rider***. If the ***Prescription Drug Benefit Rider*** is not part of this ***plan***, these items are subject to a $100 ***co-payment*** for a 30-day supply.

Anti-hemophilic factor products covered under the medical outpatient benefit must be ***prior authorized***. Anti-hemophilic factor products must be obtained and administered consistent with an approved ***prior authorization***. Coverage may be limited to ***providers*** specifically contracted by ***Quartz*** to provide anti-hemophilic factor products. To obtain the list of contracted ***providers***, please visit ***our*** website or call Customer Success.

Durable Medical Equipment (DME) and Medical Supplies
Durable Medical Equipment (DME) and medical supplies must be ***medically necessary*** to qualify for coverage.

Enteral feedings and medical foods necessary to treat genetic disorders are covered as medical supplies. Coverage is limited to:

- Ketogenic formula for bottle or enterally-fed children under the age of two with intractable seizures;
- Prescribed oral nutrition or supplementation for patients with inborn errors of metabolism or inherited metabolic disease, including maple syrup urine disease (MSUD) and phenylketonuria (PKU); and,
- Feeding through a tube to treat an anatomical or motility disorder of the gastrointestinal tract that prevents food from reaching the small bowel, disease of the small bowel that impairs absorption of an oral diet, a central nervous system/neuromuscular condition that significantly impairs the ability to safely ingest oral nutrition.

Infant formulas for conditions other than those listed above, whether provided orally or through a tube, are not covered.

The purchase or repair of ***DME*** may require ***prior authorization*** to be eligible for coverage (except for the purchase of hearing aids, which do not require ***prior authorization***). Please review the list of services and items requiring ***prior authorization*** listed on ***Quartz's*** website at ***QuartzBenefits.com/WIPAList***. If ***you*** have any questions regarding a specific item, contact ***Quartz*** Customer Success. See Article IV: Exclusions and Limitations for a listing of items that are excluded from coverage.

In comparing equipment alternatives, ***Quartz*** considers whether distinct medical advantages justify greater cost or more frequent replacement. Thus, ***we*** do not cover added costs for equipment that has no advantage over a suitable alternative other than convenience or personal preference. ***We*** also do not cover repair or replacement of equipment damaged because of negligent use or abuse. ***We*** reserve the right to determine whether to rent or purchase. If more than one piece of ***durable***

medical equipment can meet ***your*** functional needs, benefits are available only for the equipment that meets the minimum specifications for ***your*** needs. Exhaustion of an active warranty is required before ***Quartz*** will replace ***durable medical equipment*** (except for the replacement of insulin infusion pumps required by Wisconsin law).

The following items are examples of covered ***DME*** (standard models only):

- Initial acquisition of prosthetic devices including artificial limbs, face, eyes, ears and nose;
- Splints, trusses, crutches, orthopedic braces and appliances;
- Rental of mechanical equipment or the purchase of such equipment, at ***Quartz's*** option;
- Initial lens(es) following cataract surgery;
- IUDs, diaphragms and implantable contraceptives;
- Breast pumps and supplies; and,
- Other medical equipment and supplies as approved by ***Quartz***.

Durable diabetic equipment also includes glucometers, insulin infusion pumps and all supplies required for use with insulin infusion pumps, and original batteries. Coverage for insulin infusion pumps is limited to one pump in a ***benefit period*** and is subject to ***medical necessity***. Disposable diabetic supplies are covered subject to the Drugs and Biologicals section, above.

Foot orthotics that are custom-molded to the ***member's*** foot are covered. Refer to ***your Schedule of Benefits*** for details, or contact ***Quartz*** Customer Success. Orthotics are limited to one pair per benefit period.

Appliances and equipment will be replaced and covered provided that:

- The item is no longer useful or has exceeded its reasonable lifetime under normal use and is still ***medically necessary***; or,
- The ***member's*** condition has significantly changed such that the original equipment is no longer appropriate;

- The member has exhausted the warranty period on the ***DME*** item. This requirement does not apply to insulin infusion pumps pursuant to s. 632.895 (6), Wis. Stat.;
- The replacement is not a "deluxe" model or "more advanced technology" model than required; and,
- The replacement request has been ***prior authorized*** by ***Quartz***.

Supplies and equipment that are not primarily intended for medical use (e.g., air conditioners, exercise bicycles, filter vacuum cleaners) are not covered. However, certain blood pressure cuffs and connected scales may be covered when medically appropriate, as determined by ***Quartz***, including services for remote monitoring of these devices. Disposable medical supplies and equipment are not covered unless provided in conjunction with a ***home health care services*** visit.

Except for ***preventive health services***, ***DME*** and medical supplies may be subject to ***co-payment***, ***co-insurance***, ***deductibles*** and maximum amount limitations. Refer to ***your Schedule of Benefits*** for details or contact ***Quartz*** Customer Success.

Hearing aids and cochlear implants, and the cost of treatment related to hearing aids and cochlear implants, including procedures for the implantation of cochlear devices, that are prescribed by a ***physician***, or by an audiologist licensed under Ch. 459, Subch. II, Wis. Stat., in accordance with accepted professional medical or audiological standards are covered subject to the following conditions and limitations:

- The ***member*** must be certified as deaf or hearing impaired by a physician or audiologist;
- Coverage of the cost of hearing aids is limited to the cost of one hearing aid per ear per ***member*** once every three years;
- Prescription hearing aids are limited to specific models. To obtain the list of covered hearing aid models, visit ***QuartzBenefits.com/hearing-aid*** or contact ***Quartz*** Customer Success. ***Quartz*** will also cover the cost of over-the-counter hearing aids in lieu of prescribed hearing aids.

    - If the hearing aid that is recommended to ***you*** is not on the list of covered models, including over-the-counter models, coverage will be limited to $1,500 per ear every three years;
- Costs of treatment related to hearing aids such as ear molds and fittings are covered; and,
- Hearing aids are subject to the ***co-payment***, ***co-insurance***, ***deductibles*** and maximum amount limitations for ***DME***.

Bone anchored hearing aids are covered when medically indicated.

Emergency Services

Services for the treatment of accident, ***injury*** or sudden ***illness*** are covered when provided at the nearest emergency room.

Review ***your Schedule of Benefits*** to determine if a ***co-payment*** or ***co-insurance*** applies. If ***you*** are admitted for an inpatient ***hospitalization*** directly from the emergency room, the ***emergency room co-payment*** will be waived and the ***hospital services benefit*** applies.

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

Services recommended as follow-up to emergency treatment are not covered as ***emergency services***. Follow-up services must be provided by an ***in-network provider*** to be paid at the ***in-network benefit level***. Follow-up services received from an ***out-of-network provider*** will be paid at the ***out-of-network benefit level***.

Extraction and Replacement of Sound Natural Teeth Because of Accidental Injury

If ***sound natural teeth*** are damaged due to trauma to the teeth or jaw, ***Quartz*** covers repair, extraction and replacement of non-restorable natural teeth by implant, dentures or bridges, regardless of whether the individual was covered under the ***policy*** during the time of the accidental ***injury***. Treatment must begin within three months after the accident (unless extenuating circumstances exist, such as prolonged

hospitalization or the presence of fixation wires from fracture care), and will be covered for a maximum of 12 months after treatment begins. Accidents caused by chewing are not covered. Repair and replacement of a ***member's*** dental implants damaged during an accident are not covered.

Gender-Affirming (Transgender) Services

Services, procedures and surgery for the treatment of ***gender dysphoria*** may require prior authorization.

Habilitative Services

Medically necessary physical and occupational therapy, speech-language pathology, other services, and habilitative devices for people with disabilities. Vocational therapy and custodial services are not covered.

Home Health Care Services

Home health care services means care and treatment of a ***member*** under a plan of care. These services must consist of one or more of the following:

- Part-time or intermittent home nursing care by, or supervised by, a registered nurse;
- Part-time or intermittent home health aide services that are ***medically necessary*** as part of the home care plan. Services must be supervised by a registered nurse or medical social worker and consist of caring for the patient;
- Physical, respiratory, occupational and speech therapy provided by a registered therapist. (See "Therapy Services" in this section);
- Medical supplies, drugs and medications prescribed by a ***physician***, and laboratory services performed by or on behalf of a ***hospital***, if necessary under the home care plan. These supplies and services are covered to the extent that they would be covered if the ***member*** were hospitalized;
- Nutrition counseling provided or supervised by a registered or certified dietitian. Such services must be ***medically necessary*** as part of the home care plan; or,

- Evaluation of the need for and development of the home care plan. Evaluation must be provided by a registered nurse, physician extender or medical social worker, and approved or requested by the ***attending physician***.

The home care plan must be established, approved in writing and reviewed by the ***attending physician***.

Home health care services must be ***prior authorized*** by ***Quartz***. ***Home health care services*** will not be covered unless the ***attending physician*** submits a treatment plan to ***Quartz***. The treatment plan must certify all of the following:

- Hospitalization or ***confinement*** in a ***skilled nursing facility*** would otherwise be needed if ***home health care services*** were not provided;
- Necessary care and treatment are not available from the ***member's immediate family*** or other persons living with the ***member*** without causing undue hardship; and,
- The ***home health care services*** will be provided or coordinated by a state-licensed or ***Medicare***-certified home health agency or certified rehabilitation agency.

If the ***member*** was hospitalized immediately before ***home health care services*** began, then the home care plan will initially be approved by the ***physician*** who was the primary ***provider*** of care while the ***member*** was hospitalized. Up to four consecutive hours in a 24-hour period of ***home health care services*** will be considered as one ***home health care*** visit.

Hospice Care

Quartz will provide ***hospice care*** if such care is determined to be ***medically necessary*** and is ***prior authorized*** by ***Quartz***. Room and board in a ***skilled nursing facility*** are not covered for hospice.

Immunizations and Allergy Injections

Appropriate and necessary immunizations and allergy injections are covered. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved, are not subject to ***deductibles***, ***co-insurance*** and ***co-payments.*** See "Preventive Health Services" for details.

Maternity Services

Prenatal and postnatal care and treatment are covered, including support care that may be available through ***Quartz's*** contracted doula and midwifery service providers. The ***member*** is entitled to inpatient ***hospital*** services for up to 48 hours following a vaginal delivery and up to 96 hours following a cesarean section.

Nurse Practitioner and Physician Assistant Services

Services performed by nurse practitioners and physician assistants are covered when performed under the supervision and guidance of ***your provider***.

Nutritional Counseling

Nutritional counseling is covered. However, weight loss medications and services related to non-covered surgical procedures are not covered.

Oral Surgery Services

Covered oral surgery procedures are:

- Surgical removal of bony or tissue-impacted teeth;
- Removal of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth;
- Removal of apex of tooth root (apicoectomy);
- Removal of exostoses of the jaw and hard palate;
- Treatment of fractured jaw and facial bones due to an accident;
- External and internal incision and drainage of cellulitis;
- Cutting of accessory sinuses, salivary glands or ducts;
- Frenectomy;

- Vestibuloplasty (surgical modification of the gingival-mucous membrane relationship in the vestibule of the mouth); and,
- Residual root removal and root amputation.

These services also include diagnostic radiology by a dentist or oral surgeon when ordered in conjunction with a covered surgery.

The following services are excluded from coverage under the Oral Surgery benefit: (1) extraction of teeth by pulling; (2) root canal procedures; (3) filling, capping or recapping of teeth.

Mandibular and/or maxillary osteotomy are excluded.

Dental implants are excluded. However, see the limited coverage of dental implants for the replacement of sound natural teeth following an accidental ***injury***.

Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belt;
- Irrigation sleeves, bags and ostomy irrigation catheters; and,
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Preventive Health Services

Preventive health services are covered upon renewal 12 months after publication of the recommendation or guideline. ***Preventive health services*** are not subject to ***deductibles, co-insurance*** and ***co-payments***.

Primary Care Provider Services

Services provided by the ***primary care provider (PCP)*** for the treatment of ***illness*** or ***injury*** and preventive care.

Radiation Therapy and Chemotherapy
Generally accepted therapeutic methods, such as radiology, radium or radioactive isotopes.

Routine Foot Care
Procedures such as removing corns or calluses, nail trimming and other routine hygiene care of the foot.

Second Opinion
A second opinion from an ***in-network provider*** is covered at the ***in-network benefit level***. A second opinion from an ***out-of-network provider*** is covered at the ***out-of-network benefit level***.

Surgical Services
Recognized surgical procedures are covered, including, but not limited to, the following:

- Pre-operative and post-operative care and the services of assistants and consultants that are necessary for the treatment of ***illness*** and ***injury***;
- Elective sterilization procedures;
- Medically recognized procedures performed as an alternative to surgery;
- Mastectomy and reconstruction of the breast on which the mastectomy was performed and reconstruction of the other breast to produce a symmetrical appearance;
- Cataract surgery, including the placement of a standard monofocal intraocular lens implanted at the time of the surgery or as a separate subsequent surgical procedure; and,
- LINX procedure to treat gastroesophageal reflux disease (GERD).

Specialty intraocular lenses implanted at the time of cataract surgery or as a separate subsequent surgical procedure are not covered. Specialty intraocular lenses include but are not limited to toric astigmatism-correcting intraocular lenses and multifocal presbyopia-correcting intraocular lenses.

Telehealth Visits

Telehealth visits with ***in-network providers*** are covered in the same manner as in-person visits. Contact ***your provider's*** office to see if a ***telehealth visit*** is available. If so, they'll schedule a time and give ***you*** details on how and when to connect with the ***provider***.

You may also have access to additional therapy ***telehealth*** visit options for mental health and substance use disorders. Contact ***Quartz*** Customer Success for more information.

Temporomandibular Joint (TMJ) Treatment

Diagnostic procedures and surgical and non-surgical treatment for the correction of TMJ disorders. The treatment must be ***medically necessary***, and all of the following must apply:

- The condition is caused by ***congenital***, developmental or acquired deformity, disease or ***injury***;
- Under the accepted standards of the profession of the ***provider*** rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition; and,
- The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

For purposes of this section only, non-surgical treatment may include intra-oral splint and therapy devices and appliances. These items are covered as ***durable medical equipment (DME)***.

Surgical procedures for the correction of functional deformities or malocclusion of the mandible and maxillae are excluded (e.g., mandibular/maxillary osteotomy). ***Covered services*** under this section are subject to certain exclusions and limitations. Review Article IV: Exclusions and Limitations for additional information.

Therapy Services

Outpatient Physical, Occupational, Speech and Hearing Therapy

Refer to the ***Schedule of Benefits*** for specific levels of coverage.

Outpatient Therapy for the Treatment of Mental Health and Substance Use Disorders

Outpatient therapy for the treatment of mental health and substance use disorders is covered based on ***medical necessity***; no specific visit limits apply to traditional therapy services. However, ***you*** may also have access to additional therapy ***telehealth*** visit options for mental health and substance use disorders. Contact ***Quartz*** Customer Success for more information.

Cardiac Rehabilitation Therapy

Cardiac rehabilitation therapy services are covered for eligible ***members*** with a recent history of heart attack (myocardial infarct), coronary artery bypass graft (CABG), onset of stable angina pectoris, onset of decubiti angina, heart valve surgery, PTCA and cardiac transplant.

Benefits are payable only for an eligible ***member*** for one of the seven covered conditions. Refer to the Summary of Benefits and Coverage (SBC) for specific levels of coverage. Benefits are not payable for behavioral or vocational counseling and maintenance cardiac rehabilitation. Phase IV cardiac rehabilitation is not covered.

Inpatient Therapy

Benefits are payable for inpatient therapy at a medical rehabilitation center. This benefit does not refer to inpatient therapy provided for the treatment of substance use disorders (which is described under the ***Behavioral Health and Substance Use Disorder*** section). Refer to the ***Schedule of Benefits*** for specific levels of coverage.

Post Cochlear Implant Aural Therapy
Long-term therapy and ***maintenance and supportive care and/or therapy*** are not ***covered services***.

Refer to the Summary of Benefits and Coverage (SBC) for specific levels of coverage.

Acupuncture

Acupuncture services are covered only when:

- Provided for the treatment of nausea/vomiting when associated with pregnancy, ***chemotherapy***, or for the treatment of chronic pain, including migraine or tension headaches, fibromyalgia, chronic neck and back pain, knee pain due to arthritis, or myofascial pain. Acupuncture is not covered for the treatment of any other conditions; and,
- Obtained from licensed acupuncture ***providers*** or licensed ***physicians***.

Coverage is limited to 12 visits per ***benefit period***.

Transplant and Related Surgical Services

Benefits are payable for organ or tissue transplant services. The ***charges*** must be incurred during a transplant benefit period that begins with the initial transplant evaluation while a ***member*** is insured under this ***plan***. The ***charges*** must be due to an ***injury*** or ***illness*** covered by this benefit as determined by ***Quartz***. The transplant procedure must be performed at a ***hospital*** designated by ***Quartz***. This applies to all ***plan benefits*** covered under this section. All transplant services and treatments require ***prior authorization***.

"Covered transplant procedure" means any of the following human-to-human organ or tissue transplants: cornea, heart, lung, heart with lung, liver, kidney, kidney with pancreas, and bone marrow (e.g., peripheral stem and cord blood). Bone marrow transplant for the treatment of solid tumors in adults is not covered.

"Recipient" means the insured person who receives an organ or tissue transplant.

"Organ or tissue transplant services" means the following as it relates to a covered transplant procedure: (1) organ and tissue procurement (consists of removing, preserving and transporting the donated part, as well as tissue-typing for related or unrelated donors), (2) ***hospital*** room and board and medical supplies, and (3) diagnosis, treatment, surgery and follow-up care by a ***physician***, including dressings and supplies.

Donor Services

Donor services are covered only if the transplant recipient is a ***member***.

Special Exclusions and Limitations Applicable to Transplant Services

Benefits are not payable for the following:

- Services not ordered by a ***physician***;
- Services for which a ***member*** has no legal obligation to pay in the absence of insurance;
- Services for an ***injury*** or ***illness*** due to employment with an employer or self-employment that are otherwise covered by a Workers' Compensation or other occupational disease law;
- ***Custodial care***;
- Services for bone marrow transplants for the treatment of solid tumors in adults, and other transplants not indicated as covered transplant procedures;
- Services received from a facility or ***provider*** not ***prior authorized*** by ***Quartz***; and,
- Artificial organ implant procedures.

Urgent Care Services

Urgent care services for the treatment of an accident, ***injury*** or ***illness*** are covered. If ***you*** require ***urgent care services***, call ***your primary care provider*** for instructions if possible. Otherwise, seek care at the nearest urgent care facility. Follow-up treatment will not be covered as ***urgent***

care services. Follow-up treatment is subject to the same ***referral*** and ***prior authorization*** requirements as elective services.

If ***you*** receive ***urgent care services*** from an ***out-of-network provider***, ***you*** should notify ***Quartz*** within three business days of receiving the services or as soon as medically feasible. Contact ***Quartz*** Customer Success to provide this notice.

Virtual Visits

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

Vision Services

Coverage for all members:

- Routine eye care provided by a vision care specialist (ophthalmologist or optometrist) is covered, with or without refraction.
- ***Medically necessary*** Contact Lenses: Contact lenses may be determined to be ***medically necessary*** and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be ***medically necessary*** and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. An initial external lens per eye may be covered when determined ***medically necessary*** for each of the following reasons: (1) to heal from surgery, (2) due to a malformation of the eye, and (3) due to an injury to the eye. Any subsequent contact lenses after the initial lens per eye for each reason (1) – (3) will not be covered. ***Medically necessary*** contact lenses are dispensed in lieu of other eyewear.

In-network providers will obtain the necessary ***prior authorization*** for these services.

- Examples of conditions for which contact lenses may be determined to be ***medically necessary*** include but are not limited to: Keratoconus, Keratoconjunctivitis sicca (severe dry eyes), Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, and Irregular Astigmatism.

Hospital Services Benefit

Inpatient and outpatient services that are necessary for admission, diagnosis and treatment are covered. Facility ***charges*** for dental anesthesia are covered.

Inpatient Care

Hospitals and Specialty Hospitals

Benefits are for semi-private room, ward or intensive care unit and necessary and reasonable ancillary ***hospital charges***. A private room is covered if ***Quartz*** determines it is ***medically necessary.***

Licensed Skilled Nursing Facility

The ***member*** must be admitted within 24 hours of discharge from a ***hospital*** for continued treatment of the same condition. Care must be ***skilled nursing care***. The daily rate payable under this benefit will be at least the daily minimum rate established for licensed ***skilled nursing care facilities*** by the Wisconsin Department of Health Services. Coverage under this benefit applies only to ***skilled nursing care*** that is:

- Certified as ***medically necessary*** by ***Quartz***; and,
- Re-certified as ***medically necessary*** every seven days.

Coverage is for the continued treatment of the same condition for which the ***member*** was treated in the ***hospital*** before entry into the ***skilled nursing facility***. There is no coverage for care that is:

- Essentially domiciliary or ***custodial care***;
- Available to the ***member*** without ***charge***; or,
- Paid for under a governmental health care program other than ***Medicaid***.

Nervous and Mental Disorders and Substance Use Disorder Confinements

See ***Behavioral Health and Substance Use Disorder Services*** in this Article and the ***Schedule of Benefits*** for details.

Outpatient Care

Emergency Room

Emergency services are those services that are necessary to treat an ***emergency medical condition***. ***Emergency services*** include both professional and facility components. Follow-up care is not covered as an ***emergency service***.

Ambulatory Surgical Care

These are services provided in an outpatient setting. Unless specifically authorized in this ***certificate,*** services may require ***prior authorization***.

Behavioral Health (Mental Health) Services
See ***Behavioral Health and Substance Use Disorder Services*** in this Article and the ***Schedule of Benefits*** for benefit details.

Diagnostic Testing
Includes laboratory, radiology, standard allergy testing and other diagnostic tests. Standard allergy testing does not include sublingual allergy testing.

Clinic Visits
Physician services and facility services associated with immunizations and well-child care.

Out-of-Plan Services Requiring Prior Authorization

Prior authorization is required to receive coverage for certain services. Visit ***QuartzBenefits.com*** or contact ***Quartz*** Customer Success for services requiring ***prior authorization***. If a ***prior authorization*** is not obtained when one is required, the service will not be considered a ***covered service***. ***Providers*** may not be familiar with ***Quartz's prior authorization*** requirements. Therefore, when ***you*** seek services, it is ultimately ***your*** responsibility to arrange for ***prior authorization***.

At least three business days before ***you*** plan to receive the service, contact ***Quartz*** Customer Success to obtain ***prior authorization***. ***You*** will need the following information:

- ***Your member*** number;
- The name of ***your primary care physician***;
- The name of the ***provider*** who will provide the service;
- Telephone number of the ***provider***;
- Procedure to be performed;
- Date of the procedure;
- Name of the facility at which the procedure will be performed; and,
- Telephone number of the facility.

Customer Success will explain ***your*** benefits and transfer ***you*** to the appropriate representative to obtain ***prior authorization***.

You will receive written authorization or denial from ***Quartz*** regarding coverage of the requested service. An authorization will indicate all services approved for coverage and the location where services are to be received. ***Quartz*** will mail the authorization to ***you***. If there is not sufficient time to mail the authorization or denial, ***Quartz*** will call ***you*** with the information. If a denial is issued, a reason for the denial will be given along with information about ***Quartz's grievance*** process.

If a ***prior authorization*** is not obtained when one is required, the service will not be considered a ***covered service***.

ARTICLE IV: EXCLUSIONS AND LIMITATIONS

Exclusions

This ***plan*** does not provide coverage for the following:

Surgical Services

1. Procedures to correct obesity or treat the complications or co-morbidities of obesity. Treatment of complications arising from such procedures are also excluded. This ***exclusion*** does not apply to bariatric surgery services, if specifically covered in Article III: Covered Services;
2. Removal of excess skin resulting from weight loss, other than panniculectomy;
3. Plastic or cosmetic surgery, including Chemical Peel, undertaken solely to improve the ***member's*** appearance;
4. Treatment, services and supplies for cosmetic or beautifying purposes. This ***exclusion*** includes removal of keloids. However, treatment is covered:
   - When it serves to correct a functional impairment related to congenital bodily disorders or conditions; or,
   - When associated with covered ***reconstructive surgery*** due to an ***illness*** or accidental ***injury*** (including subsequent removal of a prosthetic device that was related to such ***reconstructive surgery***).

   Psychological reasons do not represent a medical/surgical necessity;
5. ***Reconstructive surgery*** (unless the purpose is to correct a functional defect);
6. Breast augmentation and any treatment for complications resulting from these procedures. This ***exclusion*** does not apply to the reconstruction of affected tissue incident to a mastectomy or for complications of mastectomy, including lymphedema;
7. Refractive eye surgery for vision correction;
8. Removal of skin tags; and,
9. Penile implants and other erection devices.

Medical Services

1. Examinations and assessments required for employment, participation in sports, licensing, education or insurance, or any third-party request, including court-ordered treatment that does not otherwise qualify for coverage. This ***exclusion*** does not apply to court-ordered mental health services pursuant to s. 609.65, Wis. Stat.;
2. Immunizations covered or requested by an employer, educational institution or other third party;
3. Expenses for the preparation and presentation of medical reports and records;
4. Weight control programs. This ***exclusion*** does not apply to services provided through ***care management*** to ***members*** who are eligible for and enrolled in a ***Quartz***-sponsored clinical or disease management program;
5. Psychological and neuropsychological testing for educational purposes;
6. ***Custodial care*** and ***maintenance and supportive care and/or therapy*** and ***long-term therapy***;
7. Sublingual (under the tongue) allergy testing and/or treatment, except coverage is provided under the ***Prescription Drug Benefit Rider*** if the medication is FDA-approved and has been designated as a ***formulary*** drug by ***Quartz's*** Pharmacy and Therapeutic Committee; and,
8. Any health care service, item or investigational drug that is the subject of a ***clinical trial***; any health care service, item or drug provided solely to satisfy data collection and analysis needs that is not used in the direct clinical management of the patient; an investigational drug or device that has not been approved for marketing by the United States Food and Drug Administration (FDA); transportation, lodging, food or other expense for the patient, family member or companion of the patient that is associated with travel to or from a facility providing the ***clinical trial***; any service, item or drug provided by the ***clinical trial*** sponsor free of ***charge*** for any patient; or any service, item or drug that is eligible for reimbursement by an entity other than ***Quartz***, including the sponsor of the ***clinical trial***.

Ambulance Services

Travel and transportation for a consultation or to receive non-emergent treatment, except for approved ambulance service. Ambulance services are not covered when the ***member*** is not actually transported by ambulance.

Therapies

1. ***Long-term therapy and maintenance and supportive care and/or therapy*** for chronic conditions. Therapies of this type include but are not limited to general exercise programs, maintenance exercise programs, physical conditioning programs, massage therapy, assistance with ***activities of daily living***, and any therapy services that ***Quartz*** determines are not ***medically necessary***;
2. Physical therapy services for athletic performance enhancement purposes;
3. Relationship counseling;
4. Vocational rehabilitation, including work-hardening programs;
5. Massage therapy;
6. Group homes and halfway houses for supportive and maintenance care; and,
7. Prolotherapy, except when ***prior authorized*** and ***medically necessary*** for the treatment of lateral epicondylosis, symptomatic knee osteoarthritis, or sacroiliac (SI) joint pain. Prolotherapy is not covered for the treatment of any other conditions.

Oral Surgery and Dental Services

All dental procedures, including but not limited to examination, care, treatment, filling, removal, restoration or replacement of teeth; oral surgery procedures related to the correction of functional deformities of the mandible or maxillae; procedures that shorten, lengthen or reposition the mandible or maxillae; procedures to correct malocclusion; dental implants; and any oral surgical procedure not listed as a benefit under Article III: Covered Services. This ***exclusion*** does not apply to covered oral surgery procedures or covered dental services required because of accidental ***injury***, or the treatment of Temporomandibular Joint Disorder (TMJ) as specified in Article III.

Transplants

1. Transplants not listed as a covered benefit under Article III: Covered Services;
2. Follow-up care related to non-covered transplant procedures;
3. Medical or other costs related to the donation of organ(s) intended for a person who is not a ***Quartz member***; and,
4. Anti-rejection and immuno-suppressive drugs for non-covered transplant procedures.

Reproductive Services

1. ***Infertility*** services which are not for treatment of ***illness*** or ***injury*** (i.e., that are for the purpose of achieving pregnancy). The diagnosis of ***infertility*** alone does not constitute an ***illness***;
2. Fertility and ***infertility*** treatments. Services related to intrauterine insemination (IUI), in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) or any other similar means of achieving pregnancy. Services that diagnose ***infertility*** are covered up to the time that treatment begins. Once treatment begins, diagnostic and evaluative services are not covered. No fertility drug, whether given in the ***physician's*** office or received from a pharmacy, is covered;
3. Reversal of voluntary sterilization procedures and related procedures;
4. ***Charges*** related to surrogate mother services when the surrogate is not a ***member***;
5. Home delivery for childbirth;
6. Contraceptive medications or devices that are available without a prescription, except when the medication or device is both FDA-approved and prescribed by a ***provider***; and,
7. Services for storage or processing of semen (sperm), donor sperm, harvesting of eggs and their cryopreservation, and surrogate mother services.

Hospital Inpatient Services

1. Personal comfort or convenience items, including but not limited to, television, telephone, housekeeping and homemaker services.

Charges for a private room will not be covered unless ***medically necessary***; and,

2. ***Hospital charges*** for services not covered under Article III of this ***policy***.

Outpatient Prescription Drugs

1. ***Prescription drugs***, unless the ***Prescription Drug Benefit Rider*** is made a part of this ***plan***. This does not exclude orally administered ***chemotherapy*** drugs, diabetic insulin and supplies as listed on ***Quartz's drug formulary***;
2. ***Prescription drugs*** prescribed for cosmetic purposes or for conditions or treatments that are not covered benefits under this ***policy*** (e.g., ***prescription drugs*** related to ***infertility*** treatment or the treatment of obesity);
3. Take-home ***prescription drugs*** and supplies that can be purchased on an outpatient basis, whether billed directly or separately by a ***hospital*** or other health care facility. This includes pharmacy supply fees and dispensing fees on medical benefit drugs dispensed for self-administration at the patient's home;
4. ***Prescription drugs*** not approved by the FDA;
5. The medication aducanumab-avwa (Aduhelm); and,
6. The clinically-administered medications eteplirsen (Exondys 51), golodirsen (Vyvondys 53), casimersen (Amondys 45), vitolarsen (Viltepso) , and delandistrogene moxeparvovec-rokl (Elevidys).

Durable Medical Equipment (DME) and Disposable Medical Supplies

1. Equipment, appliances, devices and supplies that are not prescribed to treat ***illness*** or ***injury***, including but not limited to safety equipment such as, helmets, some braces and safety seats. This ***exclusion*** does not apply to items provided to ***members*** who are eligible for and enrolled in a ***Quartz***-sponsored clinical, ***care management*** or disease management program, or when items are provided through ***care management***;
2. Automated external defibrillators (AEDs);
3. The repair or the replacement of ***durable medical equipment (DME)***, other than those items that are covered as specified in Article III. Also

excluded is the repair and replacement of ***DME*** that is covered by a homeowner's insurance policy or other similar policy;

4. Eyeglasses and contact lenses and fittings for contact lenses, except as described under the Vision Services section in Article III: Covered Services;
5. Orthopedic shoes, unless they are part of a brace. Orthopedic shoes are covered for persons with diabetes or peripheral vascular disease if the orthopedic shoes are ***prior authorized*** by ***Quartz***;
6. Repair or replacement of supplies, equipment or prostheses if lost, stolen, or if unusable or non-functioning because of misuse, abuse or neglect;
7. Optional accessories or devices primarily for the ***member's*** comfort or convenience, footwear, and orthodontic devices;
8. Elastic support stockings that are not ***medically necessary***, foot pads, bunion covers, batteries, antiseptics, tape, over-the-counter shoe inserts, supports, and elastic bandages;
9. Customization of vehicles and/or lifts for wheelchairs and/or scooters;
10. Any and all types of modifications to the ***member's*** home and items associated with such modifications (e.g., ramps, grab bars, stair lifts and chair lifts);
11. Items that are generally considered to be comfort or convenience items (e.g., personal sound amplification products (PSAPs). This exclusion does not apply to items provided to ***members*** who are eligible for and enrolled in a ***Quartz***-sponsored clinical, ***care management*** or disease management program, or when items are provided through ***care management***;
12. Alternative communication devices (e.g., electronic keyboard for a hearing impairment, computers, hand-held phones or devices); and,
13. Penile implants and other erection devices.

General

1. Any service that is not ***medically necessary***. Any service that is not required in accordance with accepted standards of medical, surgical or psychiatric practice. ***Hospital*** stays extended for reasons other than ***medical necessity*** are not covered and become the ***member's*** responsibility for payment. For example, inclement weather, lack of

transportation, lack of a caregiver at home and other social reasons do not justify coverage for an extended ***hospital*** stay;

2. Services obtained which require ***prior authorization***, in which the member did not receive ***prior authorization***, are not covered. Any treatment, services, and supplies in excess of what is ***prior authorized***;
3. Treatment, services and supplies that exceed any maximum benefit limit specified in this policy;
4. Any service for which the ***member*** refuses to authorize or provide for the release of medical information, including names of all ***physicians*** and ***providers*** from whom ***you*** received medical attention, and information regarding the circumstances of ***your injury***;
5. ***Experimental or investigative*** treatment, services, devices and supplies;
6. Nutritional supplements and special feedings, other than covered enteral feedings and meal services that are part of a ***home health care*** program;
7. Grocery products or prepared meals, unless provided to ***members*** who are eligible for and enrolled in a ***Quartz***-sponsored clinical, ***care management*** or disease management program, or when provided through ***care management*** following an inpatient or skilled nursing facility stay;
8. Over-the-counter infant formulas (e.g., Similac, Nutramigen, Enfamil), medical food products prescribed without a diagnosis requiring such foods, organic medical food products and pre-packaged blenderized foods (e.g., Nourish, Liquid Hope);
9. Medical food and commercially available food products used for the treatment of any of the following: food allergies, multiple protein intolerances, lactose intolerances, celiac disease, milk allergies, sensitivities to intact protein, protein or fat maldigestion, or intolerances to soy formulas or protein hydrolysates;
10. Services rendered by a masseuse or massage therapist;
11. Hypnotherapy;
12. Orthoptics (eye exercise-training programs);
13. Private duty nursing;
14. Platelet-rich plasma;

15. Robotic-assisted surgeries;
16. ***Custodial***, domiciliary or convalescent care that does not require skilled care;
17. Coma stimulation programs;
18. Hypnotherapy, acupuncture and laser treatment for smoking cessation;
19. Services that ***Quartz*** has no legal obligation to cover, such as services provided by free clinics and government programs;
20. ***Charges*** for services or items that the ***member*** has no legal obligation to pay;
21. Services available under a federal, state, county, municipal or other governmental agency or law now existing, or subsequently enacted or amended, such as Veterans Administration programs covering service-connected disabilities or conditions; services available under "No-Fault" automobile insurance; services related to any ***illness*** or ***injury*** covered by a Workers' Compensation Act or employer liability law. However, ***Quartz*** coordinates benefits with ***Medicare*** as allowed under state and federal law. For situations involving occupational injury or hazard, also see the Workers' Compensation section under Article IX: General Provisions;
22. Health and benefit expenses incurred before coverage under this ***policy*** begins and after coverage or eligibility terminates;
23. Any federal, state or local taxes due on benefits, goods or services; shipping and handling charges;
24. Services required while incarcerated in a federal, state or local penal institution, or services required while in custody of federal, state or local law enforcement authorities, including criminal competency evaluations;
25. Residential treatment as a substitute for legal actions or to provide respite for the family;
26. Recreational or non-skilled services or activities conducted through wilderness and camp programs, therapeutic boarding schools and academy-vocational programs;
27. Any condition, disability or ***charge*** resulting from or sustained as a result of being engaged in an illegal occupation or the commission or attempted commission of an assault or a criminal act;

28. Services provided to or received by a ***member*** as a collateral medical procedure in connection with the treatment of any person who is not a ***member***;
29. Services, care or treatment for medical complications resulting from or associated with non-covered services;
30. Any treatment or service rendered by a person residing in ***your*** home or rendered by a member of ***your immediate family*** or any other person related to ***you*** or a ***dependent*** in a similar fashion. However, if one of the persons described above is a licensed medical ***provider*** and you receive ***urgent*** or ***emergency services*** from that person in an ***urgent care facility*** or ***hospital***, this ***exclusion*** does not apply;
31. Treatment, services and supplies not specifically identified by ***Quartz*** as being covered;
32. Expenses related to repatriation and medical evacuation;
33. Travel expenses including but not limited to rental car services, tolls, mileage reimbursement, gas, lodging, food, and airfare;
34. ***Foreign claims*** (except for emergency care). See the "Emergency Services" section. ***Members*** should always bring their ***Quartz*** ID Card when traveling inside or outside the United States;
35. Hair removal, unless authorized by ***Quartz*** as part of covered gender-affirming care;
36. Hair transplantation;
37. Wart removal;
38. This ***policy*** does not pay or reimburse ***you*** for services ***you*** administer to ***yourself***, even if ***you*** are a ***provider***;
39. Any items offered over the counter that are not listed as covered in ***your policy*** documents; and
40. Amounts charged to a ***member*** for services that were not rendered.

Limitations

Major Disaster or Epidemic

If a major disaster or epidemic occurs, ***physicians*** and ***hospitals*** will render medical services and arrange for extended care services and ***home health***

care services as is practical according to their best medical judgment and within the limitation of available facilities and personnel. Neither ***Quartz*** nor any ***plan provider*** shall incur any liability or obligation for delay or failure to provide or arrange for medical services that the disaster or epidemic renders unavailable.

Circumstances Beyond the Control of Quartz

Covered services may be delayed or made impractical by circumstances not reasonably within ***Quartz's*** control, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, disability of a significant part of ***hospital*** or medical group personnel or similar causes. If services are delayed or made impractical, ***Quartz*** and its ***plan providers*** will use their best efforts to provide services and benefits covered under this ***policy***, but neither ***Quartz*** nor any ***plan provider*** shall incur any liability or obligation for failure to provide services or other benefits.

Treatment of Growth Retardation

Treatment of growth retardation is covered only when (1) the ***Prescription Drug Benefit Rider*** is part of this ***plan***, and (2) production of the growth hormone is absent due to pituitary gland loss or failure. With the exception of Turner Syndrome, coverage is not extended for short stature syndrome or other related growth abnormalities.

Proof of Claim

You must submit proof of ***claim*** within 90 days of the date of service. Circumstances beyond ***Your*** control might make this time limit unreasonable. If so, ***you*** must file the ***claim*** as soon as possible, and pursuant to s. 631.81, Wis. Stat., ***we*** will still process ***your claim*** if ***you*** submit it within one year after the time required under this provision.

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. In order to be reimbursed, the service(s) or product(s) ***you*** received must not be used for employment reasons, will not be used for resale, and are intended for ***your*** own personal use. If ***you*** submit

false receipts or fraudulently altered documents, ***you*** may be disenrolled by the ***plan*** and/or subject to civil or criminal penalties.

Emergency Services

You are required to notify ***Quartz*** of ***emergency services***. Contact ***Quartz*** Customer Success to provide this notice. Services provided as follow-up to emergency treatment are not covered as ***emergency services***.

Urgent Care Services

If ***you*** need ***urgent care services***, call ***your primary care provider*** for instructions if possible. Otherwise seek care at the nearest urgent care facility. If ***you*** receive ***urgent care services*** from an ***out-of-network provider***, ***you*** should notify ***Quartz*** within three business days following the date of service or as soon as medically feasible. Contact ***Quartz*** Customer Success to provide this notice.

Specialty Providers

You must use ***in-network providers*** in order for certain specialty care to be payable at the ***in-network benefit level***. All specialty services must be ***medically necessary*** and a ***covered service*** under the ***plan***.

Referrals are not necessary to access the following services: chiropractic, ***emergency care***, oral surgery, OB/GYN ***physician services***, and optometrist services. ***Quartz*** encourages ***you*** to ask ***your*** oral surgeon to submit a pre-treatment plan before services are rendered to determine whether the services are ***covered services***.

For assistance in accessing ***behavioral health and substance use disorder Services***, contact Behavioral Health Care Management at (800) 683-2300.

Out-of-Pocket Costs

Your Schedule of Benefits includes details relating to ***co-payments, co-insurance*** and ***deductibles*** which may apply to office visits, specialty visits, inpatient ***hospital*** stays, ***emergency room*** visits and urgent care facility visits. ***Your Schedule of Benefits*** identifies the amount of ***co-payment, co-insurance*** and/or ***deductible*** applicable to ***your plan***.

Other Limitations

In addition to the limitations set forth in this ***Certificate of Coverage***, see the limitations in ***your Schedule of Benefits***.

ARTICLE V: COORDINATION OF BENEFITS (COB)

If ***you*** have health care coverage through another group program or individual policy, ***Quartz*** will coordinate the payment of benefits in accordance with applicable law and as set forth in this ***COB*** provision. The purpose of this provision is to ensure that ***you*** receive the benefits to which ***you*** are entitled without providing more benefits than the total cost of care received.

Definitions

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

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

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

Claim determination period means a ***contract 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 similar provision takes effect.

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

- ***Group*** insurance or group-type coverage, whether insured or uninsured (self-insured), that includes continuous 24-hour coverage. This includes pre-payment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage; or,
- 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.

This ***plan*** means the ***group health plan*** offered by ***Quartz*** and described in this ***policy***.

Effect of Benefits

Quartz will apply these provisions when ***you*** incur ***allowable expenses***, during a ***claim determination period***, for which benefits are payable under any other ***plan***. The provisions will apply only when the sum of the ***allowable expenses*** under this ***plan*** and any other ***plan*** would, in the absence of this ***COB*** provision or any similar provision in the other ***plan***, exceed the ***allowable expenses***.

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

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

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

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

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

Order of Benefit Determination

For the purpose of the Effect of Benefits provision above, the rules establishing the order of benefit determination are as follows:

1. **Non-Dependent/Dependent**
   The benefits of a ***plan*** which covers the person on whose ***expenses*** the ***claim*** is based other than as a ***dependent*** shall be determined before the benefits of a ***plan*** which covers such person as a ***dependent***.

2. **Dependent Child/Parents Not Separated or Divorced**
   The benefits of a ***plan*** which covers the person on whose expense the ***claim*** is based as a ***dependent child*** are determined according to which parent's birth date occurs first in a calendar year, excluding the year of birth. If both parents have the same birthday, the ***plan*** that has covered a parent longer pays before the ***plan*** that has covered a parent for any shorter period of time.

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:

- When parents are separated, or divorced and the parent with custody of the ***child*** has not remarried, the benefits of a ***plan*** that covers the ***child*** as a ***dependent*** of the parent with custody of the ***child*** will be determined before the benefits of a ***plan*** that covers the ***child*** as a ***dependent*** of the parent without custody;
- If two or more ***plans*** cover a person as a ***dependent child*** of divorced or separated parents and the parent with custody of the ***child*** has remarried, benefits for the ***child*** are determined in the following order:
  - First, the ***plan*** of the parent with custody of the ***child***;
  - Then, the ***plan*** of the spouse of the parent with custody of the ***child***; and,
  - Finally, the ***plan*** of the parent not having custody of the ***child***;
- Notwithstanding the first two provisions above, 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 parent's ***plans*** have actual knowledge of those terms, benefits for the ***dependent child*** shall be determined according to rule 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 ***benefit period*** during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. **Active/Inactive Employee**
   When rules 1, 2 and 3 above do not establish an order of benefits determination, the benefits of a ***plan*** that has covered such person as a laid-off or retired ***employee*** or as the ***dependent*** of the person are

determined after the benefits of a ***plan*** that has covered such person through present employment.

5. **Continuation of Coverage**
   If a person has continuation coverage under federal or state law and is also covered under another ***plan***, the ***plan*** covering the person as an ***employee***, ***member*** or ***subscriber*** or as a ***dependent*** of an ***employee***, ***member*** or ***subscriber*** is primary and the continuation coverage is secondary.

6. **Longer/Shorter Length of Coverage**
   When the rules above do not establish an order of benefits determination, the benefits of a ***plan*** that has covered the person for the longer period of time are determined before the benefits of a ***plan*** that has covered the person for the shorter period of time.

   Whenever one ***plan*** does not contain a ***COB*** provision, that ***plan*** must pay its benefits before any other ***plan*** pays.

   When these provisions reduce the total amount of benefits otherwise payable to ***you*** under this ***plan*** during any ***claim determination period***, each benefit that would be payable in the absence of this provision is reduced proportionately and such reduced amounts are charged against any applicable benefit limit under this ***plan***.

Right to Receive and Release Necessary Information

Quartz may require certain information in order to apply and coordinate these provisions with other ***plans***. To get the needed information, ***Quartz*** may, without ***your*** consent, release or obtain from any insurance company, organization, or person information needed to implement this provision. ***You*** agree to notify ***Quartz*** of the existence of any other group coverage that ***you*** have and to furnish any information ***Quartz*** needs to apply these provisions.

COB with Medicare

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

If ***you*** are eligible for ***Medicare*** on a primary basis (***Medicare*** pays before ***Quartz***), ***you*** should enroll in and maintain coverage under both ***Medicare*** Part A and ***Medicare*** Part B. If ***you*** do not enroll and maintain that coverage when ***we*** are the secondary payer, ***we*** will pay benefits as if ***you*** were covered under both ***Medicare*** Part A and Part B. As a result, ***you*** will be responsible for the costs that ***Medicare*** would have paid, and ***You*** will incur a larger ***out-of-pocket*** cost. These additional amounts will not apply to ***your*** annual maximum ***out-of-pocket limit***.

However, ***Quartz*** will not reduce benefits that are otherwise available under the ***policy*** for kidney disease treatment solely because a ***member*** is eligible for but not enrolled in ***Medicare***.

Facility of Payment

A payment made under another ***plan*** may include an amount that should have been paid under this ***plan***. If this occurs, ***Quartz*** may pay that amount to the organization that made that payment. That amount will then be treated as if it were a benefit paid under this ***plan***. ***Quartz*** will be fully discharged from liability under this ***plan*** to the extent of any payment so made. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right to Recovery

Quartz reserves the right to recover any payment made for an ***allowable expense*** under this ***plan*** in the amount by which the payment exceeds the maximum amount ***Quartz*** is required to pay under these provisions.

This right of recovery applies to ***Quartz*** against the following:

1. Any person(s) to, for or with respect to whom, such payments were made; or,
2. Any other insurance company or organization which, according to these provisions, owes benefits due for the same ***allowable expense*** under any other ***plan***.

Quartz shall determine against whom this right of recovery will be exercised.

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.

ARTICLE VI: ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

Employee Coverage

Eligibility

See the PPO Employee Plan Eligibility Map at http://quartzbenefits.com/PPOEligibilityMap for the current information on where an ***employee*** may live and be eligible for a PPO plan. ***Quartz*** considers an ***employee's*** "residence" to be the location in which they spend at least nine months out of a 12-month period. The ***employee's*** county of residence is based on the United States Postal Service (USPS) record.

Eligibility for coverage begins on the date an ***employee*** meets all eligibility criteria specified on the ***Group Application*** and ***Group Master Policy Agreement***. Note: An individual may not be enrolled as both an eligible ***employee subscriber*** and as a ***child*** or spouse ***dependent*** under the same employer group policy.

Enrollment and Effective Date

An ***employee*** may apply for enrollment in the ***plan*** by submitting a completed ***Enrollment Application Form*** and, if necessary, an ***Employer's Certification of Group Health Plan Coverage***, or other acceptable documentation as indicated by federal law. Application must be made during an annual enrollment period or within 31 days of becoming eligible. The ***Enrollment Form*** may be obtained from the ***group's*** benefit administrator.

Quartz, at its discretion and with the mutual agreement of the employer, may allow for an ***open enrollment period*** or a ***dual choice enrollment period***.

New Entrant

A new entrant may enroll within 31 days from the date they are eligible to enroll and will be covered on the date ***Quartz*** specifies. A new entrant is an ***employee*** who becomes part of the ***group*** after the first enrollment period.

Special Enrollment

An ***employee*** that previously waived or otherwise declined coverage under the ***plan*** is entitled to enroll during a ***special enrollment period*** when the ***employee*** marries or has a new ***child*** as a result of marriage, birth, adoption or placement for adoption.

An ***employee*** entitled to enroll during a ***special enrollment period*** must submit an ***enrollment application*** to ***Quartz*** within 31 days of the date of the marriage, or within 60 days of the birth, adoption or placement for adoption. Coverage will be effective:

- With respect to a marriage, the date of marriage or the first of the month following the date of marriage; or,
- With respect to a birth, adoption or placement for adoption, on the date of birth, adoption or placement for adoption.

Special Enrollment for Loss of Other Coverage

An ***employee*** who is not enrolled, but who is eligible for coverage under the terms of the ***group plan***, or an ***employee's dependent*** who is not enrolled but who is eligible for coverage under the terms of the ***group plan***, may enroll for coverage during a ***special enrollment period*** if any of the following apply:

1. **Involuntary Loss of Other Coverage**
    - The ***employee*** or ***dependent*** was covered under another group health plan or had ***health insurance benefit plan*** coverage at the time coverage was previously offered to the ***employee*** or ***dependent***;
    - The ***employee*** or ***dependent*** stated in writing at the time ***Quartz*** coverage was previously offered that coverage under another group health plan or ***health insurance benefit plan*** was the reason for declining enrollment under this ***plan***; and,
    - The ***employee*** or ***dependent*** is currently covered under that prior group health plan or ***health insurance benefit plan*** or, under the terms of the ***group plan***, the ***employee*** or ***dependent*** requests enrollment no later than 31 days after the date on which the coverage under paragraph "1" is exhausted or terminated due to an involuntary loss of eligibility under the prior coverage. ***Members*** requesting coverage under this ***health***

plan more than 31 days after their other coverage ends should contact their employer to determine the date of the next ***open enrollment period***; or,

- The ***employee*** or ***dependent*** requests enrollment within 60 days of losing or being determined as eligible for Medicaid or a child health plan under title XXI of the Social Security Act. If ***your Enrollment Form*** is received within the 60-day period, ***your*** or ***your dependent's*** coverage will be effective on the first day of the month following receipt of the ***Enrollment Form*** by ***Quartz.***

2. **Termination of Another Employer's Group Health Plan Coverage During the Other Plan's *Open Enrollment Period***
   - The ***employee*** or ***dependent*** is currently covered under another employer's group health plan; and,
   - The ***employee*** or ***dependent*** declined to enroll under this ***group plan*** during the most recent ***open enrollment*** period due to having coverage under the other employer's group health plan; and,
   - The other group health plan's ***open enrollment period*** does not overlap with the ***open enrollment period*** for electing coverage under this ***group plan***; and,
   - The ***employee*** or ***dependent*** requests enrollment with this ***group plan*** no later than 31 days after the date on which the coverage under the other employer's group plan is voluntarily terminated during the other employer's group health plan ***open enrollment period***.

Dependent Coverage

Eligibility

Except for full-time students, ***Quartz*** considers a ***dependent's*** "residence" to be the location in which they spend at least nine months out of a 12-month period. Eligibility for coverage begins on:

1. The date the ***employee*** is eligible for coverage, if the ***employee*** has ***dependents*** who may be covered on that date; or,

2. Either the date of the ***employee's*** marriage or the first day of the month following the date of the marriage (as determined by the employer) for any ***dependent*** (spouse or stepchild) acquired through the marriage; or,
3. The date of birth of the ***employee's*** natural-born ***child***; or,
4. The date a minor ***child*** is placed in the ***employee's*** home for adoption, or the date that a court issues a final order granting adoption of the minor ***child*** to the ***employee***, whichever occurs first; or,
5. The date a court issues a final order granting legal guardianship of the minor ***child*** to the ***employee*** or the ***employee's*** covered spouse; or,
6. The date of change of status for a newly-eligible ***dependent***; or,
7. The date of birth of a ***child*** born to an ***employee's*** covered ***dependent child*** who is under the age of 18; or,
8. For full-time students, the first day they become full-time students if:
    - The ***child*** is a full-time student; and,
    - The ***child*** was under 27 years of age when they were called to federal active duty in the National Guard or in a reserve component of the U.S. Armed Forces while the ***child*** was attending, on a full-time basis, an institution of higher education, and applied to an institution of higher education as a full-time student within 12 months from the date the ***child*** has fulfilled their active duty obligation.

Except for continuation coverage, an ***employee*** may cover ***dependents*** only if the ***employee*** is covered.

Enrollment and Effective Date

Each ***dependent*** must be enrolled on an ***Enrollment Application Form*** or electronically through ***QuartzBenefits.com/WIMaterials***.

The ***effective date*** of coverage for each ***dependent*** (other than a newborn or an adopted ***child***) is determined as follows:

- If the ***Enrollment Form*** is received by ***Quartz*** *before* the ***dependent's*** eligibility date, the ***dependent*** is covered on the date they are eligible;

- If the ***Enrollment Form*** is received *after* the ***dependent's*** eligibility date, but within 31 days from the eligibility date, the ***dependent*** is covered on the date approved by ***Quartz***;
- A ***dependent's effective date*** may never be prior to the ***employee's effective date***; and,
- A new entrant may enroll within 31 days from the date they are notified of the opportunity to enroll and will be covered on the date ***Quartz*** specifies. A ***dependent*** is a new entrant:
  - If they are a ***dependent*** of an ***employee*** who becomes part of the ***group*** after the first enrollment period; or,
  - If a court orders them to be covered under the ***policy*** and if they request coverage after issuance of the court order; or,
  - If they did not enroll during an enrollment period and, at that time, were covered by a ***health insurance benefit plan***, lose that coverage, and request coverage under this ***plan*** within 31 days after the termination of the ***health insurance benefit plan*** coverage.

Newborn Effective Date of Coverage

The ***employee*** has 60 days from the date of birth of a ***child*** to apply for ***dependent*** coverage effective on the newborn's birth date. The ***employee*** may apply for ***dependent*** coverage for a newborn up to one year after the newborn's birth date if the ***employee*** pays all past ***premium*** plus interest on such ***premium*** at the rate of 5.5% per year.

Adopted Child Effective Date of Coverage

The ***employee*** has 60 days from the date a ***child*** is placed in the custody of the ***employee*** or from the date a court issues a final order granting adoption of the ***child*** by the ***employee***, whichever occurs first, to apply for ***dependent*** coverage effective on the date of eligibility.

Changes to Enrollment Form

Changes to the original ***Enrollment Form***, other than ***physician*** changes, must be made by completing a new ***Enrollment Form*** or by submitting the change electronically at ***QuartzBenefits.com/WIMaterials***.

Termination of Coverage

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

1. The ***policy*** terminates; or,
2. A service is no longer a ***covered service*** under the ***policy***, except that termination then relates only to that ***covered service***.

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

1. The ***employee's*** employment terminates or the ***employee*** no longer meets the definition of an "active" ***employee***; or,
2. The ***employee*** ceases to meet eligibility requirements or is no longer in a class of ***employees*** that is eligible for coverage under the ***policy***; or,
3. The ***member*** requests voluntary ***disenrollment***; or,
4. The ***employee*** retires, unless the employer requests retiree coverage on the ***Group Application Form*** and ***Quartz*** approves such request; or,
5. The ***dependent*** no longer qualifies as an eligible ***dependent***.

The termination date for these reasons will be at the end of the month in which the change occurs. Retroactive termination requests will be processed up to 60 days from the requested termination date.

Per HIPAA Final Rules - Nondiscrimination in Health Coverage in the Group Market at 45 C.F.R. §146.121, an ***employee*** is considered to be in "active" status if they are actively working, or not actively working but meet all of the following conditions:

- The ***employee*** retains employment rights in the industry;
- The ***employee*** has not had their employment terminated by the employer, if the employer provides the coverage, or has not had their membership in an employee organization (such as an association or union) terminated, if the employee organization provides the coverage;
- The ***employee*** is not receiving disability payments from an employer for more than six months;
- The ***employee*** is not receiving Social Security disability benefits; and,
- The ***employee*** has employment-based group health plan coverage that is not COBRA continuation coverage.

Termination of Dependents

A spouse and stepchildren will cease to be ***dependents*** on the last day of the month in which a divorce decree is granted, and coverage may be terminated, subject to continuation rights. Other children cease to be ***dependents*** at the end of the calendar month in which they reach age 26, except that:

1. **Full-time students called to active duty**: ***Dependents*** age 26 or older cease to be ***dependents*** at the end of the calendar month in which they cease to be full-time students.

   "***Full-time student***" means that the ***child*** is in regular full-time attendance in one of the following types of schools:
   - An accredited post-secondary vocational, technical or adult education school; or,
   - An accredited college or university that provides a schedule of courses or classes and whose principal activity is the provision of an education.

   Quartz may require proof of attendance. Full-time student status is defined by the institution in which the student is enrolled. Coverage begins on the first day that the ***child*** becomes a full-time student.

Student status includes any intervening vacation period if the ***child*** continues to be a full-time student.

2. **Disabled dependents**:
   Children who are currently covered under the Group Master Policy Agreement and who are or become incapable of self-support due to a physical or mental impairment, continue to be eligible after attainment of the limiting age if the child is:
   - Dependent on ***you*** for support and maintenance; and,
   - Incapable of self-sustaining employment.

   A physical or mental impairment is defined as *an impairment that substantially limits one or more of the major life activities of an individual.* Physical impairments include a physical disorder or condition, cosmetic disfigurement or anatomical loss affecting one or more of the major body systems.

   Coverage may be continued as long as ***you*** remain insured under the ***Group Master Policy Agreement*** and ***your dependent*** remains incapacitated and dependent upon ***you***. ***You*** must provide ***us*** with written proof of incapacity within 31 days after the ***dependent's*** attainment of the limiting age. Dependency proof will be verified by submitting a copy of ***your*** annual tax return that lists this child as a dependent. Annually, or at reasonable intervals during the first two years of the continued coverage, ***we*** may request that an ***in-network provider*** examine ***your dependent***. Following that two-year period, such examinations may occur on an annual basis. ***You*** must notify ***us*** immediately of a cessation of incapacity or dependency.
3. A ***dependent*** ceases to be a ***dependent*** on the date they are:
   - Insured as a ***subscriber*** in or through any other ***health plan***; or,
   - On active duty with the military service, including National Guard or reserves, other than for duty of less than 30 days.

Right to Continue Group Medical Coverage

The ***member*** may have the right to continue coverage under the ***plan*** if they cease to meet eligibility requirements. A ***member*** may elect this option if:

- They are an ***employee*** whose eligibility for ***group*** coverage terminates (the option is not available if the ***employee*** was fired for misconduct on the job); or,
- They are the former spouse of an ***employee***, and the marriage ends due to divorce or annulment while ***dependent*** coverage is in effect; or,
- They are a surviving ***dependent*** spouse or ***child*** of an ***employee*** who dies while ***dependent*** coverage is in effect.

Wisconsin continuation law applies to employer ***groups*** with fewer than 20 ***employees***. The maximum continuation period is 18 months. The employer must provide the ***member*** with written notice of continuation rights within five days after the date the ***member's*** eligibility for coverage terminates. The ***member*** has 30 days from the date of the notice to elect the continuation option and pay the ***premium*** due to the ***group***. The employer will tell the ***member*** when and how much payment is due and will send payment to ***Quartz***. The ***member*** must complete a new ***Enrollment Form*** if they are a former spouse or a surviving ***dependent*** spouse or ***child***.

Federal continuation law is governed by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA applies to ***groups*** with 20 or more ***employees.*** The maximum continuation period is 18 consecutive months from the date the ***member*** elects to continue coverage. This period of time is modified to:

- 29 months if the ***member*** (1) is disabled at the time ***group*** coverage terminates due to cessation of employment or reduction of hours, or (2) becomes disabled within the first 60 days thereafter, provided that the ***member*** has been determined to be disabled for Social Security purposes and the ***member*** provides ***Quartz*** with notice of such determination within 60 days of the determination and before the end of the 18-month continuation period;

- 36 months if a ***dependent*** loses coverage due to (1) divorce or death of the ***employee***, or (2) the ***employee*** becomes eligible for ***Medicare***, or (3) if a ***child*** of an enrolled ***employee*** no longer meets the definition of "***dependent***" under the ***policy***;
- Special COBRA rights apply to ***subscribers*** who have been terminated or experience a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. These ***subscribers*** are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended.

If ***you*** qualify for assistance under the Trade Act of 1974, contact ***your*** employer promptly after qualifying for assistance or ***you*** will lose these special COBRA rights.
The continuation coverage period is measured from the exact date continuation coverage is elected or becomes effective to the same calendar date of the succeeding months. Coverage continues until:

- The date the ***member*** is covered under another similar group medical plan; or,
- The end of the last month for which ***premium*** was paid by the ***member*** when due; or,
- If the ***member*** is the former spouse of an ***employee***, the date the ***employee*** is no longer covered by the ***group plan*** or replacement group policy.

A ***child*** born to a ***member*** or placed for adoption with a ***member*** is eligible for continuation coverage and may be enrolled in accordance with the provisions contained in the section entitled "Dependent Coverage."

Disenrollment from the Plan

"***Disenrollment***" means that a ***member's*** coverage under the ***plan*** is revoked. Coverage is contingent upon the ***subscriber's*** continued eligibility and timely payment of ***premium***. ***Quartz*** may disenroll a ***member*** only for the reasons listed below:

1. Required ***premium*** is not paid by the end of the grace period (31 days);
2. The ***member*** commits acts of physical or verbal abuse which pose a threat to ***providers*** or ***Quartz*** employees;
3. The ***member*** allows a non-member to use the ***member's identification card*** to obtain services;
4. The ***member*** has performed an act, practice or omission that constitutes fraud in applying for coverage and at least 30 days advance written notice has been provided to each ***member*** who would be affected by the disenrollment;
5. The ***member*** demands access to an ***in-network primary care provider*** but is unable to establish or maintain a satisfactory physician-patient relationship with that ***provider***. ***Disenrollment*** for this reason is permitted only if it can be demonstrated that ***Quartz***:
   - Provided the ***member*** an opportunity to select another ***in-network primary care provider***;
   - Made a reasonable effort to assist in establishing a satisfactory physician-patient relationship; and,
   - Properly communicated ***grievance*** procedures to the ***member***.

Except in the case of non-payment of ***premium***, ***Quartz*** will arrange to provide similar alternative medical coverage for a terminated ***member*** until the ***member*** finds his/her own coverage or until the next opportunity to change insurers, whichever occurs first.

Extension of Coverage Due to Total Disability

If ***Quartz*** terminates coverage under the ***policy***, and a ***member*** is ***totally disabled*** on the date of termination, ***Quartz*** will continue to provide benefits related to the disabling condition until the earliest of the following occurrences:

1. ***Total disability*** terminates;
2. The end of the 12 consecutive months immediately following the termination of coverage;
3. The ***benefit period*** specified in the ***policy*** ends;
4. The maximum benefit is paid; or,
5. Similar coverage for the condition or conditions causing the ***total disability*** is provided under another group policy.

This extended coverage does not apply to dental or uncomplicated pregnancy expenses or to a condition other than the condition or conditions causing the ***total disability***.

ARTICLE VII: COMPLAINT AND GRIEVANCE PROCEDURE

Resolving Complaints

If ***you*** have a ***complaint*** relating to any aspect of ***Quartz***, ***you*** may contact a Customer Success Representative who will assist in resolving the matter informally. If the ***complaint*** cannot be resolved to ***your*** satisfaction, ***you*** may file a ***grievance***.

Definitions

"***Adverse benefit determination***" includes any of the following:

- The determination that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is ***experimental or investigational***, and the requested service or payment for the service is therefore denied, reduced or terminated;
- Any ***rescission*** of coverage, as provided in 45 C. F. R. § 147.136(b)(2)(ii)(A) as amended, whether or not the ***rescission*** has an adverse effect on any particular benefit at that time;
- The denial of a request for a referral for out-of-network services when the insured requests health care services from a provider that does not participate in the insurer's provider network because the clinical expertise of the provider may be medically necessary for treatment of the insured's medical condition and that expertise is not available in the insurer's provider network;
- The determination that ***Quartz's*** application of non-quantitative treatment limitations is compliant with federal mental health parity law; and,
- The determination that "surprise billing" protections do not apply to an item or service ***you*** have received, including:

- Patient ***cost-sharing*** and surprise billing for ***emergency services***;
- Patient ***cost-sharing*** and surprise billing protections related to care provided by ***out-of-network providers*** at ***in-network*** facilities;
- Whether patients are in a condition to receive notice and provide ***informed consent*** to waive No Surprises Act (NSA) protections; and,
- Whether a claim for care received is coded correctly and accurately reflects the treatments received, and the associated NSA protections related to patient ***cost-sharing*** and surprise billing.

"***Coverage denial determination***" has the meaning as defined in s. 632.835(1)(ag), Wis. Stat., and includes, for individual insurance products, a policy reformation or change in premium charged based upon underwriting or claims information greater than 25% from the premium in effect during the period of contest-ability except to the extent the modification is due to the applicant's age or a rate increase applied by the insurer to all similar individual policy forms applied uniformly.

"***Grievance***" means any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, an insured including any of the following:

- Provision of services;
- Determination to reform or ***rescind*** a ***policy***;
- Determination of a diagnosis or level of service required for evidence-based treatment of ***autism spectrum disorders***; and,
- Claims practices.

"***Reconsideration Committee***" means ***Quartz's*** grievance panel for the investigation of each written grievance.

Filing Grievances

1. Submit the signed ***grievance*** and any supporting materials to the Reconsideration Committee at the following address, unless otherwise directed in a determination letter:

   Quartz
   Attn: Reconsideration Committee
   2650 Novation Pkwy.
   Fitchburg, WI 53713

   Or, ***you*** may email ***your*** grievance to AppealsSpecialists@QuartzBenefits.com or fax it to (608) 644-3500.

   Quartz will acknowledge receipt of the ***grievance*** within five business days of receiving it.

2. ***Quartz*** will notify ***you*** of the time and place of the Reconsideration Committee meeting at least seven calendar days in advance. ***You***, or a person acting on ***your*** behalf, have the right to appear before the Reconsideration Committee in person or by telephone to present written or oral information concerning the ***grievance***. ***You*** may also submit written questions to the persons responsible for making the determination that resulted in the denial or determination of benefits or a decision to disenroll ***you***.

3. ***Quartz*** will notify ***you*** of the disposition of the ***grievance*** within 30 calendar days of receipt. If ***we*** are not able to resolve the ***grievance*** within 30 calendar days, the time period may be extended an additional 30 calendar days. If an extension is required, ***we*** will notify ***you*** in writing:
   - Of the reasons for extension; and,
   - When resolution may be expected.

4. The time periods set forth in paragraphs 1 through 3 do not apply in urgent situations. If a ***grievance*** involves an urgent situation, ***Quartz*** will treat it as an ***expedited grievance*** and will resolve it within 72 hours after receipt. An urgent situation is one which could result in serious or irreparable harm to ***your*** health if the time periods provided by the regular ***grievance*** procedure applied. ***You*** may request an ***expedited grievance*** by calling ***us*** at (608)644-3416 or Toll Free (866)569-3426, emailing ***your*** request to AppealsSpecialists@QuartzBenefits.com, or faxing it to (608) 644-3500.

5. ***You*** may review ***Quartz's*** claim file without charge. Any new or additional evidence or rational considered, relied upon or generated by ***Quartz*** in connection with the claim after the internal ***adverse benefit determination*** will be provided to ***you*** at least three calendar days in advance of the Reconsideration Committee Meeting.

Filing Complaints with the Office of the Commissioner of Insurance

You may resolve a problem by taking the steps outlined above or by filing a ***complaint*** with the Wisconsin Office of the Commissioner of Insurance (OCI). OCI is a state agency that enforces Wisconsin's insurance laws.

You can file a complaint electronically with OCI at its website at http://oci.wi.gov/, or by writing to:

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

or ***you*** can call (800) 236-8517 outside of Madison or 266-0103 in Madison, and request a complaint form.

External Review (Independent Review)

You or ***your*** authorized representative may also begin an external review at the same time as the internal appeals process if it is an urgent situation or ***you*** are in an ongoing course of treatment. If ***you*** wish to pursue ***external review***, ***you*** or ***your*** authorized representative must notify ***us*** in writing at the following address, unless otherwise directed in a determination letter:

Quartz
Attn: Appeals Specialists
2650 Novation Pkwy.
Fitchburg, WI 53713

We will send ***your*** information to an accredited ***independent review organization (IRO)*** on a rotating basis. Neither ***you*** nor ***Quartz*** will select the ***IRO***.

1. ***You*** may appeal to an ***external review*** if:
   - The determination of the ***Reconsideration Committee*** is an ***adverse benefit determination***;
   - The determination of the ***Reconsideration Committee*** is a preexisting condition exclusion denial determination or a ***rescission*** of a ***certificate***; or,
   - The determination was made that the requested treatment was ***experimental or investigative***.

2. ***You*** must request ***external review***:
   - Within four months of the date that ***we*** denied the ***grievance***; or,
   - Within four months of ***your*** receipt of ***our*** denial letter, whichever is later. It will be assumed that ***you*** received ***our*** denial letter within three days of the postmark date unless ***you*** can establish receipt on a different date.

3. **Period of External Review**
   Quartz will forward ***your*** request for ***external review*** to the selected ***IRO*** if, after preliminary review, it is determined to be eligible. The ***IRO*** will have five days to review this material and request additional information. Any additional information provided by ***you*** or ***Quartz*** shall also be provided to the other party to the review within one business day of receipt by the ***IRO***. ***We*** will respond to any requests for additional information within five days or provide an explanation as to why more time is needed.

   The ***external review*** process shall not exceed 45 days from the date the request for independent review is received by the insurer in compliance with 45 C. F. R. § 147.136(c)(2)(xii), as amended.

4. **Bypassing Quartz's Internal Grievance Process**
   There are certain circumstances when ***you*** may be able to skip ***Quartz's*** internal ***grievance*** process and proceed directly to ***external review***. Those circumstances are as follows:
   - ***We*** agree to proceed directly to ***external review***; or,
   - ***We*** did not comply with the requirements of ***our*** internal appeals process, except for failures that do not cause prejudice or harm to ***you***; or,
   - ***Your*** situation requires ***expedited review***.

5. **Expedited External Review**
   If ***your*** situation requires ***expedited review***:
   - The ***IRO*** will review this material and request additional information. Any additional information provided by ***you*** or ***Quartz*** shall also be provided to the other party to the review within one business day;
   - Once the ***IRO*** has all the necessary information, it will make a decision as expeditiously as the ***member's*** health condition requires. This will not exceed 72 after receipt of the request for ***expedited review***;
   - If the ***external review*** decision is not in writing, the ***IRO*** must provide written confirmation of its decision within 48 hours after

the date of the notice of the decision. For individuals in urgent care situations who are also in an ongoing course of treatment for that condition, this ***external review*** decision will be provided in 24 hours;

- Once the External Reviewer makes a final coverage determination, the final coverage determination is binding upon ***Quartz*** and the ***member*** except to the extent other remedies are available under state or federal law; and,
- ***Your*** request for ***expedited review*** can be initiated by calling the toll-free number (888) 866-6205.

External Review - Formulary Exceptions

Quartz provides a process for ***you*** or ***your provider*** to request coverage of a non-formulary drug on an exception basis. If ***you*** or ***your*** prescribing ***provider*** submitted a non-formulary exception request and it was denied, ***you*** may request that ***our*** decision be reviewed by an ***independent review organization (IRO)***. The request for an external review of ***our*** decision must be submitted within four months of the date ***you*** received a denied formulary exception request. To make this request, please contact the Appeals Specialists using any of the methods listed below:

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

The timeline for this external review will vary based on the urgency of ***your*** situation.

You or ***your*** prescribing ***provider*** could also request an appeal of ***our*** decision to deny ***your*** formulary exception request. This request must be submitted within 180 days of the date ***you*** received a denied formulary exception request.

Standard Non-Formulary Exception

If ***your*** initial request for a non-formulary drug was not urgent, the request for external review of the denial will follow the standard non-formulary exception request timeline. ***We*** will notify ***you*** or ***your*** authorized representative and the prescribing ***provider*** of the ***IRO's*** decision no later than 72 hours after ***we*** receive ***your*** request. If the ***IRO*** approves ***your*** request for coverage of the non-formulary drug, ***we*** will cover the drug until ***your*** prescription expires, including refills.

Expedited Non-Formulary Exception

If ***your*** initial request for a non-formulary drug was handled as an urgent or exigent request, the request for external review of the denial will follow the expedited non-formulary exception request timeline. Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

We will notify ***you*** or ***your*** authorized representative and the prescribing ***provider*** of the ***IRO's*** decision no later than 24 hours after ***we*** receive ***your*** request. If the ***IRO*** approves ***your*** request for coverage of the non-formulary drug, ***we*** will cover the drug for the duration of the exigency.

ARTICLE VIII: CONSENT TO RELEASE INFORMATION

If ***Quartz*** requests, ***you*** must authorize any person or institution that has examined or treated ***you*** to furnish to ***Quartz*** any and all information and records or copies of records relating to the examination or treatment provided to ***you*** if related to ***claims*** payment. ***Quartz*** agrees that such information and records will be considered confidential to the extent required by law. ***Quartz*** has the right to submit any and all records concerning health care services provided to ***you*** to appropriate medical review personnel. The cost of obtaining medical records is ***your*** responsibility.

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

ARTICLE IX: GENERAL PROVISIONS

Advance Directives

If ***you*** are over age 18 and of sound mind, ***you*** may execute a living will or durable power of attorney for health care. These documents tell others what ***your*** wishes are if ***you*** are physically or mentally unable to express ***your*** wishes in the future. If ***you*** have an advance directive, give a copy to ***your primary care provider***. ***You*** do not need to send the forms to ***Quartz***.

Care Management

Care Management is a collaborative process that assesses ***member*** needs, establishes goals and care plans, helps to coordinate care, and connects ***members*** to resources with the aim of improving ***member*** health and well-living. ***Quartz*** offers ***care management*** to ***members*** of this ***plan*** at no additional cost. These services are provided by a staff of health care professionals, including registered nurses, certified social workers, and health coaches, or by other organizations contracted with ***Quartz***. Examples of these services are clinical programs that address hypertension/blood pressure (Quartz InControl), diabetes, mental resiliency, and prenatal care coordination. If ***you*** feel that ***you*** would benefit from ***care management***, ***you*** can fill out a request form at ***QuartzBenefits.com*** or call Customer Success. Someone from the Care Management Team will reach out to ***you***. As part of ***care management***, ***Quartz*** reserves the right to direct treatment to the most appropriate and cost-effective option available.

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

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

Conformity with Statutes

Any provision which, on the ***policy effective date***, is in conflict with federal or Wisconsin law is amended to conform to the minimum requirements of those laws.

Continuity of Care

Quartz will provide coverage to a ***member*** for the services of a ***provider***, regardless of whether the ***provider*** is an ***in-network provider*** at the time the services are rendered, if ***Quartz*** represented the ***provider*** as an ***in-network provider*** in marketing materials made available to the ***member*** for the current ***contract year*** and if the following conditions apply:

1. If a ***primary care provider*** leaves ***Quartz's provider network***, ***you*** may continue seeing that ***physician*** through the end of the ***plan's contract year***, regardless of whether the terminated ***provider*** is ***your*** chosen ***primary care provider***;
2. If ***you*** are seeing a specialist who leaves ***Quartz's provider network***, ***you*** may continue seeing the specialist:
   - If ***you*** are pregnant and in ***your*** second or third trimester, through the postpartum period; or,
   - For 90 days past the ***physician's*** termination date with ***Quartz*** or through the end of the course of treatment, whichever is shorter.

You may also have additional rights under federal law. If ***you*** are a *continuing care patient* under the care of an ***in-network provider*** who stops participating in the ***Quartz provider network***, ***you*** may continue receiving ***covered services*** with that ***provider*** at the ***in-network benefit level***, for a period of 90 days following the date ***Quartz*** sent notice of the ***provider's***

termination or the date on which the ***member*** is no longer a *continuing care patient* with respect to the ***provider***, whichever comes first.

A *continuing care patient* means a ***member*** who:

2. Is undergoing a course of treatment for a serious and complex condition;
3. Is undergoing a course of institutional or inpatient care;
4. Is scheduled to undergo nonelective surgery from the ***provider***, including receipt of postoperative care;
5. Is pregnant and is undergoing a course of treatment for pregnancy; or,
6. Is or was determined to be terminally ill, with a life expectance of six months or less.

These continuity of care provisions do not apply if the ***physician*** is terminated from ***Quartz's provider network*** for misconduct.

Filing Claims from Out-of-Plan Providers

If ***you*** pay for services from an ***out-of-network provider***, 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 s. 631.81, Wis. Stat., ***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 at ***QuartzBenefits.com/WIMaterials***.

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. In order to be reimbursed, the service(s) or product(s) ***you*** received must not be used for employment reasons, will not be used for resale, and are intended for ***your*** own personal use. If ***you*** submit

false receipts or fraudulently altered documents, ***you*** may be disenrolled by the ***plan*** and/or subject to civil or criminal penalties.

In-network providers will submit ***claims*** on ***your*** behalf.

Legal Action

You may not start legal action against ***Quartz*** until the earlier of:

- 60 days after ***you*** file notice of a claim and complete the ***grievance*** process; or,
- The date ***Quartz*** denies the claim and ***you*** complete the ***grievance*** process.

Despite the above provisions, ***you*** may opt to start legal action under ERISA Sec. 502(a) before completing the ***complaint*** or ***grievance*** process. If ***you*** do so, a court may dismiss ***your*** lawsuit because ***you*** failed to complete the ***complaint*** or ***grievance*** process.

You may not start legal action against ***Quartz*** more than three years from the time written proof of loss was required to be filed. ***You*** must file written proof of loss within 90 days of the date of service. This means that any legal action must be started within 39 months of the first date of service on which the action is based.

Physical Examination

Quartz, at its own expense, has the right and opportunity to examine any ***member*** when and as often as may be reasonably necessary to determine their eligibility for claimed services or benefits under this ***plan***, including, without limitation, issues relating to subrogation and ***COB***. By executing an application for coverage under the ***plan***, each ***member*** is deemed to have waived any legal right they may have to refuse consent to such examination when performed or conducted for the purposes set forth above.

Physician and Hospital Reports

Physicians and ***hospitals*** must give ***Quartz*** reports to help ***us*** determine ***plan benefits*** due to ***you***. ***You*** agree to cooperate with ***Quartz*** to either execute releases that authorize ***physicians***, ***hospitals*** and other ***providers*** or, to release all records to ***Quartz*** that relate to services ***you*** receive. This is also a condition of ***Quartz*** paying benefits. All information must be furnished to the extent ***Quartz*** deems necessary in a particular situation and as allowed by pertinent statutes.

Proof of Coverage

It is ***your*** responsibility to show ***your Quartz identification card*** each time ***you*** receive ***covered services*** from a ***provider***.

Right to Collect Needed Information

You must cooperate with ***Quartz*** and, when asked, must assist ***Quartz*** by:

- Authorizing the release of medical information, including the names of all ***physicians*** and ***providers*** from whom ***you*** received medical attention;
- Providing information regarding the circumstances of ***your injury*** or ***illness***; and,
- Providing information about other insurance coverage and benefits.

Your failure to assist ***us*** may result in the denial of claims.

Services Covered by Liability Insurance

Quartz will not refuse to cover health care services that ***you*** receive for which there is coverage under the ***plan*** on the basis that there may be coverage for the services under a liability insurance policy.

Sharing Information

You agree to permit ***Quartz***, ***physicians***, ***providers*** and reviewers to share information about ***your*** care to promote the orderly delivery of care. Sharing information also promotes ***Quartz's*** quality assurance and cost control programs. When sharing information with others, ***Quartz*** agrees to preserve ***confidential matters*** in accordance with state and federal law.

Subrogation and Reimbursement

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***, ***co-insurance***, ***co-payments***, 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.

Time Limit on Certain Defenses

If the ***health questionnaire*** or an ***employer's Certification of Group Health Plan Coverage*** is required for enrollment in this ***plan***, ***Quartz*** may investigate information provided by the ***member*** in applying for coverage for two years after the original ***effective date*** of coverage. After this two-year period expires, no misstatements may be used to void coverage or to deny a ***claim*** that arises after the two-year period expires.

This time limit does not apply to fraudulent misstatements made in the application for coverage under this ***plan***. This ***plan*** was issued on the basis that the statements, representations and warranties made at application are correct and complete. ***Quartz*** may ***rescind*** coverage if information is received that indicates a fraudulent or intentional misrepresentation was made by ***you*** or anyone acting on ***your*** behalf, if ***you*** or the person acting on ***your*** behalf knew that the representation was false and the misrepresentation (1) was material or was made with intent to deceive, or (2) contributed to a loss under the ***plan***.

Travel Distances

Quartz has established criteria to ensure that ***members*** do not have to travel excessive distances to obtain health care services. Please contact ***Quartz*** Customer Success with questions regarding these criteria.

Wellness Programs

Quartz may provide a wellness program to ***members*** which may include health management and fitness. Terms and conditions may apply. Participation in ***Quartz's*** wellness program(s) is voluntary. No ***co-payment*** or ***co-insurance*** is required to join ***Quartz's*** wellness program(s). From time to time, ***Quartz*** may offer incentives to encourage ***you*** to participate in a wellness program. The program components and incentives are not ***covered***

services and do not alter or affect ***your covered services***. ***You*** and ***your primary care provider*** can discuss whether participation is right for ***you.*** If ***you*** think ***you*** may be unable to meet a standard for an incentive offered through a wellness program, ***you*** may qualify to earn the same incentive by different means. Contact ***Quartz*** Customer Success at (800) 362-3310 and ***we*** will work with ***you*** (and, if ***you*** wish, ***your*** doctor) to find an alternative with the same incentive that is right for ***you*** in light of ***your*** health status.

Workers' Compensation

A. When the Member Sustains a Work-Related Injury or Illness unrelated to the Group Policyholder of this Health Plan

Benefits for treatment, services, and supplies are excluded under this ***health plan*** when:

1. A ***member*** sustains a work-related ***injury*** or ***illness*** that does not involve the ***group*** policyholder of this ***health plan***; and,
2. The ***member*** is eligible to receive Workers' Compensation for an ***injury*** or ***illness*** sustained in the course of an occupation or employment.

This exclusion applies to any ***injury*** or ***illness*** arising out of, or in the course of, any activity for pay, profit, or gain. This exclusion applies regardless of whether benefits under Workers' Compensation or Occupational Disease laws have been claimed, paid, waived or compromised.

B. The Member Sustains a Work-Related Injury or Illness Allegedly Related to the Group Policyholder of this Health Plan.

Beneficiary in this section means a person who may be eligible for compensation under a ***group*** policyholder's Workers' Compensation policy.

For purposes of this Workers' Compensation section, each employer that is part of an association health plan is treated the same as a ***group*** policyholder.

1. **When the Member is a Beneficiary under the Group's Workers' Compensation Policy**
   When the ***group*** policyholder has Workers' Compensation coverage and the ***member*** is a beneficiary under the Workers' Compensation policy, benefits under this health plan are excluded for all treatment, services, or supplies for any ***injury*** or ***illness*** arising out of, or in the course of, any activity for pay, profit or gain. This exclusion applies regardless of whether benefits under Workers' Compensation or occupational disease laws have been claimed, paid, waived, or compromised.

2. **When the Member is <u>not</u> a Beneficiary of the Group's Workers' Compensation Policy**
   Quartz will <u>not</u> deny claims solely based on the existence of the ***group*** policyholder's Workers' Compensation policy when <u>all</u> the following statements are true:
   - A ***member*** sustains a work-related ***injury*** or ***illness*** that allegedly involves the ***group*** policyholder of this ***health plan***; and,
   - The ***group*** policyholder has Workers' Compensation coverage; and,
   - The ***member*** is <u>not</u> a beneficiary under the Workers' Compensation policy.

3. **When the Group Policyholder is under no obligation to Carry Workers' Compensation Coverage**
   Quartz will <u>not</u> deny claims on the basis that the ***group*** failed to maintain Workers' Compensation coverage if all the following statements are true:
   - The ***group*** has no Workers' Compensation coverage; and,

- The ***group*** was not required to have Workers' Compensation coverage under applicable state law at the time the injury or illness arose.

4. **Group Policyholder Fails to Carry Required Workers' Compensation Coverage**
   When the ***group*** policyholder fails to maintain Workers' Compensation coverage required by law, ***Quartz*** will not deny ***member*** claims solely on the basis that the ***group*** failed to maintain Workers' Compensation coverage. ***Quartz*** retains all rights to recover as described under the Recovery Rights provision of the Coordination of Benefits section.

The ***Group Master Policy Agreement*** is not issued in place of Workers' Compensation coverage and does not affect any requirement for an employer to carry Workers' Compensation coverage.

If this ***policy*** covers ***injury*** or ***illness*** sustained in the course of any occupation or employment, and ***we*** determine that ***you*** also received Workers' Compensation for the same incident, ***we*** will exercise the right to recover.
The recovery rights will be applied even though:

- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that the ***injury*** or ***illness*** was sustained in the course of or resulted from ***your*** employment;
- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by ***you*** or the Workers' Compensation carrier;
- The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

In the event the Workers' Compensation carrier denied a claim, ***we*** will cover the resulting charges only if ***you*** have followed the guidelines outlined in this ***Certificate of Coverage***. See Article II: Obtaining Services for guidelines ***you*** must follow.

You agree that, in consideration for the coverage provided by the ***Group Master Policy Agreement***, ***you*** will notify ***us*** of any Workers' Compensation claim made and agree to reimburse ***us*** as described above. This provision shall also apply to coverage that ***you*** may receive under any Occupational Disease Act or law.

-END-

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

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

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

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

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

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

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

- Qualified interpreters
- Information written in other languages.

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

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

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

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

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

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

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

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

Pennsylvania Dutch - LET OP: als je Nederlands spreekt, zijn er gratis taalhulpdiensten voor je beschikbaar. Passende hulpmiddelen en diensten om informatie in toegankelijke formaten te verstrekken, zijn ook gratis beschikbaar. Bel (800) 362-3310. TTY: 711 / (800) 877-8973 of spreek met je provider."
Arabic - 3310-362 (800)1 اتصل على الرقم المجانية. كما تتوفر لك خدمات المساعدة اللغوية المجانية. فستتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. تنبيه: إذا كنت تتحدث اللغة العربية، TTY: 711 / (800) 877-8973 أو تحدث إلى مقدم الخدمة".
Polish - UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer (800) 362-3310. TTY: 711 / (800) 877-8973 lub porozmawiaj ze swoim dostawcą.
French - ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le (800) 362-3310. TTY: 711 / (800) 877-8973 ou parlez à votre fournisseur.
Hindi - ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। । (800) 362-3310. TTY / TDD: 711 / (800) 877-8973 पर कॉल करें या अपने प्रदाता से बात करें।
Korean -주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. (800) 362-3310. TTY: 711 / (800) 877-8973 번으로 전화하거나 서비스 제공업체에 문의하십시오.
Albanian - VINI RE: Nëse flisni [shqip], shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi (800) 362-3310. TTY: 711 / (800) 877-8973 ose bisedoni me ofruesin tuaj të shërbimit.
Tagalog - PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa (800) 362-3310. TTY: 711 / (800) 877-8973 o makipag-usap sa iyong provider.
Somali - FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac (800) 362-3310. TTY: 711 / (800) 877-8973 ama la hadal bixiyahaaga. Gargaarsi gargaaraa fi tajaajilli sirrii ta'ee fi odeeffannoo bifa dhaqqabamaa ta'een kennuunis bilisaan ni argama.
Cushite (Oromo) - XIYYEEFFANNOO: Afaan Kushii yoo dubbattan tajaajilli gargaarsa afaanii bilisaan isiniif ni kennama. Gargaarsi gargaaraa fi tajaajilli sirrii ta'ee fi odeeffannoo bifa dhaqqabamaa ta'een kennuunis bilisaan ni argama. (800) 362-3310 bilbili. TTY: 711 / (800) 877-8973 ykn dhiyeessaa keessan waliin haasa'aa.
Amharic - ማሳሰቢያ፡- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ አጣዛኞች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር (800) 362-3310. TTY: 711 / (800) 877-8973 ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።
Karen - ဆူ- နမ့်ကတိၤ ထၢနှာ်လီၤဖဲအံၤ အဃိ, တၢ်အိဉ်ဒီး ကျိာ်တၢ်ဆိဉ်ထွဲမၤစၢၤ လၢတလာ် ဘူဉ်လာ်စ့ၤလၢနဂီၢ်လီၤ. တၢ်အိဉ်ဒီး တၢ်မၤစၢၤတၢ်နှၢ်ဟူပီးလီဒီး တၢ်မၤစၢၤတၢ်မၤ လၢအ ကြၢးအဘဉ် လၢကဟ့ဉ်တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢတၢ်မၤန့ၢ်အီၤသ့တဖဉ် လၢတလာ်ဘူဉ်လာ်စ့ၤ လၢနဂီၢ်လီၤ. ကိး (800) 362-3310. TTY: 711 / (800) 877-8973 မ့တမ့ၢ် ကတိၤတၢ်ဒီး နပှၤလၢဟ့ဉ် နၤတၢ်ကွၢ်ထွဲမၤစၢၤတကၢ့်.
Mon-Khmer, Cambodian (Khmer) - សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ ភាសាខ្មែរ សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃដងដែរ។ ហៅទូរសព្ទទៅ (800) 362-3310. TTY: 711 / (800) 877-8973 ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។
Serbo-croatian (Serbian) - ПАЖЊА: Ако говорите српскохрватски, доступне су вам бесплатне језичке услуге. Бесплатна су и одговарајућа помоћна помагала и услуге за пружање информација у приступачним форматима. Позовите (800) 362-3 ТТИ: 711 / (800) 877-8973 или разговарајте са својим провајдером.
Thai - หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ (800) 362-3310. TTY: 711 / (800) 877-8973 หรือปรึกษาผู้ให้บริการของคุณ"
Gujarati - ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે મફત ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટે યોગ્ય સહાયક સહાય અને સેવાઓ પણ મફતમાં ઉપલબ્ધ છે. કૉલ કરો (800) 362-3310. TTY: / (800) 877-8973 અથવા તમારા પ્રદાતા સાથે વાત કરો.
Urdu - توجہ: اگر آپ اردو بولتے ہیں، تو آپ کے لیے مفت زبان کی مدد کی خدمات دستیاب ہیں۔ 3310-362 (800) پر کال کریں۔ TTY: 711 / (800) 877-8973 قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ یا اپنے فراہم کنندہ سے بات کریں۔
Italian - ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'(800) 362-3310. TTY: 711 / (800) 877-8973 o parla con il tuo fornitore.
Greek - ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το (800) 362-3310. TTY: 711 / (800) 877-8973 ή απευθυνθείτε στον πάροχό σας.
Nepali - ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंलाई निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक सहायताहरू र सेवाहरू पनि निःशुल्क उपलब्ध छन्। कल (800) 362-3310। TTY: 711 / (800) 877-8973 वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।
Ukrainian - УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером (800) 362-3310. TTY: 711 / (800) 877-8973 або зверніться до свого постачальника.
Tibetan - ཉ་སྣང་।ཀཡ་ཀེ་ཞུད་རང་གིས་བོད་སྐད་ཤེས་ན་ཞུང་རང་ལ་རིན་སྐད་སྤྲད་ཡིག་རྒྱས་སྤྲོར་གྱི་ཞབས་ཏོག་ཡོད། འོས་འཚམ་གྱི་རོགས་རམ་དང་ཞབས་ཏོག་དེ་དག་གིས་གནས་སྐབས་རྒྱལ་ཁབ་ལ་དོན་ཆུང་སྤྲོད་ཐུབ་ཡིན། ཁ་པར་(८००)३८२-३३१० TTY: 711 / (800) 877-8973 ཡང་ན་ཞུང་གྱི་མཁོ་སྤྲོད་ཅིད་མཁན་ལ་སྐད་ཆ་བཤད་རོགས།
Wolof - FÀTTAL: Sooy wax Wolof, ay serwiis yu lay jàppale ci làkk wi doo fay. Ay ndimbal ak ay serwiis yu war ngir joxe leeral ci formaa yu yomb am nañu ci te doo fay. Woowal (800) 362-3310. TTY: 711 / (800) 877-8973 wala nga waxtaan ak sa joxekat.