Quartz Health Benefit Plans Corporation

www.QuartzBenefits.com

Customer Service: 800-362-3310

Quartz **2020**

A Health Maintenance Organization (High and Standard Option)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for benefits. See page 7 for details. This plan is accredited. See page 12.

Serving South Central Wisconsin.

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll.

See page 12 for requirements.

IMPORTANT

- Rates: Back Cover
- Changes for 2020: Page 15
- Summary of Benefits: Page 84

Enrollment codes for this Plan:

- **TF1 High Option - Self Only**
- **TF3 High Option - Self Plus One**
- **TF2 High Option - Self and Family**
- **TF4 Standard Option - Self Only**
- **TF6 Standard Option - Self Plus One**
- **TF5 Standard Option - Self and Family**

Special notice - This plan is being offered for the first time under the Federal Employees Health Benefits Program during the 2020 Open Season.

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-901

Important Notice from Quartz Health Benefit Plans Corporation About

Our Prescription Drug Coverage and Medicare

The Office of Personnel Management OPM has determined that the Quartz Health Benefit Plans Corporation prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE 800-633-4227, TTY: 877-486-2048.

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Introduction

This brochure describes the benefits of Quartz Health Benefit Plans Corporation, d/b/a Quartz Health Benefit Plans Corporation and Quartz under our contract (CS 2958) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 800-362-3310 or through our website at QuartzBenefits.com. The address for Quartz Health Benefit Plans Corporation's administrative offices is:

Quartz

840 Carolina Street

Sauk City, WI 53583

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2020, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2020, and changes are summarized on page. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means Quartz Health Benefit Plans Corporation.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 800-362-3310 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

This online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26.

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

Quartz Health Benefit Plans Corporation complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557, Quartz Health Benefit Plans Corporation does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own health care and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions, and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx.The Joint Commission’s Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx.The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org.The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medication.
- www.leapfroggroup.org.The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org.The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you don’t expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a health care facility.These conditions and errors are sometimes called “Never Events” or “Serious Reportable Events.”

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

FEHB Facts

Coverage information

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Minimum essential coverage (MEC)

Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

Minimum value standard

Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/healthcare-insurance for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies that participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment
- How you can cover your family members
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
- When your enrollment ends
- When the next Open Season for enrollment begins

We don’t determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For more information on your premium deductions, you must also contact your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self Plus One is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

Family member coverage

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other one eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option determined by OPM

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2020 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2019 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

When FEHB coverage ends

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment; or
- You are a family member no longer eligible for coverage.

Any person covered under the 31-day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31-day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

Upon divorce

If you are divorced from a Federal employee, or annuitant, you may not continue to get benefits under your former spouse’s enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse’s employing or retirement office to get information about your coverage choices. You can also visit OPM’s website at www.opm.gov/healthcare-insurance/healthcare/plan-information/. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Temporary Continuation of Coverage (TCC)

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse’s plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

Converting to individual coverage

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot covert);
- You decided not to receive coverage under TCC or the spouse equity law; or

- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must contact us in writing within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 800-362-3310 or visit our website at QuartzBenefits.com.

Health Insurance Marketplace

If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO). OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Quartz Health Benefit Plans Corporation holds the following accreditation: Excellent accreditation from the National Committee for Quality Assurance (NCQA). To learn more about this Plan's accreditation, please visit the following website: ncqa.org. We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory. We give you a choice of enrollment in a High Option or a Standard Option.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan’s benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General features of our High Option and Standard Options

High Option Overview

- $0 Deductible
- $20 primary care provider office copayment ($0 for children under 26 years of age)
- $40 specialist office copayment ($0 for children under 26 years of age)
- $40 urgent care copayment ($0 for children under 26 years of age)
- $100 emergency room copayment
- $250 copayment for inpatient admission
- Medical Maximum-Out-of-Pocket: $3,000 Self Only/$6,000 Self Plus One/$6,000 Self and Family
- Pharmacy: $5 copayment RX Outcomes Value Tier/$10 copayment Tier 1/$25 copayment Tier 2/$50 copayment Tier 3/ $200 copayment Specialty
- Pharmacy Maximum Out-of-Pocket: $2,350 Self-Only/$4,700 Self Plus One/$4,700 Self and Family

Standard Option Overview

- $1,000 Self Only/$2,000 Self Plus One/$2,000 Self and Family Deductible
- 20% Coinsurance after Deductible
- $30 primary care provider office copayment ($0 for children under 26 years of age)
- $60 specialist office copayment ($0 for children under 26 years of age)
- $60 urgent care copayment ($0 for children under 26 years of age)
- $100 emergency room copayment
- Medical Out-of-Pocket Maximum: $5,800 Self Only/$11,600 Self Plus One/$11,600 Self and Family
- Pharmacy: $5 copayment RX Outcomes Value Tier/$10 copayment Tier 1/$25 copayment Tier 2/$50 copayment Tier 3/ $200 copayment Specialty
- Pharmacy Out-of-Pocket Maximum: $2,350 Self Only/$4,700 Self Plus One/$4,700 Self and Family

<u>We have Open Access benefits</u>

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

Preventive care services

Preventive care services are generally covered with no cost sharing and are not subject to copayments, deductibles, or coinsurance when received from a network provider.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive care services.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayments, to no more than $6,900 for Self Only enrollment, and $13,800 for a Self Plus One or Self and Family. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed that amount.

<u>How we pay providers</u>

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

<u>Your rights and responsibilities</u>

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website www.opm.gov/healthcare-insurance/ lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Years in existence: Became Quartz Health Benefit Plans Corporation in 2019 (previously Physicians Plus Insurance Corporation and Unity Health Plans Insurance Corporation were separate entities for more than 20 years)
- Profit status: For-profit HMO

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, Quartz Health Benefit Plans Corporation at QuartzBenefits.com. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 800-362-3310, or write to Quartz Health Benefit Plans Corporation, 840 Carolina Street, Sauk City, WI 53583. You may also visit our website at QuartzBenefits.com.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website Quartz Health Benefit Plans Corporation at QuartzBenefits.com to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area is: South Central Wisconsin, which includes Adams, Buffalo, Columbia, Crawford, Dane, Dodge, Fond du Lac, Grant, Green, Green Lake, Iowa, Jackson, Jefferson, Juneau, La Crosse, Lafayette, Marquette, Monroe, Richland, Rock, Sauk, Trempealeau, Vernon, Walworth, Waukesha, and Waushara counties.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. We Are a New Plan

This Plan is new to the FEHB Program. We are being offered for the first time during the 2020 Open Season.

Section 3. How You Get Care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-362-3310 or write to us at: Quartz Health Benefit Plans Corporation, 840 Carolina Street, Sauk City, WI 53583. You may also request replacement cards online at QuartzMyChart.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims. If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to NCQA and Quartz Health Benefit Plans Corporation standards.

You can search for a provider and print a provider directory through Find a Doctor at QuartzBenefits.com.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website through Find a Doctor at QuartzBenefits.com.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care clinic. This decision is important since your primary care clinic provides or arranges for most of your health care. When you enroll, you (and your family members) must choose a primary care clinic. Each member of your family may select a different primary care clinic.

If you want to change your primary clinic or if your primary care clinic leaves the Plan, call us. We will help you select a new one.

- **Primary care**

Your primary care physician can be any of the following:

- Family Practice doctors treat people of all ages. They focus on family health problems.
- General Practice doctors treat people of all ages.
- Pediatric doctors treat children and adolescents, and generally manage their health.
- Internal Medicine doctors treat adult men and women.

Your primary care physician / clinic will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or clinics or if your primary care physician or clinic leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Quartz Health Benefit Plans Corporation does not require you to obtain a referral before seeking specialty care.

If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

If you are seeing a specialist and your specialist leaves the Plan, call your primary care clinic, who will arrange for you to see another specialist.

If you have a chronic and disabling condition and lose access to your specialist because we:

- terminate our contract with your specialist for other than cause;
- drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
- reduce our service area and you enroll in another FEHB plan;

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care clinic or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are hospitalized when your enrollment begins

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800-362-3310. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

Since your primary care clinic arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services*.

You must get prior approval for certain services. Failure to do so will result in no coverage.

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for:

- All inpatient admissions

- Surgical procedures
- Transplants
- All out-of-network provider services or supplies
- Acupuncture
- CAR T Cell therapy
- Day treatment
- Extended Cardiac Rhythm Monitoring
- Fecal Bacteriotherapy
- Intensive Outpatient program
- Non-emergent ambulance services
- Partial hospital program
- Platelet-Rich plasma injections
- Residential treatment
- Steroid releasing sinus implants
- TheraSphere / Sir-spheres treatment
- Transcranial magnetic stimulation
- Vagus Nerve stimulation
- Wireless/remote heart failure monitoring devices
- Therapies, such as biofeedback, extracorporeal shockwave therapy, hyperbaric oxygen therapy, and prolotherapy
- Bariatric surgery
- Skilled nursing care
- Transgender services for hormone therapy
- Durable medical equipment, such as airway clearance devices, bone growth stimulators, braces/splits over $500, cardiac defibrillators, continuous glucose monitors, continuous passive motion machines, CPAP/BiPAP (rental and purchase), customer shoes and foot orthotics, cystic fibrosis vests, dynamic orthotic cranioplasty bands, electric tumor treatment fields device, home monitoring devices, home phototherapy light devices for treatment of psoriasis, hospital beds and related supplies, insulin pumps, life sustaining nutritional therapies, mechanical stretching devices, patient lift equipment, prosthetics, spinal traction devices, standing frame/ stander, TENS and other e-Stim devices, walk-aid devices, wheelchairs and motorized scooters, etc.
- Wound therapy, including negative pressure therapy, non-contact normothermic wound therapy, and bioengineered skin substitutes
- Experimental and investigational treatments
- Genetic testing including pharmacogenetics testing
- Home health care including home infusion services and other in-home therapy services
- Hospice care

Prior authorization does not guarantee coverage and/or payment if you have already reached a benefit maximum or your coverage has been terminated.

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 800-362-3310 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 800-362-3310. You may also call OPM's Health Insurance 3 at (202) 606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 800-362-3310. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

Concurrent care claims

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

The Federal Flexible Spending Account Program - *FSAFEDS*

- **Health Care FSA (HCFSA)** - Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).
- FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- **Emergency inpatient admission**

You, or someone acting on your behalf, are required to notify Quartz of all Emergency Inpatient Admissions to a Non-Participating Hospital. You should notify Quartz no later than 3 business days following the day of admission or as soon thereafter as medically feasible. Contact Quartz Customer Service at 800-362-3310 to provide this notice. Participating Providers will provide this notice for you.

- **Maternity care**

Prenatal and postnatal care and treatment are covered. You are entitled to inpatient hospital services for up to 48 hours following a vaginal delivery and up to 96 hours following a cesarean section. Care received outside the Service Area during the 9th month of pregnancy will not be covered unless it is an emergency. A normal full-term delivery is not considered to be an Emergency Medical Condition.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

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. Also, if you or your Primary Care Provider believe that you need to obtain health care services from a Non-Participating Provider, you must obtain Prior Authorization from Quartz before you obtain the services. A list of services requiring Prior Authorization is available at QuartzBenefits.com/WIPAList. You may contact Quartz Customer Service or consult your Participating Primary Care Provider to obtain information about Prior Authorization.

Prior Authorization does not guarantee that benefits will be fully covered. Coverage is determined by the terms and conditions of Your Health Plan.

If you fail to provide the required notice, your benefit may be reduced by $1,000. This penalty will not apply toward Your Deductible or Out-of-Pocket limit.

If you fail to provide the required notice of a Medically Necessary inpatient admission to a Non-Participating Hospital within 3 business days, your Inpatient Hospital benefits will be reduced by $1,000. This amount will not apply toward Your Deductible or Out-of-Pocket limit.

These penalties will not reduce state-mandated benefits.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your Costs for Covered Services

This is what you will pay out-of-pocket for covered care:

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Copayment

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: With the High Option, when you see your primary care physician, you pay a copayment of $20 per office visit ($0 for children under 26 years of age); when you see a specialist you pay a copayment of $40 per office visit ($0 for children under 26 years of age); when you go in the hospital, you pay a copayment of $250 per admission.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- The High Option does not have a deductible.
- The Standard Option has a $1,000 deductible (Self Only) and a $2,000 deductible (Self Plus One and Self and Family) calendar year deductible. Under the Self Plus One and Self and Family deductible, no member is required to satisfy more than the Self Only deductible.

Note: If you change plans during Open Season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. For the Standard Option, coinsurance does not begin until you have met your calendar year deductible.

Example: You pay 50% of our allowance for infertility services and 20% of our allowance for durable medical equipment.

Deductible and Coinsurance Maximum

Includes deductible and coinsurance amounts for certain services you are required to pay when a covered service is provided. Medical copays and pharmacy expenses are not included.

Your catastrophic protection out-of-pocket maximum

High Option:

- Medical out-of-pocket maximum: $3,000 Self Only/$6,000 Self Plus One/$6,000 Self and Family
- Pharmacy out-of-pocket maximum: $2,350 Self Only/$4,700 Self Plus One/$4,700 Self and Family

Standard Option:

- Medical out-of-pocket maximum: $5,800 Self Only/$11,600 Self Plus One/$11,600 Self and Family
- Pharmacy out-of-pocket maximum: $2,350 Self Only/$4,700 Self Plus One/$4,700 Self and Family

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

High and Standard Option Benefits

See page 15 for how our benefits changed this year. Page 84 and 86 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. High and Standard Option Overview

This Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High and Standard Option benefits, contact us at 800-362-3310 or on our website at QuartzBenefits.com/FEHB.

- All UW Health, UnityPoint Health - Meriter, and Gundersen Health System providers and facilities are part of the Quartz One network, as well as many independent community clinics and hospitals.
- The Quartz Service Area includes the following counties: Adams, Buffalo, Columbia, Crawford, Dane, Dodge, Fond du Lac, Grant, Green, Green Lake, Iowa, Jackson, Jefferson, Juneau, La Crosse, Lafayette, Marquette, Monroe, Richland, Rock, Sauk, Trempealeau, Vernon, Walworth, Waukesha, and Waushara.

Each option offers unique features.

High Option Overview

- $0 Deductible
- $20 primary care provider office copayment ($0 for children under 26 years of age)
- $40 specialist office copayment ($0 for children under 26 years of age)
- $40 urgent care copayment ($0 for children under 26 years of age)
- $100 emergency room copayment
- $250 copayment for inpatient admission
- Medical Maximum-Out-of-Pocket: $3,000 Self Only/$6,000 Self Plus One/$6,000 Self and Family
- Pharmacy: $5 copayment RX Outcomes Value Tier/$10 copayment Tier 1/$25 copayment Tier 2/$50 copayment Tier 3/ $200 copayment Specialty
- Pharmacy Maximum Out-of-Pocket: $2,350 Self-Only/$4,700 Self Plus One/$4,700 Self and Family

Standard Option Overview

- $1,000 Self Only/$2,000 Self Plus One/$2,000 Self and Family Deductible
- 20% Coinsurance after Deductible
- $30 primary care provider office copayment ($0 for children under 26 years of age)
- $60 specialist office copayment ($0 for children under 26 years of age)
- $60 urgent care copayment ($0 for children under 26 years of age)
- $100 emergency room copayment
- Medical Out-of-Pocket Maximum: $5,800 Self Only/$11,600 Self Plus One/$11,600 Self and Family
- Pharmacy: $5 copayment RX Outcomes Value Tier/$10 copayment Tier 1/$25 copayment Tier 2/$50 copayment Tier 3/ $200 copayment Specialty
- Pharmacy Out-of-Pocket Maximum: $2,350 Self Only/$4,700 Self Plus One/$4,700 Self and Family

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Health Care Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- The calendar year deductible for the Standard Option is: $1,000 per person (maximum of $2,000 per Self Plus One enrollment or Self and Family enrollment). The calendar year deductible applies to some benefits in this section. There is no deductible for the High Option.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Diagnostic and treatment services	**High**	**Standard**
Professional services of physicians • In physician's office • In an urgent care center • Office medical consultations • Second surgical opinion	Adult: $20 copayment per office visit for primary care, chiropractic, optometry / ophthamology, and behavioral health; $40 copayment per office visit for most specialty and urgent care. Children (under 26 years of age): Nothing	Adult: $30 copayment per visit for primary care, chiropractic, optometry / ophthamology, and behavioral health; $60 copayment per visit for most specialty and urgent care. Children (under 26 years of age): Nothing
Professional services of physicians • During a hospital stay • In a skilled nursing facility	Nothing	20% Coinsurance after Deductible
Telehealth services	**High**	**Standard**
UW Health Care Anywhere Telehealth (video / virtual) visits for certain urgent care conditions	Adults: $10 copayment Children (under 26 years of age): Nothing	Adults: $20 copayment Children (under 26 years of age): Nothing
Lab, X-ray and other diagnostic tests	**High**	**Standard**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Electrocardiogram and EEG	Nothing	20% coinsurance after deductible

Benefit Description	You Pay	
High-tech Radiology Testing	**High**	**Standard**
Tests such as: • MRI, MRA, CT/CAT, PET scans, • Ultrasound • Nuclear Medicin scans	$50 copayment per scan	20% coinsurance after deductible
Preventive care, adult	**High**	**Standard**
Routine physical every year	Nothing	Nothing
Routine screenings, such as: • Total Blood Cholesterol • Depression • Diabetes • High blood pressure • HIV • Colorectal cancer screening annually for adults age 50 - 75, including: - Fecal occult blood test - Sigmoidoscopy - Colonoscopy - Routine Prostate Specific Antigen (PSA) test Individual counseling on prevention and reducing health risks	Nothing	Nothing
Well woman care, including but not limited to: • Cervical cancer screening (Pap smear) • Human Papillomavirus (HPV) testing for women age 30 and up once every three years • Chlamydia/gonorrhea screening • Gonorrhea prophylactic medication to protect newborns • Osteoporosis screening • Breast cancer screening • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence • Perinatal depression: counseling and interventions	Nothing	Nothing
Routine mammogram • Covered annually for women age 40 and older	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You Pay	
Preventive care, adult (cont.)	**High**	**Standard**
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule.	Nothing	Nothing
Note: any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS: www.healthcare.gov/preventive-care-benefits CDC: www.cdc.gov/vaccines/schedules/index.html **Women's preventive services:** www.healthcare.gov/preventive-care-women/ For additional information: healthfinder.gov/myhealthfinder/default.aspx	Nothing	Nothing
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.*	*All charges*	*All charges*
Preventive care, children	**High**	**Standard**
Well-child visits, examinations, and immunizations as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. • Examinations, such as: - Annual eye exam - Annual hearing exam	Nothing	Nothing
Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible.		

Preventive care, children - continued on next page

Benefit Description	You Pay	
Preventive care, children (cont.)	**High**	**Standard**
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS: www.healthcare.gov/preventive-care-benefits CDC: www.cdc.gov/vaccines/schedules/index.html For additional information: healthfinder.gov/myhealthfinder/default.aspx Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines to go brightfutures.aap.org/Pages/default.aspx		
Maternity care	**High**	**Standard**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at high risk. • Delivery • Postnatal care	Office visit: Nothing (includes pre- and post-natal care) Inpatient Admission (Delivery): $250 copayment	20% coinsurance after deductible
Breastfeeding support, supplies and counseling for each birth.	Nothing	Nothing
Note: Here are some things to keep in mind: • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision.		
Not covered: • *Services outside the service area; or any services with a non-participating provider.*	*All charges*	*All charges*

Benefit Description	You Pay	
Family Planning	**High**	**Standard**
Contraceptive counseling on an annual basis	Nothing	Nothing
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5(b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	Nothing	Nothing
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*	*All charges*
Infertility services	**High**	**Standard**
Diagnosis and treatment of infertility such as: • Artificial insemination: Intracervical insemination (ICI) • Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit. Note: Infertility is defined as the inability to conceive after 12 months of unprotected intravaginal sexual relations (or 12 cycles of artificial insemination). Examples of covered infertility services for men may include medically necessary hormone testing, semen analysis, sperm function testing, chromosomal analysis, medical imaging, surgical correction of genitourinary tract abnormalities, and sperm extraction. Note: Infertility Treatment means services, tests, supplies, devices, or drugs, which are intended to promote fertility; achieve pregnancy; or treat an illness causing an infertility condition when such treatment is done solely in an attempt to bring about a pregnancy. Note: Infertility services are covered if the couple has a relationship under which the FEHB Program recognizes each partner as a spouse of the other. FEHB does recognize same sex marriages.	50% coinsurance	50% coinsurance
Not covered:	*All charges*	*All charges*

Infertility services - continued on next page

Benefit Description	You Pay	
Infertility services (cont.)	**High**	**Standard**
• *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization (IVF)* - *Embryo transfer and gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Sperm enhancement services*	*All charges*	*All charges*
Allergy care	**High**	**Standard**
• Testing and treatment (office visits)	$40 copayment per office visit Children (under 26 years of age): Nothing	Adults: $60 copayment per office visit; Children (under 26 years of age): Nothing per office visit 20% coinsurance after deductible applies to other codes billed
• Allergy injections • Allergy serum	Nothing	20% coinsurance after deductible
Not covered: • *Cytotoxic testing in conjunction with allergy testing; provocative food testing; and sublingual allergy desensitization.*	*All charges*	*All charges*
Treatment therapies	**High**	**Standard**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 43. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone therapy (GHT) is covered under the prescription drug benefit. See section 5f 58.	Nothing	20% coinsurance after deductible

Treatment therapies - continued on next page

Benefit Description	You Pay	
Treatment therapies (cont.)	**High**	**Standard**
Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. You need prior Plan approval for certain services.	Nothing	20% coinsurance after deductible
Physical and occupational therapies	**High**	**Standard**
Coverage for Physical, Speech and Occupational therapy is limited to a combined total of 40 visits per benefit year. This limit is shared between Rehabilitation and Habilitation services. Phase II Cardiac Rehabilitation will be covered for up to 36 sessions for members with a recent history of heart attack (myocardial infarct), coronary artery bypass graft (CABG), onset of stable angina pectoris, onset of decubitil angina, heart-valve surgery, percutaneous transluminal coronary angioplasty (PTCA), and cardiac heart transplant. Prior authorization required for certain therapies, such as: • Biofeedback • Extracorporeal shockwave therapy • Hyperbaric oxygen therapy • Prolotherapy • Wound therapy Note: See Section 3 Other Services.	Nothing	20% after deductible
Not covered: • *Long-term therapy and maintenance and supportive care and/or chronic conditions exercise programs* • *Dry Needling* • *Exercise programs*	*All charges*	*All charges*
Speech therapy	**High**	**Standard**
Coverage for Physical, Speech and Occupational therapy is limited to a combined total of 40 visits per benefit year. This limit is shared between Rehabilitation and Habilitation services.	Nothing	20% coinsurance after deductible

Benefit Description	You Pay	
Hearing services (testing, treatment, and supplies)	**High**	**Standard**
Hearing exam Outside annual exam	Annual exam: Nothing Adult: $40 copayment, Children (under 26 years of age): Nothing	Annual exam: Nothing Adult: $60 copayment, Children (under 26 years of age): Nothing
Hearing testing for children through age 17. Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	Nothing	Nothing
Hearing aid coverage (Children: Ages 0-18): Coverage is limited to one hearing aid per ear every 36 months. If the hearing aid that is recommended to you is not on the list of covered models, coverage will be limited to $1,500 per ear every three years. Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	20% coinsurance	20% coinsurance
Hearing aid coverage (Adults: Age 19+): Coverage is limited to one hearing aid per ear every 36 months. If the hearing aid that is recommended to you is not on the list of covered models, coverage will be limited to $1,500 per ear every three years. Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	20% coinsurance	20% coinsurance
Not covered: • *Hearing services that are not shown as covered*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High**	**Standard**
• Eye exam • Treatment	Annual eye exam: Nothing Treatment: Adult: $20 copayment Children (under 26 years of age): Nothing	Annual eye exam: Nothing Treatment: Adults: $30 copayment Children (under 26 years of age): Nothing
• Annual eye refractions Note: See *Preventive care, children* for eye exams for children.	Nothing	Nothing
• Initial lens per surgical eye following cataract surgery (contact lens or framed lens) • Annual exam: Nothing	20% coinsurance	20% coinsurance
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics*	*All charges*	*All charges*

Vision services (testing, treatment, and supplies) - continued on next page

<table>
<tr><th>Benefit Description</th><th colspan="2">You Pay</th></tr>
<tr><td>Vision services (testing, treatment, and supplies) (cont.)</td><td>High</td><td>Standard</td></tr>
<tr><td>Not covered (continued):
• Laser photokeratotomy
• Laser keratectomy
• Refractive keratoplasty
• Radial keratectomy
• Keratotomy
• Excimer laser photorefractive keratectomy</td><td>All charges</td><td>All charges</td></tr>
<tr><td>Foot care</td><td>High</td><td>Standard</td></tr>
<tr><td>Routine foot care
Note:
• Diabetic patient care only (services include removal or corns or calluses, nail trimming, and other routine hygiene care of the foot). Services can be provided by either PCP or Specialist.</td><td>Adult: $20 copayment at primary care and $40 copayment at specialist
Children (under 26 years of age): Nothing</td><td>Adult: $30 copayment at primary care and $60 copayment at specialist
Children (under 26 years of age): Nothing</td></tr>
<tr><td>Not covered:
• Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above.
• Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</td><td>All charges</td><td>All charges</td></tr>
<tr><td>Orthopedic and prosthetic devices</td><td>High</td><td>Standard</td></tr>
<tr><td>• Artificial limbs and eyes
• Stump hose
• Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. Coverage is limited to 2 bras per year.
• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.
• External hearing aids
• Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants
• Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy.</td><td>20% coinsurance</td><td>20% coinsurance</td></tr>
</table>

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You Pay	
Orthopedic and prosthetic devices (cont.)	**High**	**Standard**
Note: Orthopedic and prosthetic devices require prior authorization. For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	20% coinsurance	20% coinsurance
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* *Prosthetic replacements: 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 (1) 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).*	*All charges*	*All charges*
Durable medical equipment (DME)	**High**	**Standard**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Blood glucose monitors • Insulin pumps • Compression stocking with minimum compression of 30mm of pressure or greater; limited to two per year.	20% coinsurance	20% coinsurance

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay	
Durable medical equipment (DME) (cont.)	**High**	**Standard**
Note: See Section 3 for items requiring prior authorization.	20% coinsurance	20% coinsurance
Not covered: • *Services, supplies and/or equipment not Medically Indicated;* • *Services, supplies and/or equipment purchased through a pharmacy or non-Participating Provider/vendor;* • *Repairs and replacement of equipment and supplies unless Prior Authorized by the Plan;* • *Lost or stolen supplies and/or equipment;* • *Disposable and/or over-the-counter supplies and/or equipment including adult diapers (and related supplies), gauze bandages, incontinent pads, lambs wool pads, catheters, ace bandages, elastic stockings, surgical face masks and irrigating kits;* • *Routine periodic maintenance and/or battery replacements;* • *Medical Supplies and Durable Medical Equipment for comfort or personal hygiene and convenience, including air cleaners, air conditioners, humidifiers, physical fitness equipment, Physician's equipment, tanning beds, whirlpools, swimming pools, hot tubs, saunas, alternative communication devices, Disposable Supplies, self-help devices and equipment not medical in nature;* • *Eyeglasses, lenses or frames and fittings, except as specifically listed in this brochure;* • *Home testing devices and monitoring supplies and related equipment except those used in connection with the treatment of diabetes;* • *Purchases or lease of, or modifications to, residences, places of work or motor vehicles;* • *Enteral feeding Disposable Supplies including bags, tubing, non-prescription or over-the-counter enteral feeds/supplements; nutritional supplements; or vitamins.*	*All charges*	*All charges*
Home health services	**High**	**Standard**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. up to 60 visits per year. • Services include oxygen therapy, intravenous therapy and medications. Note: Home care must be prior authorized.	Nothing	20% coinsurance after deductible

Home health services - continued on next page

Benefit Description	You Pay	
Home health services (cont.)	**High**	**Standard**
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*	*All charges*
Chiropractic	**High**	**Standard**
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	Adult: $20 copayment Children (under 26 years of age): Nothing	Adult: $30 copayment; Children (under 26 years of age): Nothing
Not covered: Long-term and/or maintenance therapy and service not medically indicated.	*All charges*	*All charges*
Autism Services	**High**	**Standard**
This policy will provide coverage for a primary verified diagnosis of Autism Spectrum Disorder. Autism Spectrum Disorder means: 1) Autism; 2) Asperger's syndrome; or 3) Pervasive developmental disorder not otherwise specified.	Nothing	Nothing
Alternative treatments	**High**	**Standard**
Acupuncture (up to 12 visits per year with in-network provider) is covered when provided for the treatment of nausea/vomiting when associated with pregnancy, chemotherapy, opioid addiction, or for the treatment of chronic pain. Acupuncture is not covered for the treatment of any other conditions.	Adult: $40 copayment Children (under 26 years of age): Nothing	Adult: $60 copayment Children (under 26 years of age): Nothing
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback (except as prior authorized for treatment of headaches, Spastic Torticollis or Spasmodic Torticollis and Pediatric voiding dysfunction)*	*All charges*	*All charges*
Educational classes and programs	**High**	**Standard**
Coverage is provided for: • Tobacco Cessation/E-cigarettes programs, including individual/group/telephone counseling, certain over-the-counter (OTC) products with a prescription from your doctor and must be filled at a participating pharmacy and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for counseling for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for counseling for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.
Health Management programs and resources for: • Diabetes • Asthma	Nothing	Nothing

Educational classes and programs - continued on next page

Benefit Description	You Pay	
Educational classes and programs (cont.)	**High**	**Standard**
• Attention Deficit & Hyperactivity Disorder (ADHD) • Low Back Pain / MobileBack • Complex Case Management • Depression • High Blood Pressure • Health Coaching • Tobacco Cessation • Prenatal / Postpartum • Preventive Health Note: Please call Quartz Health Benefit Plans Corporation Customer Service at 800-362-3310 for details.	Nothing	Nothing

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The calendar year deductible for the Standard Option is: $1,000 per person (maximum of $2,000 per Self Plus One enrollment, or Self and Family enrollment). The calendar year deductible applies to some benefits in this Section. There is no deductible for the High Option.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You Pay	
Surgical procedures	**High**	**Standard**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery) • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	Nothing	20% coinsurance after deductible

Surgical procedures - continued on next page

Benefit Description	You Pay	
Surgical procedures (cont.)	**High**	**Standard**
Note: Surgical treatment of morbid obesity (bariatric surgery) is covered once per lifetime with prior authorization from the Health Plan and when the procedure is performed by UW Health Medical and Surgical Weight Management Program or Gundersen Health System. Recognized bariatric surgical procedures offered by the UW Health Medical and Surgical Weight Management Program and Gundersen Health System are covered, including, but not limited to, preoperative and post-operative care and the services of physicians, assistants and consultants that are necessary for the bariatric surgery. Quartz will only cover bariatric surgery if it is the Member's first bariatric surgery. If approved, coverage is limited to one surgical procedure per lifetime of the Member. This limitation does not apply to surgeries related to complications from the initial surgery. The following services are excluded from coverage: Removal of excess skin resulting from weight loss Bariatric surgical procedures not provided by the UW Health Medical and Surgical Weight Management Program or Gundersen Health System.	Nothing	20% coinsurance after deductible
Not covered: • *Reversal of voluntary sterilization*	*All charges*	*All charges*
Reconstructive surgery	**High**	**Standard**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member’s appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts;	Nothing	20% coinsurance after deductible

Reconstructive surgery - continued on next page

Benefit Description	You Pay	
Reconstructive surgery (cont.)	**High**	**Standard**
- treatment of any physical complications, such as lymphedemas; - breast prostheses; and surgical bras and replacements (see *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing	20% coinsurance after deductible
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High**	**Standard**
ORAL SURGERY: A participating oral surgeon must perform all services. Covered services include any x-rays and anesthesia related to the listed oral surgery services only: • Surgical removal of boney 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 the tooth root (apicoectomy) • Removal of exostosis 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) • Residual root removal and root amputation. Covers diagnostic services and Medically Indicated surgical and non-surgical treatment (including intraoral splint therapy devices) for the correction of temporomandibular disorders (TMD) if all of the following apply: • A congenital, developmental or acquired deformity, disease or injury caused the condition; and • The service or device is reasonable and appropriate for the diagnosis or treatment of this condition as determined by Quartz Health Benefit Plans Corporation; and	Nothing	20% coinsurance after deductible

Oral and maxillofacial surgery - continued on next page

Benefit Description	You Pay	
Oral and maxillofacial surgery (cont.)	**High**	**Standard**
• The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction. Note: A Participating Provider designated to treat TMD must provide the services for all TMD services including intraoral splint therapy devices. The splint therapy device is considered Durable Medical Equipment.	Nothing	20% coinsurance after deductible
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*	*All charges*
Organ/tissue transplants	**High**	**Standard**
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Kidney • Kidney-Pancreas • Liver • Lung: single/bilateral lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants - Isolated Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas.	Nothing	20% coinsurance after deductible
The **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other Services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated)	Nothing	20% coinsurance after deductible

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High**	**Standard**
- Recurrent germ cell tumors (including testicular cancer)	Nothing	20% coinsurance after deductible
Blood or marrow stem cell transplants Plan extends coverage for the diagnoses as indicated below. Allogeneic transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorders (MPDs) • Advanced neuroblastoma • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Infantile malignant osteopetrosis • Kostmann's syndrome • Leukocyte adhesion deficiencies • Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) • Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy • Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Sickle cell anemia • X-linked lymphoproliferative syndrome Autologous transplants for: • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed)	Nothing	20% coinsurance after deductible

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High**	**Standard**
• Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Breast Cancer • Ependymoblastoma • Epithelial ovarian cancer • Ewing's sarcoma • Multiple myeloma • Medulloblastoma • Pineoblastoma • Neuroblastoma • Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	Nothing	20% coinsurance after deductible
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: Allogeneic transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorders (MPDs) • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Severe combined immunodeficiency • Severe or very severe aplastic anemia Autologous transplants for: • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia	Nothing	20% coinsurance after deductible

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High**	**Standard**
• Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Neuroblastoma	Nothing	20% coinsurance after deductible
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. Allogeneic transplants for: • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Beta Thalassemia Major • Chronic inflammatory demyelination polyneuropathy (CIDP) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma • Multiple sclerosis • Sickle Cell anemia Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Breast cancer • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Colon cancer • Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)	Nothing	20% coinsurance after deductible

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High**	**Standard**
• Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma • Multiple sclerosis • Myeloproliferative disorders (MSDs) • Myelopysplasia/Myelodysplastic Syndromes • Non-small cell lung cancer • Ovarian cancer • Prostate cancer • Renal cell carcinoma • Sarcomas • Sickle cell anemia Autologous Transplants for: • Advanced Childhood kidney cancers • Advanced Ewing sarcoma • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Aggressive non-Hodgkin's lymphomas • Breast Cancer • Childhood rhabdomyosarcoma • Chronic myelogenous leukemia • Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Epithelial Ovarian Cancer • Mantle Cell (Non-Hodgkin lymphoma) • Multiple sclerosis • Small cell lung cancer • Systemic lupus erythematosus • Systemic sclerosis	Nothing	20% coinsurance after deductible

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High**	**Standard**
National Transplant Program (NTP) - Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	Nothing	20% coinsurance after deductible
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*
Anesthesia	**High**	**Standard**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Outpatient: Nothing Inpatient: $250 copayment per admission	20% coinsurance after deductible

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. The calendar year deductible for the Standard Option is: $1,000 per person (maximum of $2,000 per Self Plus One enrollment or Self and Family enrollment). There is no deductible for the High Option.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You Pay	
Inpatient hospital	**High**	**Standard**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations; • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$250 copayment per admission	20% coinsurance after deductible
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	$250 copayment per admission	20% coinsurance after deductible
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools*	*All charges*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You Pay	
Inpatient hospital (cont.)	**High**	**Standard**
Not covered (continued): • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Take home drugs* • *Respite care* • *Private duty nursing care* • *Coma therapy care; coma rehabilitation therapy*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High**	**Standard**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. Prior authorization is required.	Nothing	20% coinsurance after deductible
Not covered: • *Blood and blood derivatives not replaced by the member* • *Reversal of sterilization* • *Cosmetic procedures*	*All charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High**	**Standard**
Extended care benefit: this plan will cover skilled nursing care up to 90 days per confinement per member. The member must be admitted to a Quartz-approved facility within 24 hours of discharge from a hospital for continued treatment of the same condition that required in-patient hospital care. Covered services include: • Semi-private (or lesser) room and board • Incremental nursing services • Miscellaneous hospital expenses	$250 copayment per admission	20% coinsurance after deductible

Extended care benefits/Skilled nursing care facility benefits - continued on next page

Benefit Description	You Pay	
Extended care benefits/Skilled nursing care facility benefits (cont.)	**High**	**Standard**
• Intensive care room and board • Inpatient physical, speech and occupational therapy • Inpatient medications • Inpatient lab services and x-rays	$250 copayment per admission	20% coinsurance after deductible
Not Covered: • *Custodial care* • *Domiciliary care* • *Maintenance* • *Private duty nursing care* • *Respite care*	*All charges*	*All charges*
Hospice care	**High**	**Standard**
Inpatient hospice care when: the member has a life expectancy of 6 months or less; care is provided by a participating licensed care provider.	$250 copayment per admission	20% coinsurance after deductible
Not covered: • *Independent nursing* • *Homemaker services* • *Private duty nursing*	*All charges*	*All charges*
End of life care	**High**	**Standard**
• Advanced care planning / palliative care consults	Nothing	Nothing
Ambulance	**High**	**Standard**
• Local professional ambulance service when medically appropriate	Nothing	20% coinsurance after deductible

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible for the Standard Option is: $1,000 per person (maximum of $2,000 per Self Plus One enrollment or Self and Family enrollment). The calendar year deductible applies to some benefits in this Section. There is no deductible for the High Option.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated properly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies - what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within our service area: If you require emergency medical care and you are in the Quartz Service Area, you should go to a participating hospital emergency room for services when you can safely do so. If you cannot safely travel to a participating hospital and there is a closer non-participating hospital, you should go to that closer hospital emergency room for assistance. Then contact your Primary Care Provider to arrange for follow-up care from a Participating Provider. If you are admitted to either a participating hospital or non-participating hospital, you and/or the hospital must notify Quartz no later than 3 business days or as soon thereafter as medically feasible.

Emergencies outside our service area: If you are outside of the Quartz Service Area go to the closest hospital emergency room. Then contact your Primary Care Provider to arrange for follow-up care from a Participating Provider. Follow-up care will not be covered as Emergency Services. If you are admitted to the non-participating hospital, you and/or the hospital must notify Quartz no later than 3 business days or as soon thereafter as medically feasible.

Once you are stable, Quartz will seek to have you transferred to a participating hospital in our service area. If you are not transferred to a participating hospital, Quartz will coordinate your care with the hospital and physicians.

Benefit Description	You pay	
Emergency within our service area	**High**	**Standard**
• Emergency care at a doctor's office • Emergency care at an urgent care center	Adults: $20 copayment per office visit for primary care; $40 copayment per office visit for specialty and urgent care Children (under 26 years of age): Nothing	Adults: $30 copayment per office visit for primary care; $60 copayment per office visit for specialty and urgent care Children (under 26 years of age): Nothing
• Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copayment if you are admitted to the hospital.	$100 copayment	$100 copayment

Benefit Description	You pay	
Emergency outside our service area	**High**	**Standard**
• Emergency care at a doctor's office • Emergency care at an urgent care center	Adults: $20 copayment per office visit for primary care; $40 copayment for specialty and urgent care Children (under 26 years of age): Nothing	Adults: $30 copayment per office visit for primary care; $60 copayment for specialty and urgent care Children (under 26 years of age): Nothing
• Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copayment if you are admitted to the hospital.	$100 copayment	$100 copayment
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Medical treatment that you receive on an emergency basis for an illness or an injury that is not an emergency medical condition* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*	*All charges*
Ambulance	**High**	**Standard**
Professional ambulance service (ground or air) when medically appropriate. Note: See 5(c) for non-emergency service.	Nothing	20% coinsurance after deductible
Not covered: Ground or air ambulance when medical attention is not required en route to a medical facility.	*All charges*	*All charges*

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible for the Standard Option is: $1,000 per person (maximum of $2,000 per Self Plus One enrollment or Self and Family enrollment). The calendar year deductible applies to some benefits in this section. There is no deductible for the High Option.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You Pay	
Professional Services	**High**	**Standard**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance misuse disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug misuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	Adults: $20 copayment Children (under 26 years of age): Nothing	Adults: $30 copayment Children (under 26 years of age): Nothing

Benefit Description	You Pay	
Diagnostics	**High**	**Standard**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance misuse disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Nothing	20% coinsurance after deductible
Inpatient hospital or other covered facility	**High**	**Standard**
Inpatient services provided and billed by a hospital or other covered facility. • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services.	$250 copayment per admission	20% coinsurance after deductible
Outpatient hospital or other covered facility	**High**	**Standard**
Outpatient services provided and billed by a hospital or other covered facility. • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment.	Nothing	20% coinsurance after deductible
Not covered	**High**	**Standard**
• *Services that are not prior authorized and all out-of-network provider services*	*All charges*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their prescribers obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- The calendar year deductible is: $0 per person ($0 per Self Plus One enrollment, or $0 per Self and Family enrollment).
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription?** A licensed physician or dentist, and in states allowing it, licensed certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** Covered prescription drugs must be obtained through a Participating Pharmacy and submitted electronically by the pharmacy through Quartz Health Benefit Plan Corporation's pharmacy claims adjudication system.
  - Specialty Pharmaceuticals are only covered if obtained within the Quartz Health Benefit Plan Corporation Specialty Pharmacy Network.
  - Please refer to QuartzBenefits.com/FindADoctor for a list of Participating Pharmacies.
- **How do you fill your prescription?** Bring your current Quartz Health Benefit Plans Corporation ID card to the Participating Pharmacy of your choice. Your ID card includes all the necessary information for the pharmacy to submit your Prescription Claim electronically.
  - Refer to your Summary of Benefits and Coverage for prescription claims details or contact Customer Service at 800-362-3310.

Formulary management

Quartz Health Benefit Plans Corporation maintains a Formulary, which contains medications identified by our Pharmacy and Therapeutics Committee as Formulary Drugs. Medications on the Formulary are reviewed by the Pharmacy and Therapeutics Committee for efficacy, adverse effects, and cost to maintain a high-quality, cost-efficient foundation for drug therapy. Your coverage of prescription medications is subject to the Quartz Formulary. The Formulary includes a list of medications indicating tier status as well as other coverage attributes (e.g. Prior Authorization). The Formulary is frequently updated as we consider new medications or make changes to coverage status of existing medications.

Please be aware that not all drugs can be included in the Formulary List as Covered Drugs. Non-Formulary Drugs are not Covered Drugs; these medications have not been designated by the Pharmacy and Therapeutics Committee as a Formulary Drug. There is an exceptions process available to request consideration of coverage for Non-Formulary Drugs when medically necessary, formulary options are not appropriate, and the Non-Formulary Drug is not otherwise specifically excluded.

Preventive Medications

Prescription and Over-the-Counter Drugs, determined by CMS as Preventive are available with no member cost share, as noted on the Formulary as $0. Preventive Medications include Smoking Cessation Drugs, Preventive Statins or Oral Contraceptives. A valid prescription must be written and submitted to Quartz Health Benefit Plans Corporation electronically by your pharmacy for the $0 copayment to apply. Preventive medications are also subject to formulary restrictions, such as quantity limitations, Prior Authorization, or age limitations as noted on the Formulary.

Value Tier / Rx Outcomes Benefit

In addition to Tier 1 through 4, Quartz Health Benefit Plans Corporation has a Value Tier or Rx Outcomes benefit. Some drugs are considered to be High Value drugs by improving the overall health of people significantly relative the cost of the drug. These include medications for patients with conditions like high blood pressure, high blood sugars (diabetes mellitus), and breathing difficulties (asthma). The Value Tier co-payment will apply to the drugs noted on the Formulary with "RXO".

Use of Generic and Brand drugs

A Generic Drug is typically a medication that has been approved by the Food and Drug Administration (FDA) as equivalent to an FDA-approved Brand Drug. This means the Generic Drug has the same active ingredient, strength, dosage form, and route of administration (e.g. oral tablet) as the Brand Drug.

Brand Drugs for which there is an available generic equivalent are placed at Non-Formulary status and require an approved formulary exception for coverage immediately after the generic equivalent is available to the market. As a cost-saving measure, Quartz Health Benefit Plans Corporation may choose to cover a Brand Drug as the Formulary option instead of the equivalent Generic Drug. In those select situations, the Brand Drug will be covered at the Preferred Generic Copay Tier level and the Generic Drug will be Non-Formulary.

Prior Authorization

Prior Authorization is the process by which Quartz Health Benefit Plans Corporation gives written approval for coverage of specific Prescription Drugs based on clinical criteria established by the Pharmacy and Therapeutics Committee. Some clinical criteria for restricted medications require failure of prerequisite therapies, this is referred to as Step Therapy. Medications restricted by Prior Authorization or Step Therapy will be listed on the Formulary with "PA" or "ST". Medications restricted by Prior Authorization or Step Therapy must follow the Prior Authorization process for consideration of coverage; unless, the prerequisite therapy requirements are programmed within the pharmacy claims adjudication system.

Continuation of therapy criteria may apply to members who were previously approved for coverage. Persons who were not previously approved for coverage but who instead initiated therapy using a manufacturer-sponsored free drug program, provider samples or vouchers will not be considered to have met continuation of therapy criteria for coverage.

Please visit our Pharmacy Program's Prior Authorization page at QuartzBenefits.com to review the Medication Prior Authorization Criteria document for detailed clinical criteria by drug name.

Quantity Supply and Dispensing Limitations

Coverage for medications are limited to the quantity limit shown on the Formulary and/or the quantity prescribed by the physician. One prescription fill or refill cannot exceed:

- A 30-day supply; or,
- A supply of more than 30 days if dispensing a single commercially-prepared unit of an unbreakable quantity; or,
- A 90-day supply for medications meeting Quartz Health Benefit Plans Corporation's current 90-day supply (Choice90) program requirements as described at QuartzBenefits.com/formulary; or,
- For 30-day supplies, two commercially-prepared units, if one unit does not provide a full 30-day supply.

Examples of a commercially-prepared unit include, but are not limited to (1) one inhaler, (2) one vial ophthalmic medication, and (3) one sumatriptan packet (9 tablets).

Some medications are packaged such that they will last more than 30 days. Or, they cannot reasonably be dispensed in a 30-day quantity. For these medications, Members are charged one Copayment for each 30-day time period covered by the medication.

Medications restricted by quantity limitations will be shown on the Formulary with “QL”.

Please call Customer Service to obtain a current version of the Formulary List. You can also review the most current Formulary by visiting the Quartz Pharmacy Program webpage.

<table>
<tr><th>Benefits Description</th><th colspan="2">You Pay</th></tr>
<tr><th>Covered medications and supplies</th><th>High</th><th>Standard</th></tr>
<tr><td>Subject to Quartz Health Benefit Plans Corporation’s Formulary and any prior authorization or step therapy requirements, a Covered Drug is:
1. Any Prescription Drug on the Formulary List as a Formulary Drug, including prescription contraceptives;
2. Injectable insulin, insulin syringes, and glucose test strips on the Formulary List as Formulary Drugs;
3. Any medication compounded by the Participating Pharmacy that contains a Formulary Drug when appropriate commercially available alternatives are not available, the compounded medication does not contain any drug listed as a specific Exclusion, and the specific combination of ingredients included in the compounded prescription has adequate published evidence to support use for the patient’s specific indication;
4. An Over-the-Counter Medication that Quartz Health Benefit Plans Corporation determines is a Formulary Drug, when the medication is obtained with a legal Prescription Order from a physician; or,
5. A Medical Food Quartz Health Benefit Plans Corporation determines is a Formulary Drug. The Medical Food must be listed on the Formulary List as a Formulary Drug and obtained from a pharmacy with a written Prescription Order from a physician who is supervising its use.

Specialty Medications:

See Standard Choice formulary located at QuartzBenefits.com for listing of medications.

Note: Specialty Pharmaceuticals are covered only if obtained from pharmacies participating in Quartz Health Benefit Plans Corporation’s Specialty Pharmacy Network. If the drug is authorized, the authorization letter will identify for the Member and prescribing physician where the Prescription Order can be filled. Failure to obtain the drug within the Specialty Pharmacy Network will result in a denial of coverage for the drug. Partial-fill program may be required for select medications.

Note: Pharmacy Maximum Out-of-Pocket: $2,350 Self Only/$4,700 Self Plus One/$4,700 Self and Family</td><td>Rx Outcomes Value Tier: $5 copayment

Tier 1 (Preferred Generics): $10 copayment

Tier 2 (Preferred Brands): $25 copayment

Tier 3 (Non-Preferred Generics, Brands): $50 copayment

Tier 4 (Specialty): $200 copayment

ACA preventive medication: $0 copayment

* Regardless of the tier your oral chemotherapy falls into you will never pay more than $100 for a 30-day supply, in compliance with the Wisconsin law.

Note: If an exception is made to cover a non-formulary medication, it will be covered at the Tier 3 (Non-Preferred) or Tier 4 (Specialty) copayment based on the medication.</td><td>Rx Outcomes Value Tier: $5 copayment

Tier 1 (Preferred Generics): $10 copayment

Tier 2 (Preferred Brands): $25 copayment

Tier 3 (Non-Preferred Generics, Brands): $50 copayment

Tier 4 (Specialty): $200 copayment

ACA preventive medication: $0 copayment

* Regardless of the tier your oral chemotherapy falls into you will never pay more than $100 for a 30-day supply, in compliance with the Wisconsin law.

Note: If an exception is made to cover a non-formulary medication, it will be covered at the Tier 3 (Non-Preferred) or Tier 4 (Specialty) copayment based on the medication.</td></tr>
</table>

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**High**	**Standard**
Infertility Medications: Pharmacy Benefit oral infertility drugs Note: All infertility medications require prior authorization from Quartz Health Benefit Plans Corporation.	$25 copayment	$25 copayment
Women's contraceptive drugs and devices: Note: Over-the-counter contraceptive drugs and devices approved by the FDA require a written prescription by an approved provider.	Nothing (No cost to the member if prescribed by a physician and purchased at a network pharmacy)	Nothing (No cost to the member if prescribed by a physician and purchased at a network pharmacy)
Not covered • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies* • *Nonprescription medications medicines* *Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation/ E-cigarettes benefit. (See page 38.)* *Any Non-Formulary Drug, unless an exception request has been approved by Quartz;* *Any Formulary Drug when the formulary requirements for coverage have not been met. For example, Step Therapy not completed, Prior Authorization not approved, or specialty drugs obtained outside Quartz's Specialty Pharmacy Network, among others. See Quartz's Formulary List on our website for the requirements applicable to our Formulary Drugs;* *Non-medical devices or substances such as therapeutic devices or substances, hypodermic needles, syringes (except insulin syringes and needles), support garments;* *Any drug or medication that is administered or delivered to you by or in the presence of a health care provider (other than prescription drugs dispensed from a Quartz pharmacy to be self-administered);* *Any drug or medication that is to be taken by or administered to you while you are a patient at a healthcare facility, including a licensed hospital, rest home, extended care facility, convalescent hospital, skilled nursing home, emergency room or urgent care center, ambulatory clinic, infusion center, or similar institution;*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**High**	**Standard**
Not covered (continued) *Any drug labeled "Caution: limited by Federal Law to investigational use" or other wording with similar intent, experimental drugs, or FDA approved drugs being used in an experimental manner (non-evidence based indication, dosage regimen, etc.) even though a charge is made to you, except that coverage will be provided for any Prescription Drug that meets the following criteria –* • *Is prescribed for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection; and,* • *Is approved by the federal Food and Drug Administration for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection, including each investigational new drug that is approved under 21 CFR 312.34 to 312.36, and that is in or has completed a phase-3 clinical investigation; and,* • *If the drug is an investigational new drug described in (ii) above, is prescribed and administered in accordance with the treatment protocol approved for the investigational new drug under 21CFR 312.34 to 312.36;* *Any refill of a Prescription Drug that is in excess of what is prescribed, or any refill dispensed beyond the legally-allowed time limits;* *Anabolic Steroids and athletic performance enhancing medications;* *Anti-obesity drugs, anorexients and any drug for which weight modification is the primary mechanism by which indicated results are achieved or is the primary purpose the medication is prescribed;* *Medications used to treat or prevent hair loss (e.g., topical minoxidil and finasteride);* *Medications used to enhance or facilitate fertility;* *Any Prescription Drug for a procedure not covered by your medical health insurance Certificate of Coverage;* *Any Prescription Drug for an Illness or Injury not covered by your medical health insurance Certificate of Coverage;*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**High**	**Standard**
Not covered (continued) *Over-the-Counter Medications, with or without a Prescription Order, unless the medication has been approved by Quartz. Any such approved medication is listed on Quartz's Formulary List as a Formulary Drug;* *Prescription Drugs that are covered, or the Member is entitled to receive, from any Worker's Compensation law or any municipal state or federal program. This includes prescription drugs the Member is entitled to receive without charge;* *Nutritional products and special food or feedings. This exclusion does not apply to medically necessary elemental-based infant formula prescribed for members with Phenylketonuria (PKU), or other inborn errors of metabolism;* *Any Prescription Drug dispensed to a Member prior to the Member's effective date of coverage under the Plan or after the Member's termination date;* *Cosmetic treatment medications, including but not limited to Tretinoic Acid (Retin A);* *Irrigation solutions and supplies;* *Early refills. This exclusion does not apply to Prescription Eye Drops per Minn. Stat. 62A.3075;* *Homeopathic medications;* *Medications used to facilitate, obtain, maintain, enhance or prevent pain with sexual performance;* *Vaccines, unless the vaccine has been approved by Quartz for coverage under the drug benefit;* *Any Prescription Drug that is a Restricted Medication or that requires Prior Authorization, unless Prior Authorization is requested and approved;* *Medications purchased from a pharmacy or other establishment located outside the United States for consumption inside the United States;* *Medical Foods not listed on Quartz's Formulary List as a Formulary Drug, regardless of whether they are prescribed to you;* *Medications, including Growth Hormones, used to treat growth retardation except when endogenous production of the growth hormone is inadequate and clinical criteria are met. Coverage is not extended for short stature syndrome or other related growth abnormalities;*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**High**	**Standard**
Not covered (continued) *Any compounded drug that is –* • *Otherwise available commercially in a dose form suitable for the patient;* • *an ingredient drug that is specifically excluded;* • *Contains an experimental drug; or,* • *Contains a combination of ingredients in a dose form without adequate published evidence to support use for the patient's specific indication;* *Kits intended for convenience in compounding prescriptions when they combine components or ingredients that are otherwise readily available either as prescription drugs or over the counter drugs.*	*All charges*	*All charges*
Preventive care medications	**High**	**Standard**
Some laws, such as the Affordable Care Act (ACA) require that certain drugs need to be covered at a $0 cost share for members. Quartz covers these drugs within the guidelines recommended by the United States Preventive Services Task Force (USPSTF). Restrictions, including age limits, quantity limits, prior authorization, and days' supply may apply to some drugs and are noted in Appendix D. Coverage indicators in the "Limits and Restrictions" column specific to preventive medications include: Smoking Cessation Drugs (SC) - these drugs are covered up to 180 days within a 365-day period and Preventive Statins (SD) - these doses are covered at $0 cost share for members within the specified age limits. View the Standard Choice Formulary at QuartzBenefits.com for more information.	No charge	No charge

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Accidental injury benefit	You Pay	
Accidental injury benefit	**High**	**Standard**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. Treatment must begin within 90 days after the accident and will be covered up to 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.	Nothing	20% coinsurance after deductible

Dental benefits

- There are no other dental benefits.

Section 5(h). Wellness and Other Special Features

Special feature	Description
Online Access	Quartz MyChart provides you 24/7 online access to your health insurance information and UW Health medical information (if seeing a UW Health provider). With just a few clicks, members can: • Update personal information • Print new ID cards • Review benefit and eligibility information • Review medical and pharmacy claims • Change Primary Care Provider • Message Customer Service securely To request an account or activate your account instantly, go to QuartzMyChart.com.
UW Health Care Anywhere Video (Telehealth) Visits	UW Health Care Anywhere Video Visits gives you easy, quick access to a medical provider, whenever you or your family needs urgent care. From the comfort of your home or work, Care Anywhere is available 24 hours a day, every day of the year. You can take advantage of affordable urgent care video visits from your smartphone, tablet or computer equipped with a web camera. Depending on your medical concern, the health care provider can provide a diagnosis, suggest follow-up care, and prescribe medications when appropriate. Members can use video visits for: • Abdominal pain • Allergies • Cough • Fever • Ear pain • Stuffy / runny nose • Sore throat • Painful / difficult urination • Pink eye • Nausea and vomiting • Low back pain • Diarrhea • Eye infections • Joint pain • Sprains • Headache • Minor skin problem You can download the app in the Apple Store or Play Store: • Apple Store: search "Video Visit - UW Health Care Anywhere" • Play Store: search "Video Visit - University of Wisconsin"

Non-FEHB Benefits Available to Plan Members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact Quartz Health Benefit Plans Corporation at 800-362-3310 or visit our website at QuartzBenefits.com.

Perks and Savings: Your Quartz member ID card is also a discount card at participating vendors on products and services such as acupuncture, massage therapy, eyeglasses, Lasik, fitness, and more.

Individual Health Insurance: If you or a family member are not eligible under the FEHB Plan benefits, Quartz offers a variety of individual and family health insurance plans. For more information, contact Quartz at 800-362-3310 or visit our website at QuartzBenefits.com.

Section 6. General Exclusions – Services, Drugs and Supplies We Do Not Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services.***

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency services/accidents).
- Services, drugs, or supplies you received while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Any service or medication 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;
- 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;
- Private duty nursing;
- 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;
- Experimental or investigative treatment, services, devices and supplies;
- Nutritional supplements, special feedings, and meal services that are part of a Home Health Care program;
- Services rendered by a masseuse or massage therapist;
- Hypnotherapy;
- Orthoptics (eye exercise-training programs);
- Platelet-rich plasma;
- Custodial, domiciliary or convalescent care that does not require skilled care;
- Coma stimulation programs;
- 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;
- 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;
- Services, care or treatment for medical complications resulting from or associated with non-covered services;
- Expenses related to repatriation and medical evacuation;
- Any items or services obtained or provided outside of the United States (except for emergency care);

We do not cover the following (continued):

- Any items offered over the counter that are not listed as covered in your policy documents.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical and hospital benefits	In most cases, providers and facilities file claims for you. Providers must file the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, call us at 800-362-3310, or at our website at QuartzBenefits.com. When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show: • Covered member's name, date of birth, address, phone number and ID number • Name and address of the provider that provided the services or supplies • Dates you received the services or supplies • Diagnosis • Type of each service or supply • The charge for each service or supply • A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN) • Receipts, if you paid for your services Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills. **Submit your claims to:** **Quartz Health Benefit Plans Corporation, Attn: Claims Department, 840 Carolina Street, Sauk City, WI 53583**
Prescription drugs	**Submit your claims to:** **MedImpact Healthcare Systems, Inc** **PO Box 509098** **San Diego, CA 92150-9098**
Deadline for filing your claim	Send us all the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.
Post-service claims procedures	We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing Quartz, 840 Carolina Street, Sauk City, WI 53583 or calling 800-362-3310.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

1

Ask us in writing to reconsider our initial decision. You must:

a) Write to us within 6 months from the date of our decision; and

b) Send your request to us at: Quartz Health Benefit Plans Corporation, Attn: Appeals, 840 Carolina Street, Sauk City, WI 53583; and

c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

2

In the case of a post-service claim, we have 30 days from the date we receive your request to:

a) Pay the claim; or

b) Write to you and maintain our denial; or

c) Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3

If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4

OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 800-362-3310. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Worker's Compensation Programs if you are receiving Worker's Compensation benefits.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at QuartzBenefits.com/FEHB.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

- **TRICARE and CHAMPRA**

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar federal or state agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 1-877-888-3337, TTY 1-877-889-5680, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

An approved clinical trial includes 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 and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan covers some of these costs, providing the plan determines the services are medically necessary. For more specific information. (See Page 43. We encourage you to contact the plan to discuss specific services if you participate in a clinical trial.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older

Medicare is a health insurance program for (continued):

- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure.

For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 800-772-1213, TTY 1-800-325-0778.

Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 800-772-1213, TTY 1-800-325-0778 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage.

It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you did not take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 800-362-3310 or see our website at QuartzBenefits.com.

We waive medical copays, coinsurance and deductibles if you are a Medicare annuitant (retiree) and have both Medicare Parts A & B (the Original Medicare is your primary payor for Medicare Parts A & B costs.)

Please review the following table which illustrates your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Benefit Description	You pay without Medicare	You pay with Medicare Part B
Deductible	High Option: Nothing Standard Option: $1,000 Self Only/$2,000 Self Plus One/$2,000 Self and Family	High Option: Nothing Standard Option: Nothing
Out of Pocket Maximum	High Option: Medical: $3,000 Self Only/ $6,000 Self Plus One/ $6,000 Self and Family Pharmacy: $2,350 Self Only/$4,700 Self Plus One/ $4,700 Self and Family Standard Option: Medical: $5,800 Self Only/ $11,600 Self Plus One/ $11,600 Self and Family Pharmacy: $2,350 Self Only/$4,700 Self Plus One/ $4,700 Self and Family	High Option: Medical: $3,000 Self Only/ $6,000 Self Plus One/$6,000 Self and Family Pharmacy: $2,350 Self Only/$4,700 Self Plus One/ $4,700 Self and Family Standard Option: Medical: $5,800 Self Only/ $11,600 Self Plus One/ $11,600 Self and Family Pharmacy: $2,350 Self Only/$4,700 Self Plus One/ $4,700 Self and Family
Primary Care Physician	High Option: $20 copayment Standard Option: $30 copayment	High Option: Nothing Standard Option: Nothing
Specialist	High Option: $40 copayment Standard Option: $60 copayment	High Option: Nothing Standard Option: Nothing
Inpatient Hospital	High Option: $250 copayment Standard Option: 20% coinsurance after deductible	High Option: Nothing Standard Option: Nothing
Outpatient Hospital	High Option: Nothing Standard Option: 20% coinsurance after deductible	High Option: Nothing Standard Option: Nothing

You can find more information about how our plan coordinates benefits with Medicare at www.QuartzBenefits.com/FEHB.

Tell us about your Medicare coverage

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

Medicare Advantage

(Part C)

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs in some areas of the country).

To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan: You may enroll in a Quartz Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers).

However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✔
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✔	
3) Have FEHB through your spouse who is an active employee		✔
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✔	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✔
• You have FEHB coverage through your spouse who is an annuitant	✔	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✔	
7) Are enrolled in Part B only, regardless of your employment status	✔ for Part B services	✔ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✔*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✔
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✔	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✔
• Medicare was the primary payor before eligibility due to ESRD	✔	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✔	
• Medicare based on ESRD **(for the 30 month coordination period)**		✔
• Medicare based on ESRD **(after the 30 month coordination period)**	✔	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✔
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✔	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✔	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of Terms We Use in This Brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical trials cost categories

An approved clinical trial includes 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 and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 22.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 22.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Covered Services

Care we provide benefits for, as described in this brochure.

Custodial care

Custodial care or Maintenance care means care which can be learned and performed by a person who is not medically trained or care which involves the maintenance of basic bodily functions whether by natural or artificial means; care which includes care required for patient safety; and care which includes Respite Care, which is care that is requested to give temporary relief to persons who normally assist with the care of the Member.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 22.

Experimental or investigational 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.

Group health coverage

A health insurance plan that provides coverage to members of a group of company employees.

Health care professional A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity 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 makes decisions regarding service and treatment. The Plan, through its Medical Director, 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.

Plan allowance Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows: **Usual and Customary** means the Usual and Customary amount payable based upon the average Charge for the same service provided by other Providers of a similar type, training, and experience, in the same or similar geographical area and should not exceed the fees that the Provider would Charge any other payor for the same services. Other factors such as, but not limited to, complexity, degree of skill or type of Provider may also determine a Usual and Customary fee. Amounts above the Usual and Customary amounts are not paid by this Policy and are not applied to Policy and/or benefit maximums and/or Copayments, Deductible, and Coinsurance.

Post-service claims Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction or benefits.

Reimbursement A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Us/We Us and We refer to Quartz Health Benefit Plans Corporation.

You You refers to the enrollee and each covered family member.

Urgent care claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service department at 800-362-3310. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

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Summary of Benefits for the High Option of Quartz Health Benefit Plans Corporation - 2020

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. You can obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at QuartzBenefits.com/FEHB. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- There is no deductible year deductible for the High Option Plan.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit: Adults: $20 copayment primary care, chiropractic, optometry/ophthalmology, and behavioral health; $40 copayment specialist; Children (under 26 years of age): Nothing Diagnostic and treatment services (e.g. labs, x-rays): 100% coverage	27
Services provided by a hospital:		
• **Inpatient**	$250 copayment per admission	49
• **Outpatient**	Nothing	50
Emergency benefits:		
• **In-area**	$100 copayment per emergency room visit	52
• **Out-of-area**	$100 copayment per emergency room visit	53
Mental health and substance abuse disorder treatment:	Adults: $20 copayment per office visit; Children (under 26 years of age): Nothing Inpatient: $250 copayment per admission	54 55
Prescription drugs:		
• Retail pharmacy (up to a 30-day supply)	• Rx Outcomes Value Tier: $5 copayment • Tier 1 (Preferred Generics); $10 copayment • Tier 2 (Preferred Brands): $25 copayment • Tier 3 (Non-Preferred Generics, Brands): $50 copayment • Tier 4 (Specialty): $200 copayment	56
• Mail order (up to a 90-day supply)	Mail order is not available. Member can receive up to a 90-day supply on maintenance medications from their pharmacy for three copayments.	56

High Option Benefits	You pay	Page
Dental care:	No benefit (except for accidental injury).	63
Vision care:	$20 copayment per visit	34
Protection against catastrophic costs (out-of-pocket maximum):	Medical out-of-pocket maximum: $3,000 Self Only/$6,000 Self Plus One/$6,000 Self and Family Pharmacy out-of-pocket maximum: $2,350 Self Only/$4,700 Self Plus One/$4,700 Self and Family	22

Summary of Benefits for the Standard Option of Quartz Health Benefit Plans Corporation - 2020

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. You can obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at QuartzBenefits.com/FEHB. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Annual Deductible: $1,000 Self Only/$2,000 Self Plus One/$2,000 Self and Family calendar year deductible.
- Below, an asterisk (*) means the item is subject to the $1,000 Self Only/$2,000 Self Plus One/$2,000 Self and Family calendar year deductible.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit: Adults: $30 copayment primary care, chiropractic, optometry/ophthamology, and behavioral health; $60 copayment specialist; Children (under 26 years of age): Nothing Diagnostic and treatment services (e.g. labs, x-rays): * Deductible and 20% Coinsurance	27
Services provided by a hospital:		
• Inpatient	* Deductible and 20% Coinsurance	49
• Outpatient	* Deductible and 20% Coinsurance	50
Emergency Benefits:		
• In-area	$100 copayment per emergency room visit	52
• Out-of-area	$100 copayment per emergency room visit	53
Mental health and substance abuse disorder treatment:	Adults: $30 copayment per office visit; Children (under 26 years of age): Nothing Inpatient: * Deductible and 20% Coinsurance	54 55
Prescription drugs:		
• Retail pharmacy (up to a 30-day supply)	• Rx Outcomes Value Tier: $5 copayment • Tier 1 (Preferred Generics): $10 copayment • Tier 2 (Preferred Brands): $25 copayment • Tier 3 (Non-Preferred Generics, Brands): $50 copayment • Tier 4 (Specialty): $200 copayment	56
• Mail order (up to a 90-day supply)		56

	Mail order is not available. Member can receive up to a 90-day supply on maintenance medications from their pharmacy for three separate copayments.	
Dental care:	No benefit (except for accidental injury).	63
Vision Care:	$30 copayment per office visit	34
Protection against catastrophic costs (out-of-pocket maximum):	Medical out-of-pocket maximum: $5,800 Self Only/$11,600 Self Plus One/$11,600 Self and Family Pharmacy out-of-pocket maximum: $2,350 Self Only/$4,700 Self Plus One/$4,700 Self and Family	22

Notes

Notes

2020 Rate Information for Quartz Health Benefit Plans Corporation

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, contact the agency that maintains your health benefits enrollment.

Postal rates apply to United States Postal Service employees.

- **Postal Category 1** rates apply to career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NALC, and NPMHU.
- If you are a career bargaining unit employee represented by the agreement with NPPN, you will find your premium rates on https://liteblue.usps.gov/fehb.
- **Postal Category 2** rates apply to career bargaining unit employees who are represented by the following agreement: PPOA.

Non-Postal rates apply to all career non-bargaining unit Postal Service employees and career employees represented by the NRLCA agreement. Postal rates do not apply to non-career Postal employees, Postal retirees, and associate members of any Postal employee organization who are not career Postal employees.

USPS Human Resources Shared Service Center: 877-477-3273, option 5, Federal Relay Service: 800-877-8339

Premiums for Tribal employees are shown under the monthly non-Postal column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
Wisconsin							
High Option Self Only	TF1	$235.77	$230.55	$510.84	$499.52	$227.27	$217.45
High Option Self Plus One	TF3	$504.12	$545.12	$1,092.26	$1,181.09	$538.12	$517.11
High Option Self and Family	TF2	$546.47	$572.71	$1,184.02	$1,240.87	$565.12	$542.36
Standard Option Self Only	TF4	$212.63	$70.88	$460.70	$153.57	$68.04	$58.83
Standard Option Self Plus One	TF6	$467.81	$155.93	$1,013.58	$337.86	$149.70	$129.43
Standard Option Self and Family	TF5	$510.33	$170.11	$1,105.72	$368.57	$163.31	$141.19