

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services  
This health plan is offered by Quartz Health Benefit Plans Corporation



9032686 - QUARTZ GUNDERSEN PERFORMANCE SILVER  
\$5,500 DED CSR 73

Coverage Period: 1/1/2026 - 12/31/2026  
Coverage for: Individual/Family | Plan Type: HMO



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.QuartzBenefits.com/certlookup](http://www.QuartzBenefits.com/certlookup). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call Customer Success: 1-800-362-3310 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                     | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | Individual: <b>\$5,500</b> per Benefit Year<br>Family: <b>\$5,500</b> /individual or <b>\$11,000</b> /family per Benefit Year                                                                               | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.<br><br>If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .<br><br>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without cost-sharing and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> . |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .                                                                                                 | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | Individual: <b>\$8,400</b> per Benefit Year<br>Family: <b>\$16,800</b> /family per Benefit Year                                                                                                             | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.<br><br>If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance billing</a> charges, dental <a href="#">coinsurance</a> , cost-sharing assistance for certain brand drugs, and health care this <a href="#">plan</a> doesn't | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

|                                                                              |                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                              | cover.                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| Will you pay less if you use a <a href="#">network provider</a> ?            | Yes.<br><br>See <a href="http://www.QuartzBenefits.com/FindADoct">www.QuartzBenefits.com/FindADoct</a> or call 1-800-362-3310 for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an out-of- <a href="#">network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an out-of- <a href="#">network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | In- <a href="#">Network providers</a> : No.<br>Out-of- <a href="#">Network providers</a> : Yes, written <a href="#">referral</a> is required.                                   | In- <a href="#">Network</a> : You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .<br>Out-of- <a href="#">Network</a> : This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .                                                                                                                                                                                                                                                                                          |



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event                                                   | Services You May Need                                   | What You Will Pay                                                                                            |                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                  |
|------------------------------------------------------------------------|---------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                        |                                                         | In Network<br>(You will pay the least)                                                                       | Out-of-Network<br>(You will pay the most) |                                                                                                                                                                                                                                                         |
| If you visit a health care <a href="#">provider's office</a> or clinic | Primary care visit to treat an injury or illness        | \$30 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply                                 | Not covered                               | Virtual Visits and Telehealth Visits are covered at no charge; <a href="#">deductible</a> does not apply.<br><a href="#">Deductible</a> and/or <a href="#">coinsurance</a> may apply for additional services performed at your visit.                   |
|                                                                        | <a href="#">Specialist</a> visit                        | \$90 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply                                 | Not covered                               | A covered Telehealth visit applies the same cost-sharing as an in-person visit.<br><a href="#">Deductible</a> and/or <a href="#">coinsurance</a> may apply for additional services performed at your visit.                                             |
|                                                                        | Other practitioner office visit                         | Chiro/Non-Routine Adult Vision: \$30 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply | Not covered                               | Benefits are not available for care that is Maintenance and Supportive Care.<br>Routine Adult Vision exams are not covered.<br><a href="#">Deductible</a> and/or <a href="#">coinsurance</a> may apply for additional services performed at your visit. |
|                                                                        | <a href="#">Preventive care/screening</a> /immunization | No charge; <a href="#">deductible</a> does not apply                                                         | Not covered                               | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.                                                               |

| Common Medical Event                                                                                                                                                                                                                    | Services You May Need                               | What You Will Pay                                                                    |                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                         |                                                     | In Network<br>(You will pay the least)                                               | Out-of-Network<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>If you have a test</b>                                                                                                                                                                                                               | <a href="#">Diagnostic test</a> (x-ray, blood work) | 40% <a href="#">coinsurance</a>                                                      | Not covered                               | Prior authorization may be required. See <a href="http://www.QuartzBenefits.com/WIPAList">www.QuartzBenefits.com/WIPAList</a> or call (800) 362-3310 for additional information.                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                                         | Imaging (CT/PET scans, MRIs)                        | 40% <a href="#">coinsurance</a>                                                      | Not covered                               | -----none-----                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.QuartzBenefits.com/formulary">www.QuartzBenefits.com/formulary</a> | Low Cost Generic                                    | \$10 <a href="#">copay</a> /prescription; <a href="#">deductible</a> does not apply  | Not covered                               | Preventive medications are covered without member <a href="#">cost sharing</a> as specified on the <a href="#">formulary</a> .<br>Multiple <a href="#">copays</a> will apply for <a href="#">claims</a> of greater than 30 day supply when covered; for <a href="#">claims</a> of 31 to 60 days supply, two <a href="#">copays</a> will apply, and for <a href="#">claims</a> of 61 to 90 days supply, three <a href="#">copays</a> will apply. |
|                                                                                                                                                                                                                                         | Generic   Tier 1                                    | \$35 <a href="#">copay</a> /prescription; <a href="#">deductible</a> does not apply  | Not covered                               | Coverage restrictions may apply to some medications. See the Quartz <a href="#">Formulary</a> for details; the <a href="#">formulary</a> is subject to change following quarterly Pharmacy & Therapeutics Committee meetings, or following updates to drug availability (e.g., new generic drugs).                                                                                                                                              |
|                                                                                                                                                                                                                                         | Preferred Brand   Tier 2                            | \$100 <a href="#">copay</a> /prescription; <a href="#">deductible</a> does not apply | Not covered                               | Manufacturer-funded cost-sharing assistance for your prescriptions will be credited to your Annual <a href="#">Deductible</a> or Annual Maximum Out-of-Pocket Limit.                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                         | Non-Preferred Brand & Generic   Tier 3              | 50% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply          | Not covered                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                         | Specialty   Tier 4                                  | 60% <a href="#">coinsurance</a>                                                      | Not covered                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                   | Facility fee (e.g., ambulatory surgery center)      | 40% <a href="#">coinsurance</a>                                                      | Not covered                               | Prior authorization may be required. See <a href="http://www.QuartzBenefits.com/WIPAList">www.QuartzBenefits.com/WIPAList</a> or call (800) 362-3310 for additional information.                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                                         | Physician/surgeon fees                              | 40% <a href="#">coinsurance</a>                                                      | Not covered                               | Oral Surgery: Not covered                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                          | <a href="#">Emergency room care</a>                 | 40% <a href="#">coinsurance</a>                                                      | 40% <a href="#">coinsurance</a>           | Foreign <a href="#">claims</a> for emergency care are subject to a \$20,000 limit per Benefit Year.                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                         | <a href="#">Emergency medical transportation</a>    | 40% <a href="#">coinsurance</a>                                                      | 40% <a href="#">coinsurance</a>           | Foreign <a href="#">claims</a> for emergency care are subject to a \$20,000 limit per Benefit Year.                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                         | <a href="#">Urgent care</a>                         | \$90 <a href="#">copay</a> /visit;                                                   | \$90 <a href="#">copay</a> /visit;        | Virtual Visits and Telehealth Visits are covered at                                                                                                                                                                                                                                                                                                                                                                                             |

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                                                                                                                                             |                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                       |
|---------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | In Network<br>(You will pay the least)                                                                                                                                        | Out-of-Network<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                           |                                           | <a href="#">deductible</a> does not apply                                                                                                                                     | <a href="#">deductible</a> does not apply | no charge; <a href="#">deductible</a> does not apply. <a href="#">Deductible</a> and/or <a href="#">coinsurance</a> may apply for additional services performed at your visit.                                                                                                                                                                                                                                               |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 40% <a href="#">coinsurance</a>                                                                                                                                               | Not covered                               | Prior authorization is required. See <a href="http://www.QuartzBenefits.com/WIPAList">www.QuartzBenefits.com/WIPAList</a> or call (800) 362-3310 for additional information.                                                                                                                                                                                                                                                 |
|                                                                           | Physician/surgeon fees                    | 40% <a href="#">coinsurance</a>                                                                                                                                               | Not covered                               |                                                                                                                                                                                                                                                                                                                                                                                                                              |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$30 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply                                                                                                  | Not covered                               | Benefits are not available for care that is Maintenance and Supportive Care. Virtual Visits and Telehealth Visits are covered at no charge; <a href="#">deductible</a> does not apply. <a href="#">Deductible</a> and/or <a href="#">coinsurance</a> may apply for additional services performed at your visit.                                                                                                              |
|                                                                           | Inpatient services                        | 40% <a href="#">coinsurance</a>                                                                                                                                               | Not covered                               | Prior authorization is required. See <a href="http://www.QuartzBenefits.com/WIPAList">www.QuartzBenefits.com/WIPAList</a> or call (800) 362-3310 for additional information.                                                                                                                                                                                                                                                 |
| If you are pregnant                                                       | Office visits                             | PCP: \$30 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply<br>Specialist: \$90 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply | Not covered                               | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Prior authorization is required for inpatient services. See <a href="http://www.QuartzBenefits.com/WIPAList">www.QuartzBenefits.com/WIPAList</a> or call (800) 362-3310 for additional information. <a href="#">Deductible</a> and/or <a href="#">coinsurance</a> may apply for additional services performed at your visit. |
|                                                                           | Childbirth/delivery professional services | 40% <a href="#">coinsurance</a>                                                                                                                                               | Not covered                               | Coverage is limited to 60 visits per Benefit Year. Prior authorization is required. See <a href="http://www.QuartzBenefits.com/WIPAList">www.QuartzBenefits.com/WIPAList</a> or call (800) 362-3310 for additional information.                                                                                                                                                                                              |
|                                                                           | Childbirth/delivery facility services     | 40% <a href="#">coinsurance</a>                                                                                                                                               | Not covered                               |                                                                                                                                                                                                                                                                                                                                                                                                                              |
| If you need help recovering or have other special health                  | <a href="#">Home health care</a>          | 40% <a href="#">coinsurance</a>                                                                                                                                               | Not covered                               |                                                                                                                                                                                                                                                                                                                                                                                                                              |

| Common Medical Event | Services You May Need                     | What You Will Pay                                                           |                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                              |
|----------------------|-------------------------------------------|-----------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                      |                                           | In Network<br>(You will pay the least)                                      | Out-of-Network<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                     |
| needs                | <a href="#">Rehabilitation services</a>   | 40% <a href="#">coinsurance</a>                                             | Not covered                               | Coverage is limited to 20 visits each for Physical, Speech and Occupational therapy and Pulmonary Rehab per Benefit Year.<br>Cardiac Rehab is limited to 36 visits per Benefit Year.<br>Inpatient Rehab is limited to 60 days per Benefit Year.<br>Post Cochlear Implant Aural Therapy is limited to 30 visits per Benefit Year.<br>A covered Telehealth visit applies the same cost-sharing as an in-person visit. |
|                      | <a href="#">Habilitation services</a>     | 40% <a href="#">coinsurance</a>                                             | Not covered                               | Coverage is limited to 20 visits each for Physical, Speech and Occupational therapy per Benefit Year.<br>Prior authorization may be required. See <a href="http://www.QuartzBenefits.com/WIPAList">www.QuartzBenefits.com/WIPAList</a> or call (800) 362-3310 for additional information.<br>A covered Telehealth visit applies the same cost-sharing as an in-person visit.                                        |
|                      | <a href="#">Skilled nursing care</a>      | 40% <a href="#">coinsurance</a>                                             | Not covered                               | Coverage limited to 30 days per confinement.<br>This benefit is combined with the Swing Bed Care benefit.<br>Prior authorization is required. See <a href="http://www.QuartzBenefits.com/WIPAList">www.QuartzBenefits.com/WIPAList</a> or call (800) 362-3310 for additional information.                                                                                                                           |
|                      | <a href="#">Durable medical equipment</a> | 40% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply | Not covered                               | Purchase or rental of DME items may require Prior Authorization. See <a href="http://www.QuartzBenefits.com/WIPAList">www.QuartzBenefits.com/WIPAList</a> or call (800) 362-3310 for additional information.<br>Glasses/contacts for Adult Routine Vision are not covered.<br>Coverage for --<br>Hearing Aids: Limited to one per ear every 36 months.                                                              |

| Common Medical Event                   | Services You May Need            | What You Will Pay                                                            |                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                       |
|----------------------------------------|----------------------------------|------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                                  | In Network<br>(You will pay the least)                                       | Out-of-Network<br>(You will pay the most) |                                                                                                                                                                                                                                                              |
| If your child needs dental or eye care |                                  |                                                                              |                                           | To obtain the list of covered hearing aid models log onto <a href="http://www.QuartzBenefits.com/hearingaids">www.QuartzBenefits.com/hearingaids</a> or contact Customer Success.                                                                            |
|                                        | <a href="#">Hospice services</a> | 40% <a href="#">coinsurance</a>                                              | Not covered                               | Prior authorization is required. See <a href="http://www.QuartzBenefits.com/WIPAList">www.QuartzBenefits.com/WIPAList</a> or call (800) 362-3310 for additional information. Hospice coverage excludes room and board charges in a Skilled Nursing Facility. |
|                                        | Children's eye exam              | \$30 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply | Not covered                               | -----none-----                                                                                                                                                                                                                                               |
|                                        | Children's glasses               | 40% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply  | Not covered                               | Limited to one pair of glasses or set of contacts per Benefit Year.                                                                                                                                                                                          |
|                                        | Children's dental check-up       | Not covered                                                                  | Not covered                               | -----none-----                                                                                                                                                                                                                                               |

### Excluded Services & Other Covered Services:

| Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <a href="#">excluded services</a> .)                                                                                                        |                                                                                                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Abortions (except in cases of rape, incest or when the life of the mother is endangered)</li> <li>• Acupuncture</li> <li>• Allergy testing</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Non-<a href="#">formulary</a> drugs without an approved exception</li> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> <li>• Weight loss programs</li> </ul> |

| Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.) |                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Chiropractic care</li> </ul>                                                                                 | <ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Routine foot care</li> </ul> |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Office of the Commissioner of Insurance, Complaints Department, PO Box 7873, Madison, WI 53707-7873,

the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa](http://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa), or visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or for assistance, contact: Office of the Commissioner of Insurance, Complaints Department, PO Box 7873, Madison, WI 53707-7873, or if coverage is under a group health [plan](#) the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

#### **Does this Plan Provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium](#) tax credit.

#### **Does this Coverage Meet the Minimum Value Standard? Not Applicable**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium](#) tax credit to help you pay for a [plan](#) through the [Marketplace](#).

#### **Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-362-3310 or 1-800-877-8973 (TTY).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-362-3310 or 1-800-877-8973 (TTY)

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-362-3310 or 1-800-877-8973 (TTY)

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-362-3310 or 1-800-877-8973 (TTY)

—To see *examples of how this plan might cover costs for a sample medical situation*, see *the next page*.

About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

| Peg is Having a Baby<br>(9 months of in-network pre-natal care and a hospital delivery)                                                                                                                                                                                                          |          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|
| ■ The <a href="#">plan's overall deductible</a>                                                                                                                                                                                                                                                  | \$5,500  |
| ■ <a href="#">Specialist copayment</a>                                                                                                                                                                                                                                                           | \$90     |
| ■ Hospital (facility) <a href="#">coinsurance</a>                                                                                                                                                                                                                                                | 40%      |
| ■ Other <a href="#">coinsurance</a>                                                                                                                                                                                                                                                              | 40%      |
| <b>This EXAMPLE event includes services like:</b><br>Specialist office visits ( <i>prenatal care</i> )<br>Childbirth/Delivery Professional Services<br>Childbirth/Delivery Facility Services<br>Diagnostic tests ( <i>ultrasounds and blood work</i> )<br>Specialist visit ( <i>anesthesia</i> ) |          |
| Total Example Cost                                                                                                                                                                                                                                                                               | \$12,700 |
| In this example, Peg would pay:                                                                                                                                                                                                                                                                  |          |
| Cost Sharing                                                                                                                                                                                                                                                                                     |          |
| Deductibles                                                                                                                                                                                                                                                                                      | \$5,500  |
| Copayments                                                                                                                                                                                                                                                                                       | \$100    |
| Coinsurance                                                                                                                                                                                                                                                                                      | \$1,800  |
| What isn't covered                                                                                                                                                                                                                                                                               |          |
| Limits or exclusions                                                                                                                                                                                                                                                                             | \$0      |
| The total Peg would pay is                                                                                                                                                                                                                                                                       | \$7,400  |

| Managing Joe's type 2 Diabetes<br>(a year of routine in-network care of a well-controlled condition)                                                                                                                                                   |         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|
| ■ The <a href="#">plan's overall deductible</a>                                                                                                                                                                                                        | \$5,500 |
| ■ <a href="#">Specialist copayment</a>                                                                                                                                                                                                                 | \$90    |
| ■ Hospital (facility) <a href="#">coinsurance</a>                                                                                                                                                                                                      | 40%     |
| ■ Other <a href="#">coinsurance</a>                                                                                                                                                                                                                    | 40%     |
| <b>This EXAMPLE event includes services like:</b><br>Primary care physician office visits ( <i>including disease education</i> )<br>Diagnostic tests ( <i>blood work</i> )<br>Prescription drugs<br>Durable medical equipment ( <i>glucose meter</i> ) |         |
| Total Example Cost                                                                                                                                                                                                                                     | \$5,600 |
| In this example, Joe would pay:                                                                                                                                                                                                                        |         |
| Cost Sharing                                                                                                                                                                                                                                           |         |
| Deductibles                                                                                                                                                                                                                                            | \$100   |
| Copayments                                                                                                                                                                                                                                             | \$800   |
| Coinsurance                                                                                                                                                                                                                                            | \$0     |
| What isn't covered                                                                                                                                                                                                                                     |         |
| Limits or exclusions                                                                                                                                                                                                                                   | \$0     |
| The total Joe would pay is                                                                                                                                                                                                                             | \$900   |

| Mia's Simple Fracture<br>(in-network emergency room visit and follow up care)                                                                                                                                                                              |         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|
| ■ The <a href="#">plan's overall deductible</a>                                                                                                                                                                                                            | \$5,500 |
| ■ <a href="#">Specialist copayment</a>                                                                                                                                                                                                                     | \$90    |
| ■ Hospital (facility) <a href="#">coinsurance</a>                                                                                                                                                                                                          | 40%     |
| ■ Other <a href="#">coinsurance</a>                                                                                                                                                                                                                        | 40%     |
| <b>This EXAMPLE event includes services like:</b><br>Emergency room care ( <i>including medical supplies</i> )<br>Diagnostic test ( <i>x-ray</i> )<br>Durable medical equipment ( <i>crutches</i> )<br>Rehabilitation services ( <i>physical therapy</i> ) |         |
| Total Example Cost                                                                                                                                                                                                                                         | \$2,800 |
| In this example, Mia would pay:                                                                                                                                                                                                                            |         |
| Cost Sharing                                                                                                                                                                                                                                               |         |
| Deductibles                                                                                                                                                                                                                                                | \$2,200 |
| Copayments                                                                                                                                                                                                                                                 | \$100   |
| Coinsurance                                                                                                                                                                                                                                                | \$100   |
| What isn't covered                                                                                                                                                                                                                                         |         |
| Limits or exclusions                                                                                                                                                                                                                                       | \$0     |
| The total Mia would pay is                                                                                                                                                                                                                                 | \$2,400 |

The plan would be responsible for the other costs of these EXAMPLE covered services.



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

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

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

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

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

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

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

- Qualified interpreters
- Information written in other languages.

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

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

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

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

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

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

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

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



