IMPORTANT NOTICE: You are covered under a point of service ("POS") policy issued by Arise Health Plan. This Policy describes the essential features of such insurance.

Your Right to Return This Policy. Please read this Policy right away. If you're not satisfied with this Policy for any reason, you may return it by notifying us in writing or by calling the number shown on your identification card within 10 days after you receive your new member materials. If you notify us within that 10-day period, we will cancel your coverage under this Policy and refund all premium payments that you've made to us for it. The Policy will become null and void and no coverage will be provided to you under it.

The Policy provides benefits for covered health care services you receive from participating providers and non-participating providers. For a list of participating providers and information about how to select one, please visit at www.arisehealthplan.com or contact our Customer Service Department by calling the telephone number shown on your Arise Health Plan identification card.

This Policy includes a Schedule of Benefits. It may also include one or several endorsements. Please read all of these documents carefully so you know and understand your coverage.

Unless otherwise stated, Arise Health Plan (hereinafter “Arise”, “we”, “our”, or “us”) will not pay for most health care services under the Policy until you have paid certain out-of-pocket amounts, called annual deductibles. Please see the Schedule of Benefits to determine your annual deductible amounts. Other cost-sharing aspects of the Policy, such as coinsurance and copayments, are discussed in Section 4. (Payment of Benefits). Please review that section carefully so that you understand what your share of each health care expense will be under the Policy.

The amount we pay for a covered health care service will always be limited to the maximum allowable fee, as defined in Section 14. (Definitions). This amount may be less than the amount billed and in certain cases, you will be responsible for paying the difference. If you would like more information, please contact our Customer Service Department by calling the telephone number shown on your Arise identification card.

This Policy does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your agent or the Federally-Facilitated Marketplace if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

This Policy is issued by Arise and delivered in Wisconsin. All terms, conditions, and provisions of this Policy, including, but not limited to, all exclusions and coverage limitations contained in the Policy, are governed by the laws of Wisconsin. All benefits are provided in accordance with the terms, conditions, and provisions of the Policy, any endorsements attached to this Policy, your completed application for this insurance, and applicable laws and regulations.

THIS POLICY IS RENEWABLE WITH CONSENT OF ARISE HEALTH PLAN AS STATED IN SECTION 9.
(PREMIUMS, RENEWAL AND GRACE PERIOD PROVISIONS)

WPS Health Plan, Inc.

Michael F. Hamerlik
President
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1. GENERAL INFORMATION

A. General Description of Coverage

This policy is part of the contract between Arise and the subscriber named on the Arise identification card. In return for the subscriber's premium payments and each covered person's compliance with all of the terms, conditions and provisions of this Policy, each covered person is insured for the benefits described in this Policy.

This Policy describes the two benefit levels. One benefit level applied when you receive covered health care services from a participating provider. The other benefit level applies when you receive covered health care services from a non-participating provider.

Coverage is subject to all terms, conditions and provisions of this Policy. This Policy replaces and supersedes any policies we issued to the subscriber before the effective date of this Policy and any written or oral representations that we or our representatives made.

B. Effective Date

After the applicant applies for coverage, we will review his/her application and determine whether those named on the application are eligible for coverage. This Policy will only be issued if we approve all persons named on the application for coverage. Once it is issued, the effective date of this Policy will be the effective date stated in the subscriber’s application for coverage, as determined by us.

C. Entire Contract

The entire contract between you and us is made up of this Policy, the Schedule of Benefits, any endorsements, your application, and any supplemental applications.

D. How to Use This Policy

You should read this Policy, including its Schedule of Benefits and all endorsements, carefully and completely. The provisions of this Policy are interrelated. This means that each provision is subject to all of the other provisions. Therefore, reading just one or two provisions may not give you a full understanding of your coverage under the Policy.

Each italicized term used in this Policy has a special meaning, which is explained in Section 14. (Definitions) or in the definitions section of the relevant subsection. Whenever you come across an italicized word, please review its definition carefully so you understand what it means.

Throughout this Policy, the terms “you” and “your” refer to any covered person. The terms “we”, “us”, and “our” refer to Arise Health Plan (“Arise”).

E. How to Get More Information

When you have questions about your coverage or claims, contact our Customer Service Department by calling the telephone number shown on your identification card. You can also find lots of additional information and answers to common questions on our website, www.arisehealthplan.com. We also recommend that you register for an Arise online member account, where you can access your Explanation of Benefits (EOBs) and policy materials, check your claims processing status, find a participating provider, verify plan benefits, and check your deductible.

F. Your Choice of Health Care Providers Affects Your Benefits

Participating providers are health care providers who are part of our network as shown on your Arise identification card. See Section 14. (Definitions) for more information.
If you use a *participating provider*, covered charges will be payable under this Policy based on the provider’s agreement with us, subject to any deductible, coinsurance, and copayment provisions. If there is a difference between the amount we allow and the amount the *participating provider* bills, you are not responsible for that amount.

*Non-participating providers are health care providers* who have not agreed to participate in the health care network shown on your Arise identification card.

If you use a *non-participating provider*, covered charges will be payable under this policy up to the *maximum out-of-network allowable fee* as defined in Section 14. (Definitions). If there is a difference between the amount that we pay and the amount that the *non-participating provider* bills, you are responsible for that amount.

**G. Covered Expenses**

The Policy only provides *benefits* for certain *health care services*. Just because a *health care provider* has performed or prescribed a *health care service* does not mean that it will be covered under the Policy. Likewise, just because a *health care service* is the only available *health care service* for your *illness or injury* does not mean that the *health care service* will be covered under the Policy. We have the sole and exclusive right to interpret and apply the Policy’s provisions and to make factual determinations. We also have the sole and exclusive right to determine whether *benefits* are payable for a particular *health care service*.

In certain circumstances for purposes of overall cost savings or efficiency, we have full discretionary authority to pay *benefits for health care services*: (1) at the *participating provider* level of benefits for a *health care service* provided by a *non-participating provider*; or (2) that are not covered under the Policy, to the limited extent provided in Section 5. C. (Covered Expenses / Alternative Care). The fact that we provide such coverage in one case will not require us to do so in any other case, regardless of any similarities between the two.

We have full discretionary authority to arrange for other persons or entities to provide administrative services related to the Policy, including claims processing and utilization management without notice to you. We also have full discretionary authority to authorize other persons or entities to exercise discretionary authority with regard to the Policy without notice to you. By accepting this Policy, you agree to cooperate fully with those persons or entities in the performance of their responsibilities.

### 2. ENROLLMENT OPTIONS

**A. Annual Enrollment Period**

Each year the *subscriber* will have an enrollment period in which he/she can enroll dependents who did not enroll under this Policy when first eligible. The annual enrollment period also provides an opportunity for a *subscriber* to change to a different health insurance plan. The annual enrollment period and the effective date of coverage are determined by federal law.

**B. Special Enrollment Periods**

If the *subscriber* does not request enrollment during the annual enrollment period, his/her dependent(s) must wait to enroll for coverage during the next annual enrollment period unless he/she becomes eligible for special enrollment, as described below.

A special enrollment period is available for the following reasons:

1. A *subscriber* or a dependent loses minimum essential coverage or certain government-sponsored pregnancy-related or medically needy coverage. This does not include a loss of coverage due to rescission, failure to pay premiums on a timely basis or voluntary loss of coverage;

2. A *subscriber* gains a dependent through marriage, birth, adoption or *placement for adoption*, placement in foster care, or child support or other by court order If the *subscriber* gains a dependent through marriage, one spouse must meet one of the following:
a. Had minimum essential coverage for one or more days during the 60 days preceding the date of the marriage; or
b. Was living outside of the United States or a United States territory prior to the marriage;
c. Is an Indian as defined by section 4. of the Indian Health Care Improvement Act; or
d. Was living for one or more days during the 60 days preceding the date of marriage in a service area where no qualified health plan was available through a Health Insurance Marketplace.

3. Your enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Health Insurance Marketplace or the Department of Health and Human Services, or its instrumentalities as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;

4. You adequately demonstrate to the Health Insurance Marketplace that we substantially violated a material provision of your contract with us;

5. You are determined newly ineligible for advance payments of the premium tax credit or had a change in eligibility for cost-sharing reductions, regardless of whether the subscriber is already enrolled in a qualified health plan;

6. You gain access to new qualified health plans as a result of a permanent move, and either:
   a. Had minimum essential coverage for one or more days during the 60 days preceding the date of the permanent move;
   b. Was living outside of the United States or a United States territory at the time of a permanent move;
   c. Is an Indian as defined by section 4. of the Indian Health Care Improvement Act; or
   d. Was living for one or more days during the 60 days preceding the date of marriage in a service area where no qualified health plan was available through a Health Insurance Marketplace.

   Moving solely for medical treatment or vacation does not qualify.

7. A subscriber’s renewal of a non-calendar year plan;

8. You gain access to new qualified health plans due to no longer being incarcerated;

9. You are the victim of domestic abuse or spousal abandonment enrolled in minimum essential coverage seeking to enroll in coverage separate from the perpetrator of the abuse or abandonment;

10. You exhaust any group continuation coverage required by any state or federal law;

11. You apply for coverage with the Health Insurance Marketplace during the annual open enrollment period or due to a qualifying event, are assessed by the Health Insurance Marketplace as potentially eligible for Medicaid or Children’s Health Insurance Program (CHIP), and are determined ineligible for Medicaid or CHIP after open enrollment has ended or more than 60 days after the qualifying event; or

12. You apply for Medicaid or CHIP coverage during the annual open enrollment period and are determined ineligible for Medicaid or CHIP after open enrollment has ended.

Except for birth of a child, as stated below, the subscriber must request enrollment within 60 days after one of the events listed above. If he/she does not request enrollment within this time, he/she or his/her dependents will have to wait until the next annual enrollment period. If he/she requests enrollment within the 60-day time frame, the effective date of coverage will be determined as follows, unless the Health Insurance Marketplace authorizes a different date:

1. In the case of birth, adoption, placement for adoption, placement in foster care or court order, the effective date of coverage is either (a) the date of birth, adoption, placement for adoption, placement in foster care, or effective date of the court order, or (b) at the request of the subscriber, the first of the month following plan selection;

2. In the case of marriage, the effective date of coverage is the first day of the month following plan selection;
3. In the case of loss of coverage described above, the effective date of coverage is the first day of the month following plan selection; or

4. For all special enrollment reasons not addressed in Paragraphs 1-3, if the request for enrollment is received by us between the first and fifteenth of any month, the effective date of coverage is the first day of the month following your request. If the request for enrollment is received between the sixteenth and the last day of the month, the effective date of coverage is the first day of the second following month.

C. **Birth of a Child**

If a subscriber has family coverage, coverage is provided for a newborn biological child who meets the definition of eligible dependent from the moment of that child's birth. You must notify us of the child's birth.

If a subscriber has single coverage, coverage is provided for a newborn biological child who meets the definition of eligible dependent from the moment of that child’s birth and for the next 60 days of that child’s life immediately following that child's date of birth. If a subscriber wishes to change to family coverage to add his/her newborn natural child and any other eligible dependent(s), we must receive an enrollment form, listing all eligible dependent(s) for whom the subscriber wishes coverage, within the first 60 days after the birth of his/her natural child.

To add a newborn natural child, you must submit an enrollment form and pay any required premium within 60 days after the date of birth. If you fail to notify us and do not make any required payment beyond the 60-day period, coverage will end, unless you make all past due payments with 5.5% interest, within one year of the child's birth. In this case, benefits are retroactive to the date of birth. If we do not receive the enrollment form within one year after the child’s birth, the newborn may not be added until the next annual enrollment period.

D. **Adoption of a Child or a Child Placed for Adoption or Foster Care**

If a subscriber has family coverage, coverage is provided for a child who meets the definition of eligible dependent from the date of that child's adoption, placement for adoption or placement in foster care. You must notify us of the child's adoption, placement for adoption, or placement in foster care.

If a subscriber has single coverage and wishes to change to family coverage because of his/her adoption of a child or a child was placed for adoption or foster care, we must receive an enrollment form listing the eligible dependent(s) the subscriber wants to enroll within 60 days after the date of the adoption, placement for adoption, or placement in foster care. If we receive the enrollment form after the 60-day enrollment period ends, the eligible dependent(s) may not be added until the next annual enrollment period.

If the adoption of a child who is placed for adoption or foster care with the subscriber is not finalized, the child’s coverage will terminate when the child’s placement for adoption or foster care with the subscriber terminates.

E. **Court Order**

To the extent required by Wis. Stat. § 632.897(10)(am), a subscriber may change from single coverage to family coverage to cover the health care expenses of his/her child if a court orders him/her to do so and we determine, in our discretion, that the child is an eligible dependent under the Policy.

In order to obtain coverage, the subscriber, the child's other parent, the Wisconsin Department of Children and Families, or the county child support agency under Wis. Stat. § 59.53(5) must submit the following to us after the applicable court order is issued: (a) a completed enrollment form listing all eligible dependents the subscriber wishes to cover; (b) a copy of the court order; and (c) payment for the appropriate premium.

The effective date of family coverage under this paragraph will be either the date that court order is issued; or another coverage date contained in that court order. Such coverage will continue in effect until the earliest of the following dates:

1. The date upon which the subscriber is no longer eligible for family coverage under the Policy;
2. The date upon which the court order expires;
3. The date upon which the child obtains coverage under another group policy or individual policy that provides comparable health care coverage, as applicable; or

4. The date upon which the child’s coverage ends sooner in accordance with Section 8. (When Coverage Ends).

The subscriber must notify us in writing as soon as reasonably possible after he/she becomes aware that the applicable court order is expiring and/or that other health care coverage is becoming effective for that child.

3. OBTAINING SERVICES

A. Choosing a Primary Care Practitioner

Each covered person must choose a primary care practitioner (PCP) from our directory of participating providers and notify us of his/her selection. You may choose any PCP who participates in our network and who is available to accept you. For children, a subscriber may designate a participating pediatrician as the child’s PCP. Please note that if you do not choose a PCP, we may designate one for you.

Regardless of who you choose as your PCP, no referral is required to receive health care services from a participating provider who is licensed under Wisconsin Statutes ch. 448 and who specializes in obstetrics and gynecology.

For a complete list of PCPs in your network, please use the “Find A Doctor” tool on our website or contact Customer Service. Although you may change your PCP at any time, we encourage you to establish a relationship with one PCP. You must notify us each time you select a different PCP.

B. Participating Provider Benefits

1. Except as stated in the Policy, participating provider benefits are payable only when you receive health care services from:

   a. A participating provider;

   b. A non-participating provider if you have submitted and we have approved a prior authorization to seek health care services from that provider. We will only approve health care services provided by a non-participating provider when those health care services are not available from a participating provider and necessary to treat your illness or injury;

   c. A radiologist, pathologist, or anesthesiologist who is on staff at a participating hospital or ordered by a participating provider; or

   d. A radiologist, pathologist, or anesthesiologist who is on staff at a non-participating hospital if you have submitted and we have approved a prior authorization to seek health care services at a non-participating hospital.

2. Participating providers are not permitted to bill you for any medically necessary covered expenses above the maximum allowable fee. Health care services you receive from participating providers are only subject to your deductible, copayments, and coinsurance. See Section 4. (Payment of Benefits) for additional information about the costs you are responsible for under the Policy.

3. If you receive any health care services from a non-participating provider, even those approved under paragraph 1. above, the non-participating provider may bill you for the difference between the amount billed and the amount that we determine to be the maximum allowable fee.

C. Non-Participating Provider Benefits

If, you receive health care services from a non-participating provider, benefits provided are limited to the maximum out-of-network allowable fee and you will be responsible for paying any difference between that amount and the charge billed. For example, if the non-participating provider’s charge is $1,000 and the maximum out-of-network allowable fee is $700, you will be responsible for paying the remaining balance of $300 in addition to any applicable copayment, deductible or
D. Prior Authorization

1. What is Prior Authorization? Prior authorization is the process we use to determine if a prescribed health care service, including certain prescription legend drugs, is covered under the Policy before you receive it. This process is intended to protect you from unnecessary, ineffective, and unsafe services and to prevent you from becoming responsible for a large bill for health care services or prescription legend drugs, that are not covered by the Policy.

2. When Do I Have to Obtain Prior Authorization? You are required to obtain prior authorization before you visit certain health care providers or receive certain health care services, such as planned inpatient admissions, pain management, spinal surgery, new technologies (which may be considered experimental/investigational/unproven), non-emergency ambulance services, high-cost durable medical equipment, genetic testing, prescription legend drugs, or procedures that could potentially be considered cosmetic treatment. A current list of health care providers and health care services for which prior authorization is required is located on our website at www.arisehealthplan.com. Please refer to this website often, as we have full discretionary authority to change it from time to time without notice to you.

3. How do I Request Prior Authorization?
   a. Health Care Services Other Than Prescription Legend Drugs: Ask your health care practitioner to contact our Customer Service Department by calling the telephone number shown on your identification card or to download, complete, and submit the printable Prior Authorization Form on our website. You should then call Customer Service to verify that we have received the prior authorization request. Please note that for genetic services, We will not accept prior authorization requests from the laboratory that will perform the genetic services unless there is supporting documentation from the ordering health care provider.
   b. Prescription Legend Drugs: Prescription legend drugs that require prior authorization are noted on our website at www.arisehealthplan.com. Your health care practitioner should contact us or our delegate, as indicated, to initiate the process. To find out about the prior authorization process for prescription legend drugs, see Section 5. LL. (Covered Expenses / Prescription Legend Drugs and Supplies).

4. What Happens After My Provider Submits the Prior Authorization Request? After we, or our delegate, receive your health care provider’s request, we or our delegate, will review all of the documentation provided and send a written response to you and/or the health care provider who submitted the request within the timeframe required by law. See Sections 11. (Claim Filing and Processing Procedures) and 12. (Internal Grievance and Appeals Procedures) for additional details.

5. What Are My Responsibilities During the Prior Authorization Process? Although your health care provider should initiate the prior authorization process, it is your responsibility to ensure that we have approved the prior authorization request before you obtain the applicable health care services.

6. My Prior Authorization Request Was Approved – Now What? If we, or our delegate, approve your request, our prior authorization will only be valid for: (a) the covered person for whom the prior authorization was made; (b) the health care services specified in the prior authorization and approved by us; and (c) the specific period of time and service location approved by us.

   A standing authorization is subject to the same prior authorization requirements stated above. If we approve a standing authorization, you may request that the designated specialist provide primary care services, as long as your health care provider agrees.

7. My Prior Authorization Request Was Denied – Now What? If we disapprove your request for a health care service, you can request that we review and reconsider the denial of benefits by following the procedures outlined in Section 11. (Claim Filing and Processing Procedures) and 12. (Internal Grievance and Appeals Procedures). If we disapprove your request for a health care service from a non-participating provider, because we determine services are available from a participating provider, benefits may still be available as stated in the Schedule of Benefits for non-participating providers. You can request that we review and reconsider the denial of the prior service.
authorization request by following the procedures outlined in Section 11. (Claim Filing and Processing Procedures) and 12. (Internal Grievance and Appeals Procedures).

8. What Happens If I Do Not Obtain a Prior Authorization? Failure to comply with our prior authorization requirements will initially result in no benefits being paid under the Policy. If, however, benefits are denied solely because you did not obtain our prior authorization, you can request that we review and reconsider the denial of benefits by following the procedures outlined in Section 11. (Claim Filing and Processing Procedures) and 12. (Internal Grievance and Appeals Procedures). If you prove to us that the health care service would have been covered under the Policy if you had followed the prior authorization process, we will reprocess the affected claim(s) in accordance with your standard benefits.

9. What Health Care Services Do Not Require a Prior Authorization? You do not need a prior authorization from us or any other person (including your PCP) to obtain the following:
   a. Obstetrical or gynecological (OB/GYN) care from a participating provider who specializes in obstetrics or gynecology. The participating provider, however, may be required to comply with certain procedures, including obtaining a prior authorization for certain health care services, following a pre-approved treatment plan, or making referrals. For a list of participating OB/GYN providers, use the “Find A Doctor” tool on our website or contact Customer Service.
   b. Emergency medical care or urgent care at an emergency or urgent care facility.
   c. Covered radiologist, pathologist and anesthesiologist services at a participating facility.

E. Coding Errors

In some cases, we may determine that the health care provider or its agent did not use the appropriate billing code to identify the health care service provided to you. We follow the coding guidelines of the Center for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), Current Procedural Terminology (CPT), the Healthcare Common Procedure Coding System (HCPCS) and the International Class of Diseases and Related Health Problems 10th Edition (ICD-10).

F. Our Utilization Management Program

Utilization management (UM) is the evaluation of a health care service’s medical necessity. Our UM program is designed to ensure that you are receiving high-quality medical care that is both appropriate and cost effective. You will receive benefits under the Policy only when health care services are determined to be medically necessary. The fact that a health care provider has prescribed, ordered, recommended, or approved a health care service or has informed you of its availability does not, in itself, make the service medically necessary.

We will make the final determination of whether any service is medically necessary. If you choose to receive a health care service that we determine is not medically necessary, you will be responsible for paying all charges and no benefits will be paid under the Policy.

G. Continuity of Care

If a health care provider leaves our network, you may, under the following circumstances, continue to receive care from that health care provider at the participating provider benefit level for a designated period of time. The continuity of care provisions outlined below do not apply when: (1) the health care provider no longer practices within the geographical service area; or (2) the health care provider’s participation with us is terminated because of his/her misconduct.

1. Primary Care Practitioner (PCP). We will continue to cover health care services provided by a participating primary care practitioner until the end of the plan year for which we represented that the health care practitioner was, or would be, a participating provider.

2. Other than PCP Participating Providers. If you are undergoing a course of treatment with a participating provider, other than a PCP, we will continue to cover health care services from that participating provider for the
following period of time, whichever is shorter: (a) for the remainder of the course of treatment; or (b) for 90 days after the participation in our network terminates.

3. Maternity Services. We will continue to cover services for a covered person who is in the second or third trimester of pregnancy until the completion of postpartum care for the covered person and the infant.

4. PAYMENT OF BENEFITS

Any payment of benefits under the Policy is subject to: (1) the applicable deductible; (2) the applicable coinsurance; (3) the applicable copayment; (4) your out-of-pocket limit; (5) exclusions; (6) our prior authorization requirements; (7) our maximum allowable fee; (8) all other limitations shown in the Schedule of Benefits; and (9) all other terms, conditions and provisions of the Policy.

A. Deductible

Each year, you are required to pay a deductible before most benefits are payable under the Policy. Your deductible is shown in the Schedule of Benefits. No benefits are payable under the Policy for charges used to satisfy your deductible.

After you satisfy your deductible, charges for covered expenses will still be subject to any copayment and/or coinsurance amounts shown in your Schedule of Benefits.

The participating provider and non-participating provider deductibles are separate. However, charges for health care services provided by a non-participating provider and paid at the participating provider level of benefits shall be applied to the participating provider deductible shown in the Schedule of Benefits.

B. Coinsurance

After you satisfy your deductible, you will only be responsible for the copayment and coinsurance amounts shown in the Schedule of Benefits. Any applicable coinsurance will apply until you have reached your out-of-pocket limit.

C. Copayments

Your copayments are set forth in your Schedule of Benefits. Copayment amounts may vary by the type of service. You may also have a copayment when you get a prescription filled. See Section 5. LL. (Covered Expenses / Prescription Legend Drugs and Supplies) for information about prescription copayments.

If you receive health care services other than emergency room care at a hospital-based outpatient clinic or location, your bill may show two separate charges – one for the health care practitioner and one for the facility. The copayment only applies to the charge billed by the health care practitioner. Facility charges are subject to the applicable deductible and coinsurance amounts of the Policy. See Section 5. T. (Covered Expenses / Emergency Medical Care).

D. Out-of-Pocket Limits

After your out-of-pocket limit is reached, we will pay 100% of the charges up to the maximum allowable fee for covered health care services you receive during the remainder of the calendar year, subject to all other terms, conditions and provisions of the Policy.

Charges for health care services provided by a non-participating provider and paid at the participating provider level of benefits shall be applied to the participating provider out-of-pocket limit shown in the Schedule of Benefits.

E. Maximum Allowable Fee

We’ll pay charges for the covered expenses described in Section 5. (Covered Expenses) up to the maximum allowable fee. If you see a non-participating provider, you are solely responsible for paying any charge that exceeds the maximum out-of-network allowable fee. Regardless of what health care provider you see, you are also solely responsible for paying any charge for a health care service that we do not cover under the Policy.
You may contact us before receiving a health care service to determine if the health care provider’s estimated charge is less than or equal to the maximum allowable fee. In order for us to make this determination you will need to provide us with the following information: (1) the estimated amount that your health care provider will bill for the health care service; (2) the procedure code, if applicable; (3) the name of the health care provider providing the service; and (4) the facility where the service will be provided.

5. COVERED EXPENSES

Health care services described in this Section 5. are covered expenses as long as they are medically necessary, ordered and provided by a health care provider licensed to provide them and not subject to an exclusion or limitation outlined in this section and Section 6. (General Exclusions). If a health care service is not listed in this Section 5., it is not covered under the Policy and no benefits are payable for it.

Please note that any of the health care services listed below may require our prior authorization. Please see Section 3. D. (Obtaining Services / Prior Authorization) for detailed information about our prior authorizations. Additionally, all benefits are subject to the deductible, coinsurance, and copayment amounts, out-of-pocket limits and all other provisions stated in the Schedule of Benefits. See Section 4. (Payment of Benefits) for an explanation of these cost-sharing structures.

A. Alcoholism Treatment

See Section 5.G. (Covered Expenses / Behavioral Health Services) for benefits for alcoholism and other substance use disorders.

B. Allergy Testing and Treatment

Therapy and testing for treatment of allergies.

C. Alternative Care

If your attending health care practitioner advises you to consider alternative care for an illness or injury that includes health care services not covered under the Policy, your attending health care practitioner should contact us so we can discuss it with him/her. We have full discretionary authority to consider paying for such non-covered health care services and we may consider an alternative care plan if we find that:

1. The recommended alternative care offers a medical therapeutic value equal to or greater than the current treatment or confinement;
2. The current treatment or confinement is covered under the Policy;
3. The current treatment or confinement may be changed without jeopardizing your health; and
4. The health care services provided under the alternative care plan will be as cost effective as the health care services provided under the current treatment or confinement plan.

We will make each alternative care coverage determination on a case by case basis and no decision will set any precedent for future claims. Payment of benefits, if any, will be determined by us.

Any alternative care decision must be approved by you, the attending health care practitioner, and us before such alternative care begins.

Health care services must be medically necessary as determined by us to be a covered expense.
D. Ambulance Services

1. Ambulance services used to transport you when you are sick or injured:
   a. From your home or the scene of an accident or medical emergency to a hospital;
   b. Between hospitals;
   c. Between a hospital and a skilled nursing facility;
   d. From a hospital or a skilled nursing facility to your home for hospice care; or
   e. From your home to a facility for hospice care covered under Section 5. Z. (Covered Expenses / Hospice Care).

2. Your ambulance services benefits include coverage of any emergency medical care directly provided to you during your ambulance transport. In other words, if the ambulance service bills emergency medical care along with transport services, benefits are payable as stated in this Subsection D. If, however, the ambulance service bills emergency medical care separate from the transport services, benefits will be payable as stated elsewhere in the applicable provisions of the Policy.

3. Emergency ambulance transports must be made to the closest local facility or participating provider that can provide health care services appropriate for your illness or injury, as determined by us. If none of these facilities are located in your local area, you are covered for transports to the closest facility outside your local area.

4. Benefits are not payable for ambulance services:
   a. When you can use another type of transportation without endangering your health;
   b. When ambulance services are used solely for the personal convenience or preference of you, a family member, health care practitioner, or other health care provider; or
   c. When ambulance services are provided by anyone other than a licensed ambulance service.

E. Anesthesia Services

Anesthesia services provided in connection with other health care services covered under the Policy.

F. Autism Services

Benefits are payable for charges for covered expenses as described in Paragraph 1 below (Covered Autism Services) for covered persons who have a primary verified diagnosis of autism spectrum disorder, which includes autism disorder, Asperger’s syndrome, and pervasive development disorder not otherwise specified. A verified autism spectrum disorder diagnosis determination must be made by a health care practitioner skilled in testing and in the use of empirically-validated tools specific for autism spectrum disorders. We may require confirmation of the primary diagnosis through completion of empirically-validated tools or tests from each of the following categories: intelligence, parent report, language skills, adaptive behavior and direct observation of the covered person. Please see Wisconsin Administrative Code Ins. 3.36 for applicable definitions.

This Section 5. F. is not subject to the exclusions in Section 6. (General Exclusions). The only exclusions that apply to this Section are outlined in Paragraph 2 below (Autism Services Exclusions), except for durable medical equipment and prescription legend drugs. Please see Sections 5.S. (Covered Expenses / Durable Medical Equipment) and 5.LL. (Covered Expenses / Prescription Legend Drugs and Supplies).

1. Covered Autism Services:
   a. Diagnostic testing. The testing tools used must be appropriate to the presenting characteristics and age of the covered person and empirically valid for diagnosing autism spectrum disorders consistent with the criteria provided in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.
published by the American Psychiatric Association. We reserve the right to require a second opinion with a provider mutually agreeable to the covered person and us.

b. Intensive-level services. We will provide up to four years of intensive-level services that commence after you are two years of age and before you are nine years of age. The majority of the services must be provided to you when your parent or legal guardian is present and engaged. While receiving intensive-level services, you must be directly observed by the qualified provider at least once every two months. In addition, the intensive-level services must be all of the following:

1) Evidence-based.

2) Provided by a qualified provider, professional, therapist, or paraprofessional, as those terms are defined by state law.

3) Based on a treatment plan developed by a qualified provider or professional as defined by state law that includes an average of 20 or more hours per week over a six-month period of time with specific cognitive, social, communicative, self-care or behavioral goals that are clearly defined, directly observed and continually measured. Treatment plans shall require that you be present and engaged in the intervention.

4) Provided in an environment most conducive to achieving the goals of your treatment plan.

Assessed and documented throughout the course of treatment. We may request and review your treatment plan and the summary of progress on a periodic basis.

6) Designed to include training and consultation, participation in team meetings and active involvement of the covered person’s family and treatment team for implementation of the therapeutic goals developed by the team.

c. Concomitant services by a qualified therapist. We will cover services by a qualified therapist when all the following are true:

1) The services are provided concomitant with intensive-level evidence-based behavioral therapy;

2) You have a primary diagnosis of an autism spectrum disorder;

3) You are actively receiving behavioral services from a qualified intensive-level provider or qualified intensive-level professional; and

4) The qualified therapist develops and implements a treatment plan consistent with their license and this Section 5. F.

d. Non-intensive-level services. You are eligible for non-intensive-level services, including direct or consultative services, that are evidence-based and are provided by a qualified provider, supervising provider, professional, therapist or paraprofessional under one of the following scenarios: (i) after the completion of intensive-level services, as long as the non-intensive-level services are designed to sustain and maximize gains made during the intensive-level treatment; or (ii) if you have not and will not receive intensive-level services but non-intensive-level services will improve your condition. Non-intensive-level services must be all of the following:

1) Based upon a treatment plan and include specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that you be present and engaged in the intervention.

2) Implemented by qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals as defined by state law.

3) Provided in an environment most conducive to achieving the goals of your treatment plan.

4) Designed to provide training and consultation, participation in team meetings and active involvement of the covered person’s family in order to implement therapeutic goals developed by the team.

5) Designed to provide supervision for qualified professionals and paraprofessionals in the treatment team.
6) Assessed and documented throughout the course of treatment. We may request and review your treatment plan and the summary of progress on a periodic basis.

2. Autism Services Exclusions:

This Section 5. F. is only subject to the following exclusions. This Policy provides no benefits for:

a. Acupuncture;

b. Animal-based therapy including hippotherapy;

c. Auditory integration training;

d. Chelation therapy;

e. Child care fees;

f. Cranial sacral therapy;

g. Hyperbaric oxygen therapy;

h. Custodial care or respite care;

i. Special diets or supplements;

j. Provider travel expenses;

k. Therapy, treatment or services when provided to a covered person who is residing in a residential treatment center, inpatient treatment or day treatment facility;

l. Costs for the facility or location or for the use of a facility or location when treatment, therapy or services are provided outside of your home;

m. Claims that have been determined by us to be fraudulent; and

n. Treatment provided by parents or legal guardians who are otherwise qualified providers, supervising providers, therapists, professionals or paraprofessionals for treatment provided to their own children.

G. Behavioral Health Services

1. Definitions. The following definitions apply to this Section 5. G. only:

a. Collateral: a member of your immediate family.

b. Day Treatment Programs: nonresidential programs for the treatment of substance use disorders and nervous or mental disorders that are operated by certified inpatient and outpatient Alcohol and Other Drug Abuse (AODA) facilities that provide case management, counseling, medical care and therapies on a routine basis for a scheduled part of a day and a scheduled number of days per week; also known as partial hospitalization.

c. Hospital: (1) a hospital licensed under Wis. Stat. § 50.35; (2) an approved private treatment facility as defined in Wis. Stat. § 51.45(2)(b); or (3) an approved public treatment facility as defined in Wis. Stat. § 51.45(2)(c).

d. Inpatient Hospital Services: services for the treatment of nervous or mental disorders or substance use disorders that are directly provided to a covered person who is a bed patient in a hospital. This definition does not include inpatient hospital services for detoxification associated with a substance use disorder. Please see Section 5. AA. (Covered Expenses / Hospital Services) for this coverage information.

e. Outpatient Services: nonresidential services for the treatment of nervous or mental disorders or substance use disorders directly provided to a covered person and, if for the purpose of enhancing his/her
treatment, a collateral by any of the following: (a) a program in an outpatient treatment facility, if both the program and facility are approved by the Department of Health Services and established and maintained according to rules promulgated under Wis. Stat. § 51.42(7)(b) and § 51.04; (b) a licensed physician who has completed a residency in psychiatry, in an outpatient treatment facility or the physician's office; (c) a psychologist; (d) a licensed mental health professional practicing within the scope of his/her license under Wis. Stat. Chapter 457 and applicable rules; or (e) a health care practitioner licensed to provide nonresidential services for the treatment of nervous or mental disorders or substance use disorders within the scope of that license.

f. Residential Treatment Programs: therapeutic programs for treatment of nervous or mental disorders and substance use disorders, including therapeutic communities and transitional facilities.

g. Transitional Treatment: services for the treatment of nervous or mental disorders and substance use disorders that are directly provided to you in a less restrictive manner than inpatient hospital services but in a more intensive manner than outpatient services, if both the program and the facility are approved by the Department of Health Services as defined in the Wis. Admin. Code INS 3.37. Transitional treatment includes any of the following health care services if provided by a health care provider certified by the Department of Health Services:

1) Mental health services for covered adults in a day treatment program;
2) Mental health services for covered children and adolescents in a day treatment program;
3) Services for covered persons with chronic mental illness provided through a community support program;
4) Residential treatment programs for treatment of a covered person's nervous or mental disorders and/or substance use disorders;
5) Services for substance use disorders provided in a day treatment program;
6) Intensive outpatient programs for substance use disorders and for treatment of nervous or mental disorders; and
7) Coordinated emergency mental health services which are provided by a licensed mental health professional for covered persons who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided.

Transitional treatment also includes out-of-state services and programs that are substantially similar to 1 through 7 above if the health care provider is in compliance with similar requirements of the state in which the health care provider is located.

2. Covered Behavioral Health Services:

a. Inpatient hospital services;

b. Outpatient services; and


3. Review Criteria for Transitional Treatment:

a. The criteria that we use to determine if a transitional treatment is medically necessary and covered under the Policy include, but are not limited to, whether:

1) The transitional treatment is certified by the Department of Health Services;
2) The transitional treatment meets the accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations;
3) The specific diagnosis is consistent with the symptoms;
4) The transitional treatment is standard medical practice and appropriate for the specific diagnosis;
5) The transitional treatment plan is focused for the specific diagnosis; and
6) The multidisciplinary team running the transitional treatment is under the supervision of a licensed psychiatrist practicing in the same state in which the health care provider’s program is located or the service is provided.

b. We will need the following information from the health care provider to help us determine the medical necessity of a transitional treatment:

1) A summary of the development of your illness and previous treatment;
2) A well-defined treatment plan listing treatment objections, goals and duration of the care provided under the transitional treatment program; and
3) A list of credentials for the staff who participated in the transitional treatment program or service, unless the program or service is certified by the Department of Health Services.

4. Behavioral Health Services Exclusions:

The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

a. Health care services to treat academic problems not due to a clinically diagnosed nervous or mental disorder, or health care services a child’s school is legally required to provide, whether or not the school actually provides them and whether or not a covered person chooses to use those services.

b. Behavioral health care services or treatment for, or in connection with, developmental delays. Please see Section 5. TT. (Covered Expenses / Therapy Services), which provides benefits for other health care services provided for or in connection with developmental delays.

c. Treatment of a behavioral or psychological problem that is not due to a clinically diagnosed nervous or mental disorder. Examples include occupational problems such as job dissatisfaction, antisocial behavior, parent-child problems such as impaired communication or inadequate discipline, marital problems, and other interpersonal problems.

d. Health care services provided by wilderness programs, boot camps, therapeutic boarding schools, and outward bound programs.

e. Bereavement counseling.

f. Marriage counseling.

g. Charges for health care services provided to or received by a covered person as a collateral of a patient when those health care services do not enhance the treatment of another covered person under the Policy.

H. Blood and Blood Plasma

Whole blood; plasma; and blood products, including platelets.

I. Cardiac Rehabilitation Services

1. Covered Cardiac Rehabilitation Services:

a. Phase I cardiac rehabilitation sessions while you are confined as an inpatient in a hospital; and

b. Up to 36 supervised and monitored Phase II cardiac rehabilitation sessions per covered illness while you are an outpatient receiving services in a facility with a facility-approved cardiac rehabilitation program.

2. Cardiac Rehabilitation Exclusions:

The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).
a. Cardiac rehabilitation beyond Phase II.
b. Behavioral or vocational counseling.

J. Chiropractic Services

For therapy benefits, please see Section 5. TT (Covered Expenses / Therapy Services).

1. Covered Chiropractic Services:

Medically necessary services and diagnostic tests provided by a chiropractor.

2. Chiropractic Services Exclusions:

The Policy provides no benefit for chiropractic services which are considered maintenance care or supportive care. This exclusion applies in addition to the exclusions outlined in Section 6. (General Exclusions).

K. Clinical Trials

1. Definitions. The following definitions apply to this Section 5. K. only:

   a. Category B Devices: as determined by the FDA, nonexperimental/investigational devices where the incremental risk is the primary risk in question (i.e., underlying questions of safety and effectiveness of that device type have been resolved), or it is known that the device type can be safe and effective because, for example, other manufacturers have obtained FDA approval for that device type.

   In order to be covered as a category B device, the device must meet all of the following criteria:

   1) Used within the context of an FDA-approved clinical trial;

   2) Used according to the clinical trial's approved protocols;

   3) Fall under a covered benefit category and not excluded by law, regulation or current Medicare coverage guidelines;

   4) Medically necessary for the covered person, and the amount, duration and frequency of use or application of the service is medically appropriate; and

   5) Furnished in a setting appropriate to the covered person's medical needs and condition.

   b. Life-Threatening Condition: any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

   c. Qualifying Clinical Trial: with respect to cancer or other life-threatening conditions, a qualifying clinical trial is 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 condition and which meets any of the criteria in the bulleted list below.

   With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the criteria in the bulleted list below.

   1) Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

   a. National Institutes of Health (NIH), including the National Cancer Institute (NCI).

   b. Centers for Disease Control and Prevention (CDC).
c. Agency for Healthcare Research and Quality (AHRQ).

d. Centers for Medicare and Medicaid Services (CMS).

e. A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA).

f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

g. The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:

i. Comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and

ii. Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

2) The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.

3) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

In order to be a qualifying clinical trial, the clinical trial must also have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial. Additionally, the subject or purpose of the trial must be the evaluation of an item or service that would be covered under the Policy if it were not experimental/investigational/unproven.

d. Routine Patient Care Costs:

1) Include costs associated with any of the following:

a) Health care services that are typically covered under the Policy absent a clinical trial;

b) Covered health care services required solely for the provision of the trial health care service and clinically appropriate monitoring of the effects of the health care service trial;

c) Reasonable and necessary health care services used to diagnose and treat complications arising from your participation in a qualifying clinical trial; and

d) Covered health care services needed for reasonable and necessary care arising from the provision of a trial health care service.

2) Do not include costs associated with:

a) Experimental/investigational/unproven health care services with the exception of:

   i. Category B devices;

   ii. Certain promising interventions for patients with terminal illnesses; and

   iii. Other health care services that meet specified criteria in accordance with our medical policy guidelines.

b) Health care services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
c) Health care services provided by the research sponsors at no charge to any person enrolled in the trial; or

d) Health care services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

2. Benefits.

Routine patient care costs that you incur while participating in a qualifying clinical trial for the treatment of cancer, or a life-threatening condition, cardiovascular disease (cardiac/stroke); surgical musculoskeletal disorders of the spine, hip and knees or other diseases or disorders for which we determine a clinical trial meets the qualifying clinical trial criteria. Benefits are available only when you are eligible to participate in an approved clinical trial according to the trial protocol.

L. Cognitive Rehabilitation Therapy

Outpatient cognitive rehabilitation therapy following a brain injury or cerebral vascular accident limited to 20 visits per calendar year. No other benefits are payable for cognitive rehabilitation therapy services.

M. Colorectal Cancer Screening and Diagnosis

Routine colorectal cancer screenings are covered as preventive screenings under Section 5. MM. (Covered Expenses / Preventive Care Services). Diagnostic colorectal cancer tests are covered under Section 5. Q. (Covered Expenses / Diagnostic Services) and Section 5. TT. (Covered Expenses / Surgical Services).

N. Contraceptives for Birth Control

FDA-approved contraceptive methods prescribed by a health care practitioner, including related health care services. Examples of devices, medications, and health care services covered under this Policy include, but are not limited to:

1. Barrier methods, like diaphragms and sponges;
2. Hormonal methods, like birth control pills and vaginal rings;
3. Implanted devices, like intrauterine devices (IUDs);
4. Emergency contraception, like Plan B® and ella®;
5. Female sterilization procedures; and
6. Patient education and counseling.

Please note that oral contraceptives, contraceptive patches, diaphragms and contraceptive vaginal rings are covered under Section 5. LL. (Covered Expenses / Prescription Legend Drugs and Supplies) and male sterilization procedures are covered under Section 5. RR. (Covered Expenses / Surgical Services).

O. Dental Services

For oral surgery benefits, please see Section 5. RR. (Covered Expenses / Surgical Services).

1. Definition of Natural Teeth: teeth that: (1) are naturally developed by normal growth means; (2) are not created within a lab or other setting; (3) have not been extensively restored by amalgam, composite or resin, or do not have an inlay or onlay extending through mesial and distal contacts; (4) do not contain extensive decay or are not periodontally involved; and (5) are not more susceptible to injury than whole organic teeth.

2. Covered Dental Services:
   a. Any of the following health care services associated with dental repair or replacement of your sound natural teeth due to an injury if treatment begins within three months of the injury and is completed within 12 months of the injury (unless
extenuating circumstances exist such as prolonged hospitalization or the presences of fixation wires from fracture care):

1) Emergency examination;
2) Necessary diagnostic X-rays;
3) Endodontic (root canal) treatment;
4) Temporary splinting of teeth;
5) Prefabricated post and core;
6) Simple minimal restorative procedures (fillings);
7) Extractions;
8) Post-traumatic crowns if such are the only clinically acceptable treatment; and
9) Replacement of lost teeth due to the injury by implant, dentures or bridges.

b. Hospital or surgical center charges incurred, and anesthetics provided, in conjunction with dental care that is provided to you in a hospital or surgical center if any of the following apply:

1) You are a child under the age of five;
2) You have a chronic disability that meets all of the following:
   a) Is attributable to a mental or physical impairment or combination of mental and physical impairments;
   b) Is likely to continue indefinitely; and
   c) Results in substantial limitations as determined by us in one or more of the following areas: self-care, receptive and expressive language, learning, mobility, capacity for independent living, and economic self-sufficiency; or
3) You have a medical condition that requires hospitalization or a medical condition that requires general anesthesia for dental care.

c. Dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which benefits are available under the Policy, limited to:
   (a) transplant preparation; (b) prior to the initiation of immunosuppressive drugs; and (c) the direct treatment of acute traumatic injury, cancer or cleft palate.

2. Dental Services Exclusions:

The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

a. The general dental care and treatment of teeth, gums, or alveolar process including dentures, appliances, or supplies used in such care or treatment.

b. Injury or damage to teeth (natural or otherwise) caused by chewing food or similar substances.

c. Dental implants or other implant-related procedures, except as specifically stated in Paragraph 2. above.

d. Orthodontic treatment (e.g. braces).

e. Tooth extraction of any kind, except as specifically stated in Paragraph 2. above.

f. Periodontal care.
P. **Diabetes Services**

1. **Covered Diabetes Services:**
   a. Purchase and installation of up to one insulin infusion pump per *covered person per calendar year*.
   b. Continuous glucose monitor.
   c. All other equipment and *supplies* used in the *treatment* of diabetes when they are dispensed by a *health care provider* other than a pharmacy. When insulin syringes and needles, lancets and lancet devices, diabetic test strips, alcohol pads, blood glucose monitors, auto injectors, and glucose control solution are dispensed by a pharmacy, *benefits* are payable according to Section 5. LL. (Covered Expenses / Prescription Legend Drugs and Supplies).
   d. Medical eye exams (dilated retinal examinations).
   e. Preventive foot care for *covered persons* with diabetes.
   f. Diabetic self-management education programs.

2. **Diabetes Services Limitation:**
   a. Insulin is not covered under this Section 5. P. For coverage of insulin, see Section 5. LL. (Covered Expenses / Prescription Legend Drugs and Supplies).

3. **Diabetes Services Exclusion:**
   The Policy provides no *benefit* for the replacement of equipment unless *medically necessary* as determined by us. This exclusion applies in addition to the exclusions outlined in Section 6. (General Exclusions).

Q. **Diagnostic Services**

See Section 5. U. (Covered Expenses / Genetic Services) for *benefits* for genetic services.

1. **Covered Diagnostic Services:**
   The services must be directly provided to you and related to a *covered physical illness or injury*:
   a. Radiology; (including x-rays and *high-technology imaging*); and
   b. Laboratory services.

2. **Diagnostic Services Exclusions:**
   The Policy provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).
   a. *Charges* for computer-aided detection (except for screening mammogram interpretation).
   b. *Charges* for imaging studies not for purposes of diagnosis (e. g. assisting in the design or manufacture of individualized orthopedic implants).

R. **Drug Abuse Treatment**

See Section 5. G. (Covered Expenses / Behavioral Health Services) for *benefits* for the *treatment* of *substance use disorders*. 

MRA, MRS, PET scans, CCTA and any other *high-technology imaging* may require *prior authorization*. See www.arisefhealthplan.com
S. Durable Medical Equipment

1. Covered Durable Medical Equipment:
   a. Rental or, at our option, purchase of durable medical equipment that is prescribed by a health care practitioner and needed in the treatment of an illness or injury.
   b. Subsequent repairs necessary to restore purchased durable medical equipment to a serviceable condition.
   c. Replacement of durable medical equipment if such equipment cannot be restored to a serviceable condition, subject to approval by us.
   d. Breastfeeding equipment in conjunction with each birth.
   e. Speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to illness or injury.

2. Durable Medical Equipment Limitations:
   a. Benefits will be limited to the standard models, as determined by us.
   b. If the durable medical equipment is purchased, benefits are limited to a single purchase of each type (including repair and replacement) every three years.
   c. We will pay benefits for only one of the following: a manual wheelchair, a motorized wheelchair, a knee walker, or a motorized scooter, as determined by us.

3. Durable Medical Equipment Exclusions:
   The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).
   a. Rental fees that are more than the purchase price.
   b. Continuous passive motion (CPM) devices and mechanical stretching devices.
   c. Home devices such as: home spinal traction devices or standers; home phototherapy for dermatological conditions; light boxes designed for Seasonal Affective Disorder; home pneumatic compression devices for DVT (deep vein thrombosis) prevention; cold therapy (application of low temperatures to the skin) including, but not limited to, cold packs, ice packs, and cryotherapy; and home automated external defibrillator (AED).
   d. Durable medical equipment that we determine to have special features that are not medically necessary.
   e. Durable medical equipment that we determine to be for your comfort, personal hygiene, or convenience including, but not limited to, physical fitness equipment, health care practitioner’s equipment, and self-help devices not medical in nature.
   f. Routine periodic maintenance, except for periodic maintenance for oxygen concentrators under a maintenance agreement which consists of a one-month rental billed every six months.
   g. Replacement of equipment unless we determine that it is medically necessary.
   h. Replacement of over-the-counter batteries.
   i. Repairs due to abuse or misuse as determined by us.
   j. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which benefits are provided in Paragraph 1. above.
   k. Blood pressure cuffs and monitors.

Certain durable medical equipment may require prior authorization. See www.arisehealthplan.com
l. Enuresis alarms.
m. Trusses.
n. Ultrasonic nebulizers.
o. Oral appliances for snoring.

T. Emergency Medical Care

1. Covered Emergency Medical Care:

   a. Emergency medical care in an emergency room, as described below:

      1) Benefits are payable for health care services provided in an emergency room as shown in the Schedule of Benefits. If a copayment is shown, this copayment applies to the emergency room visit. We will waive the emergency room visit copayment if you are admitted as a resident patient to the hospital directly from the emergency room. If you are placed in observation care directly from the emergency room, the emergency room visit copayment, if applicable, will not be waived.

      2) If you are admitted as a resident patient to the hospital directly from the hospital emergency room, charges for covered expenses provided in the hospital emergency room will be payable as stated in the Schedule of Benefits which applies to that hospital confinement.

      3) If you are outside of the geographical service area and a medical emergency arises that requires you to go to an emergency room, you are eligible for coverage regardless of which emergency room you use.

   b. Emergency medical care received in a health care practitioner’s office, urgent care facility, or any place of service other than an emergency room will be payable as shown in the Schedule of Benefits.

2. Emergency Medical Care Limitations:

   a. If follow-up care or additional health care services are needed after the medical emergency has passed, you will need our prior authorization before receiving such services from a non-participating provider if you want those health care services to be paid at the participating provider level of benefits.

   b. Covered health care services received from a non-participating provider will be limited to the amounts that we determine to be the maximum out-of-network allowable fee. You will be responsible for the difference between the amount charged and the maximum out-of-network allowable fee.

   c. If an ambulance service is called and you are transported to an emergency room, coverage for any emergency medical care directly provided to you during your ambulance transport is payable under Section 5. D. (Covered Expenses / Ambulance Services). If an ambulance service is called, but you are not transported, emergency medical care provided to you will be payable under this Section 5.T., as shown in the Schedule of Benefits.

U. Genetic Services

IMPORTANT NOTE: Genetic testing that we consider experimental/investigational/unproven will not be covered.

We may authorize genetic testing if the ordering health care provider shows that the results of such testing will directly impact your future treatment. Your health care practitioner must describe how and why, based on the results for the genetic testing results, your individual treatment plan would be different than your current or expected treatment plan based on a clinical assessment without genetic testing. Upon request, the ordering health care provider must submit information regarding the genetic testing’s clinical validity and clinical utility. Genetic testing that we consider...
experimental/investigational/unproven will not be covered. We will not accept prior authorization requests from the laboratory that will perform the genetic services unless there is supporting documentation from the ordering health care provider.

1. **Covered Genetic Services:**
   a. Genetic counseling provided to you by a health care practitioner, a licensed or Master’s trained genetic counselor or a medical geneticist;
   b. Amniocentesis during pregnancy;
   c. Chorionic villus sampling for genetic testing and non-genetic testing during pregnancy;
   d. Identification of infectious agents such as influenza and hepatitis. Panel testing for multiple agents is not covered unless your health care practitioner provides a justification for including each test in the panel;
   e. Compatibility testing for a covered person who has been approved by us for a covered transplant;
   f. Cystic fibrosis and spinal muscular testing as recommended by the American College of Medical Genetics;
   g. Molecular genetic testing of pathological specimens (such as tumors). All other molecular testing of blood or body fluids require prior authorization unless the test is otherwise specified on our website www.arisehealthplan.com. Please note that many molecular tumor profiling tests and gene-related or panel tests are not covered;
   h. BRCA testing for a covered person whose family history is associated with an increased risk for harmful BRCA1 and BRCA2 gene mutations and testing has been recommended after receiving genetic counseling. When such genetic counseling and testing is provided by a participating provider, benefits are payable at 100% of the charges, without application of the applicable annual deductible amount; and
   i. All other genetic testing for which you receive our prior authorization.

2. **Genetic Services Exclusions:**

   The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

   a. Genetic testing for the purposes of confirming a suspected diagnosis of a disorder that can be diagnosed based on clinical evaluations alone.
   b. Genetic testing for conditions that cannot be altered by treatment or prevented by specific interventions.
   c. Genetic testing solely for the purpose of informing the care or management of your family members.
   d. Genetic counseling performed by the laboratory that performed the genetic test.
   e. Genetic testing that is not supported by documentation from the ordering health care provider.

V. **Health and Behavior Assessments**

1. **Covered Health and Behavior Assessments:**
   a. Health and behavior assessments and reassessments;
   b. Diagnostic interviews; and
   c. Neuropsychological testing.

   Please note that health and behavioral interventions provided by a psychologist pursuant to a health and behavior assessment are covered under Section 5. FF. (Covered Expenses / Medical Services).

2. **Health and Behavior Assessments Exclusions:**
The Policy provides **no benefits** for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

a. Intensive inpatient **treatment** by a psychologist to treat a medical condition.

b. Baseline neuropsychological testing, for example, ImPACT® Immediate Post-Concussion Assessment and Cognitive Testing.

W. **Hearing Aids, Implantable Hearing Devices, and Related Treatment**

1. **Definitions:**

a. **Bone Anchored Hearing Aid (BAHA):** a surgically implantable system for treatment of hearing loss that works through direct bone conduction.

b. **Cochlear Implant:** an implantable instrument or device that is designed to enhance hearing.

c. **Hearing Aid:** any externally wearable instrument or device designed or offered for the purpose of aiding or compensating for impaired human hearing and any parts, attachments, or accessories of such an instrument or device, except its batteries and cords.

d. **Implantable Hearing Device:** any implantable instrument or device that is designed to enhance hearing, including cochlear implants and bone anchored hearing aids.

2. **Covered Hearing Services:**

Any of the following, provided you are certified as deaf or hearing impaired by a health care practitioner and that your hearing aids and/or devices are prescribed by a health care practitioner in accordance with accepted professional medical or audiological standards:

a. One hearing aid (including fitting and testing), per ear, per covered person once every three years;

b. Implantable hearing devices;

c. Treatment related to hearing aids and implantable hearing devices covered under this subsection, including procedures for the implantation of implantable hearing devices; and

d. Post-cochlear implant aural therapy.

3. **Hearing Services Exclusions:**

The Policy provides **no benefits** for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

a. Hearing protection equipment.

b. Hearing aid batteries and cords.
X. Home Care Services

This Section 5. X. applies only if charges for home care services are not covered elsewhere under the Policy.

1. Definitions:
   a. Home Care: health care services provided directly to you in your home under a written plan that meets the following criteria: (1) the plan is developed by your attending health care practitioner; (2) the plan is approved by your attending health care practitioner in writing; (3) the plan is reviewed by your attending health care practitioner every two months (or less frequently if your health care practitioner believes and we agree that less frequent reviews are enough); and (4) home care is provided or coordinated by a home health agency or certified rehabilitation agency that is licensed by the Wisconsin Department of Health Services or certified by Medicare.
   b. Home health aide services: nonmedical services performed by a home health aide which: (1) are not required to be performed by a registered nurse or licensed practical nurse; and (2) primarily aid the patient in performing normal activities of daily living, which may include custodial care.

2. Covered Home Care Services:
   a. Home safety evaluations, evaluations for a home treatment program, and/or initial visit(s) to evaluate you for an independent treatment plan;
   b. Part-time or intermittent home nursing care by or under supervision of a registered nurse;
   c. Part-time or intermittent home health aide services that consist solely of care for the patient as long as they are: (1) medically necessary; (2) appropriately included in the home care plan; (3) necessary to prevent or postpone confinement in a hospital or skilled nursing facility; and (4) supervised by a registered nurse or medical social worker.
   d. Physical or occupational therapy or speech-language pathology or respiratory care;
   e. Medical supplies, drugs and medications prescribed by a health care practitioner; and laboratory services by or on behalf of a hospital if needed under the home care plan. These items are covered to the extent they would be if you had been hospitalized;
   f. Nutrition counseling provided or supervised by a registered or certified dietician; and
   g. Evaluation of the need for a home care plan by a registered nurse, physician extender or medical social worker. Your attending health care practitioner must request or approve this evaluation.

Home Care Limitations:
   a. Benefits are limited to 60 home care visits per covered person per calendar year. Each visit by a person to provide services under a home care plan, to evaluate your need for home care, or to develop a home care plan counts as one home care visit. Each period of up to four straight hours of home health aide services in a 24-hour period counts as one home care visit.
   b. The maximum weekly benefit payable for home care won’t be more than the benefits payable for the total weekly charges for skilled nursing care available in a licensed skilled nursing facility, as determined by us.

3. Home Care Exclusions:
   The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).
   a. Home care that is not ordered by a health care practitioner; and
   b. Home care provided to a covered person who is not confined to his/her home due to an illness or injury or because leaving his/her home would be contraindicated.
Y. Home Intravenous (IV) Therapy or Infusion Therapy

Intravenous (IV) therapy/infusion therapy prescribed by a health care practitioner and performed in your home, including but not limited to: (1) injections (intra-muscular, subcutaneous, continuous subcutaneous); (2) Total Parenteral Nutrition (TPN); and (3) antibiotic therapy.

Z. Hospice Care

1. Definition of Hospice Care: health care services that are: (a) provided to a covered person whose life expectancy, as certified by a health care practitioner, is six consecutive months or less; (b) available on an intermittent basis with on-call health care services available on a 24-hour basis; and (c) provided by a licensed hospice care provider approved by us. Hospice care includes services intended primarily to provide pain relief, symptom management, and medical support services. Hospice care may be provided at hospice facilities or in your place of residence.

2. Covered Hospice Care Services:
   a. Hospice care services provided to you if you are terminally ill if: (1) your health condition would otherwise require your confinement in a hospital or a skilled nursing facility; and (2) hospice care is a cost-effective alternative, as determined by us.
   b. Covered expenses for hospice care include:
      1) Room and board at a hospice facility while you are receiving acute care to alleviate physical symptoms of your terminal illness;
      2) Health care practitioner and nursing care; and
      3) Services provided to you at your place of residence.
   c. We will pay benefits for charges for covered expenses for hospice care services provided to you during the initial six-month period immediately following the diagnosis of a terminal illness. Coverage for hospice care services after the initial six-month period will be extended by us under the Policy beyond the initial six month period, provided, a health care practitioner certifies in writing that you are terminally ill.

3. Hospice Care Services Exclusions:

The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

   a. Room and board for residential care at a hospital facility.
   b. Hospice care services provided to you after the initial six-month period immediately following the diagnosis of a terminal illness, unless we have extended coverage per Paragraph 2. c. above.

AA. Hospital Services

Transplant services are not covered under this Section 5. AA. Please see Section 5. VV. (Covered Expenses / Transplants) for this coverage information. This Section 5. AA. does not include charges for outpatient physical, speech, or occupational therapy; please see Section 5. TT. (Covered Expenses / Therapy Services). Additionally, except for inpatient hospital services for detoxification, services for the treatment of substance use disorders and/or nervous or mental disorders are not covered under this Section 5. AA. Please see Section 5. G. (Covered Expenses / Behavioral Health Services) for these coverage details.
1. Covered Hospital Services:
   a. Inpatient Hospital Services. Benefits are payable for the following inpatient hospital services for a physical illness or injury:
      1) Charges for room and board;
      2) Charges for nursing services;
      3) Charges for miscellaneous hospital expenses; and
      4) Charges for intensive care unit room and board.
   b. Outpatient Hospital Services. Benefits are payable for miscellaneous hospital expenses, including services in observation care, for a physical illness or injury received by you while you are not confined in a hospital.
   c. Facility Fees. Benefits are payable for facility fees charged by the hospital for office visits and for urgent care visits.

2. Hospital Services Limitations:
   a. If you are confined in a hospital other than a participating hospital as an inpatient due to a medical emergency, we reserve the right to coordinate your transfer to a participating hospital once you are stable and can be safely moved to that participating hospital.
   b. If you are stable and refuse such transfer, further services in the non-participating hospital will not be covered at the participating provider benefit level.
   c. We will not cover inpatient stays at a hospital if care could safely and effectively be provided to you in a less acute setting.

BB. Infertility or Fertility Treatment

1. Definitions:
   a. Infertility: the inability or diminished ability to produce offspring including, but not limited to, a couple’s failure to achieve pregnancy after at least 12 consecutive months of unprotected sexual intercourse or a woman’s repeated failures to carry a pregnancy to fetal viability. Repeated failures to carry a pregnancy to fetal viability means three consecutive documented spontaneous abortions in the first or second trimester. Such inability must be documented by a health care practitioner.
   b. Infertility or Fertility Treatment: a health care service that is intended to: (1) promote or preserve fertility; or (2) achieve and maintain a condition of pregnancy. For purposes of this definition, infertility or fertility treatment includes, but is not limited to:
      1) Fertility tests and drugs;
      2) Tests and exams done to prepare for or follow through with induced conception;
      3) Surgical reversal of a sterilized state that was a result of a previous surgery;
      4) Sperm enhancement procedures; and
      5) Direct attempts to cause or maintain pregnancy by any means including, but not limited to: hormone therapy or drugs; artificial insemination; in vitro fertilization; GIFT or ZIFT; embryo transfer; and freezing or storage of embryo, eggs, or semen.

2. Covered Infertility or Fertility Treatment:
   Health care services required to treat or correct underlying causes of infertility (e.g. blocked fallopian tube, endometriosis).
3. **Infertility or Fertility Treatment Exclusions:**

The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

a. *Health care services* associated with expenses for *infertility*, including assisted reproductive technology, except for those services related to a covered medical condition.

b. Direct attempts to achieve pregnancy or increase chances of achieving pregnancy by any means.

c. Any laparoscopic procedure during which an ovum is manipulated for the purpose of *fertility treatment* even if the laparoscopic procedure includes other purposes.

**CC. Kidney Disease Treatment**

Dialysis *treatment*, including any related *medical supplies* and laboratory services provided during dialysis and billed by the outpatient department of a *hospital* or a dialysis center.

Kidney transplantation services are payable under the organ transplant *benefit* in Section 5.VV. (Covered Expenses / Transplants).

**DD. Mastectomy Treatment**

A *covered person* who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy and who elects breast reconstruction, will also receive coverage for:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Breast prostheses; and
4. Treatment of physical complications for all stages of mastectomy, including lymphedemas.

**EE. Maternity Services**

1. **Covered Maternity Services:**
   a. Any of the following maternity services when they are provided by a *hospital* or *health care practitioner*:

   1) *Global maternity charge.* The global maternity charge is a unique procedure billed by a *health care practitioner* that includes prenatal care, delivery, and one postpartum care *office visit*. Examples of *health care services* for this procedure may include the prenatal physical examinations, recording of weight, blood pressures, fetal heart tones, and routine chemical urinalysis. Monthly *office visits* up to 28 weeks, biweekly *office visits* to 36 weeks, and weekly *office visits* until delivery are also included.

   2) *Charges* by a *hospital* for vaginal or cesarean section delivery.

   3) *Exams* and testing that are billed separately from the global maternity fee.

   4) *Health care services* for miscarriages.

   5) *Health care services* related to an abortion provided the abortion procedure for the termination of a mother’s pregnancy is: (a) considered a life-threatening complication of the mother’s existing *physical illness*; or (b) a result of rape or incest; and (c) the abortion procedure is permitted by and performed in accordance with law.

   b. With respect to *confinements* for pregnancy, the Policy will not limit the length of stay to less than: (i) 48 hours for a normal birth; and (ii) 96 hours for a cesarean delivery. However, a mother is free to leave the *hospital* earlier if she and her *health care practitioner* mutually agree to shorten the stay.

2. **Maternity Exclusions:**
The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

a. Birthing classes, including Lamaze classes.

b. Abortion procedures, except as specifically stated in Paragraph 1. a. above.

c. Home births.

d. Continued hospital stay for the mother solely because her newborn infant remains hospitalized.

e. Continued hospital stay for the newborn infant solely because the mother remains hospitalized.

FF. Medical Services

1. Health and behavior interventions billed with a medical diagnosis.

2. Medical services for a physical illness or injury, including second opinions. Services must be provided in a hospital, health care practitioner’s office, urgent care center, surgical care center, convenient care clinic, or in your home. Medical services covered under this Section 5. FF. do not include health care services covered elsewhere in the Policy, including home care services covered under Section 5.X. (Covered Expenses / Home Care Services).

GG. Medical Supplies

1. Covered Medical Supplies: Medical supplies prescribed by a health care practitioner, including but not limited to:

   a. Strapping and crutches;

   b. Ostomy supplies limited to the following: pouches, face plates and belts; irrigation sleeves, bags and ostomy irrigation catheters; and skin barriers; and

   c. Disposable supplies, tubing, and masks for the effective use of covered durable medical equipment.

2. Medical Supplies Exclusions:

   The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

   a. Medical supplies that we determine to be for your comfort, personal hygiene, or convenience including, but not limited to disposable supplies.

   b. Ostomy supplies that are not listed in Paragraph 1. above (such as deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover).

   c. Over-the-counter ace bandages, gauze and dressings.

   d. Urinary catheters and compression stockings that you purchase from a durable medical equipment provider or pharmacy.

HH. Nutritional Counseling

Nutritional counseling that is: (1) for treatment of an illness or injury; and (2) provided by a health care practitioner, dietician or nutritionist licensed in the state where the counseling is provided to you. Nutritional counseling billed as educational services will not be covered, except as noted in Section 5. MM. (Covered Expenses / Preventive Care Services).

II. Orthotic Devices and Appliances

1. Covered Orthotic Devices and Appliances:
a. Externally applied devices or appliances, including fittings and adjustments of custom-made rigid or semi-rigid supportive devices, that: (i) are used to support, align, prevent, or correct deformities; (ii) improve the function of movable parts of the body; or (iii) limit or stop motion of a weak or diseased body part.

b. Covered orthotic devices and appliances include, but are not limited to:
   1) Casts and splints;
   2) Orthopedic braces, including necessary adjustments to shoes to accommodate braces.
   3) Cervical collars; and
   4) Corsets (back and special surgical).

c. Orthotic devices or appliances to support the foot are not covered unless they are a permanent part of an orthopedic leg brace.

d. Orthotic devices or appliances may be replaced once per calendar year per covered person. The replacement must be medically necessary. Additional replacements will be allowed: (1) if you are under age 19 due to rapid growth; or (2) when a device or appliance is damaged and cannot be repaired.

2. **Orthotic Devices and Appliances Exclusions:**

   Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

   a. Routine periodic maintenance, such as testing, cleaning and checking of the device or appliance.

   b. Cranial banding or orthotic helmets, unless required after cranial surgery.

J.J. **Pain Management Treatment**

Pain management *treatment* including injections and other procedures to manage your pain related to an *illness or injury*.

K.K. **Palliative Care Services**

1. **Definition of Palliative Care:** care that optimizes quality of life for people with serious *illness* by anticipating, preventing, and treating their suffering. *Palliative care* may be provided throughout the continuum of *illness*. It generally involves addressing physical, emotional, and social needs and facilitating patient autonomy, access to information, and choice.

2. **Covered Palliative Care Services:** We will cover *palliative care* that is otherwise a *covered expense* under the Policy.

L.L. **Prescription Legend Drugs and Supplies**

1. **Definitions.** The following definitions apply to this Subsection L.L. only:
   a. **Biosimilar(s):** a *prescription legend drug* of biological origin developed such that there are no clinically meaningful differences between the biological product and its FDA-approved reference product in terms of safety, purity, and potency, and demonstrates similarity to the reference product in terms of quality characteristics, biological activity, safety and efficacy. A *biosimilar* may be classified as a *brand-name drug*, *generic drug*, and/or *specialty drug*.
   b. **Brand-Name Drug(s):** a *prescription legend drug* sold by the pharmaceutical company or other legal entity holding the original United States patent for that *prescription legend drug*. For purposes of the Policy, we may classify a *brand-name drug* as a *generic drug* if we determine that its price is comparable...
to the price of the equivalent generic drug. The term brand-name drug may also include over-the-counter drugs that we determine to be covered drugs.

c. Generic Drug(s): a prescription legend drug, whether identified by its chemical, proprietary, or non-proprietary name, that is therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient(s) and approved by the FDA. For purposes of the Policy, we may classify a generic drug as a brand-name drug if we determine that the generic drug's price is comparable to the price of its brand-name equivalent. The term generic drug may also include over-the-counter drugs that we determine to be covered drugs.

d. Home Delivery Pharmacy: a participating pharmacy that dispenses extended supplies of maintenance medications (typically greater than a 30-34 day supply).

e. Participating Pharmacy: a pharmacy that we have contracted with and that bills us directly for the charges you incur for covered drugs.

f. Preferred Drug(s): any generic drug or brand-name drug named on our list of preferred drugs, which is available at https://secure.wpsic.com/sales-materials/files/31712_individual-small-group-formulary.pdf. The list of preferred drugs may change from time to time.

g. Prescription Order: a written, electronic, or other lawful request for the preparation and administration of a prescription legend drug made by a health care practitioner with the authority to prescribe a drug for you.

h. Preventive Drug(s): drugs that we are currently required by law to define as preventive drugs, include to: (1) aspirin for the prevention of cardiovascular disease (age 50-59) and after 12 weeks of gestation in women who are at high risk for preeclampsia; (2) fluoride supplements if you are older than six months; (3) folic acid for women planning or capable of pregnancy; (4) oral contraceptives, contraceptive patches, contraceptive devices (e.g., diaphragms, sponges, gel) and contraceptive vaginal rings for birth control; (5) nicotine replacements (e.g., patches and gum) and covered drugs used for smoking cessation if you are age 18 and over; (6) Vitamin D if you are age 65 and over and are at an increased risk for falls; (7) risk reducing medications, such as tamoxifen or raloxifene, for women who are at increased risk for breast cancer and at low risk for adverse medication effects; (8) immunizations; and (9) low/moderate dose statins for ages 40-75 with at least one cardiovascular disease risk factor and a 10-year calculated risk of at least 10%. The USPSTF may change the definition of preventive drugs during the course of the year. Please see www.uspreventiveservicestaskforce.org.

i. Specialty Drugs: prescription legend drugs that we determine to be: (a) associated with a high level of clinical management and/or patient monitoring; (b) associated with special handling or distribution requirements; or (c) generally high cost. To determine if a drug is a specialty drug and if that specialty drug requires our prior authorization, visit our website at www.arisehealthplan.com or call the telephone number shown on your identification card.

j. Specialty Pharmacy: a participating pharmacy and designated by us to dispense specialty drugs. To locate a specialty pharmacy, contact us by calling the telephone number shown on your identification card or visit the website of the pharmacy benefit manager listed on your identification card.

2. Covered Drugs.

a. Any prescription legend drug not otherwise excluded or limited under the Policy;

b. Any medicine a participating pharmacy compounds as long as it contains at least one prescription legend drug that is not excluded under the Policy, provided it is not considered experimental/investigational/unproven or not medically necessary; if a compound drug contains non-covered ingredients, reimbursement will be limited to the covered prescription legend drug(s);

c. Preventive drugs that are obtained pursuant to a prescription order;

d. Injectable insulin;
e. Prescription legend drugs that are FDA-approved for the treatment of HIV infection or an illness or medical condition arising from, or related to, HIV;

f. An immunization that is not excluded elsewhere in the Policy;

g. Oral chemotherapy drugs; and

h. Experimental/investigational/unproven drugs that are FDA approved, administered according to protocol, and required by law to be covered.

3. Covered Supplies.

   a. Insulin syringes and needles;
   b. Lancets and lancet devices;
   c. Formulary diabetic test strips;
   d. Alcohol pads;
   e. Formulary blood glucose monitors;
   f. Auto injector; and
   g. Glucose control solution.

4. Our Discretion. We have full discretionary authority to cover drugs or supplies that vary from the benefits described in the Policy if there is an advantage to both you and us.

5. Cost Sharing. See your Schedule of Benefits for information about copayments, deductibles, and coinsurance amounts that apply to drugs and supplies. You will have no applicable copayment, deductible or coinsurance for any preventive drug. All other covered drugs and supplies are subject to any copayment, deductible, or coinsurance amounts listed in your Schedule of Benefits. If the participating pharmacy’s charge is less than the copayment and/or deductible, you will only be responsible for the amount of the charge. Otherwise, you must pay any applicable copayment, deductible and coinsurance amount for each separate prescription order or refill of a covered drug or covered supply.

6. Prescription Legend Drugs and Supplies Limitations.

   a. Participating Pharmacies. Benefits are generally not payable for covered drugs and supplies dispensed by someone other than a participating pharmacy, home delivery pharmacy, or specialty pharmacy. We will, however, reimburse you for any covered drugs and supplies you receive during a medical emergency outside of the geographical service area. In this situation, you must pay for the covered drugs or supplies up front. Then you must send us, or our delegate, a claim with written proof of payment and enough detail to allow us to process the claim. After we receive your claim and supporting documentation, we will determine if benefits are payable for the drug or supply. If so, we will pay you the benefit amount that we would have paid had you purchased the covered drug or supply from a participating pharmacy. You are responsible for the copayment, deductible or coinsurance, and any difference between our benefit amount and the price you paid for the covered drug or supply.

   b. Covered Drugs Available from a Home Delivery Pharmacy. If any covered drug is available through a home delivery pharmacy, we will only cover three fills at a retail pharmacy unless you have opted-out of the home delivery pharmacy program.

   c. Step Therapy. If there is more than one prescription legend drug that has been determined to be safe and effective for the treatment of your illness or injury, we may only provide benefits for the less expensive prescription legend drug. Alternatively, we may require you to try the less expensive prescription legend drug(s) before benefits are payable for any other alternative prescription legend drug(s).

   d. Prior Authorization. We have full discretionary authority to require prior authorization for certain drugs before they are eligible for coverage under the Policy. This applies to all prescription legend drugs, including specialty drugs and drugs administered by a health care provider. To determine whether a drug

To see formulary diabetic tests strips and blood glucose monitors, go to www.arisehealthplan.com
requires prior authorization, visit www.arisehealthplan.com or call the telephone number shown on your identification card. If you do not receive prior authorization before receiving such drugs, benefits may not be payable under the Policy.

If a drug requires prior authorization, your health care practitioner must contact us, or our delegate, to supply the information needed, such as copies of all corresponding medical records and reports for your illness or injury.

After receiving the required information, we (or our delegate) will determine if the drug is covered under the Policy and notify you of our coverage determination. If we determine that the treatment is not a covered drug or is otherwise excluded under the Policy, no benefits will be payable for that drug.

**Use of Brand-Name Drugs When Lower Cost Equivalents Are Available.** If you obtain a brand-name drug and we determine that a lower cost equivalent drug (e.g. generic drug or biosimilar) is available, you must pay the difference in cost between the drug obtained and its equivalent plus the applicable copayment/deductible/coinsurance amount. Determination that a drug is equivalent must be supported by scientific evidence and/or determinations by regulatory entities such as the FDA. For preventive drugs, coverage is also generally limited to generic drugs when they are available. If, however, your health care practitioner submits proof to us that it is medically necessary for you to use a preventive drug that is a brand-name drug instead of the equivalent generic drug, we will cover the brand-name drug in full and you will not be charged.

However, we will cover a brand-name drug if substitution of an equivalent generic drug is prohibited by law.

e. **Quantity Limits.** The following quantity limits apply to all prescription legend drug benefits under this Subsection LL. We have full discretionary authority to enforce additional quantity limits on specific drugs to ensure the appropriate amounts are dispensed. Please note that in certain circumstances, we may approve a partial amount (i.e. less than a 30-day supply) of a specialty drug until we, or our delegate, determine you are tolerating the specialty drug. In this case, your financial responsibility will be prorated.

<table>
<thead>
<tr>
<th>Item</th>
<th>Quantity Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription legend drugs or supplies dispensed by a participating pharmacy</td>
<td>30-day supply per fill or refill</td>
</tr>
<tr>
<td>Prescription legend drugs (other than specialty drugs) or supplies dispensed by a home delivery pharmacy</td>
<td>90-day supply per fill or refill</td>
</tr>
<tr>
<td>Preventive drugs used for Tobacco Cessation</td>
<td>180-day supply of nicotine replacement treatment (e.g., patches or gum) per covered person per calendar year; and 180-day supply of another type of covered tobacco cessation drug (e.g., varenicline or bupropion) per covered person per calendar year</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>30-day supply per fill or refill, except as noted above</td>
</tr>
<tr>
<td>Blood glucose monitor dispensed by a participating pharmacy</td>
<td>One per covered person per calendar year</td>
</tr>
</tbody>
</table>

f. **Miscellaneous.** Copayment or coinsurance applies to each cycle of hormone replacement therapy.

g. **Limitations on Covered Drugs and Covered Supplies Provided by a Provider Other than a Pharmacy.** If we determine a prescription legend drug can safely be administered in a lower-cost place of service, for example: (1) a participating pharmacy where the drug can be obtained for self-administration; or (2) by a home care company, benefits for such prescription legend drugs purchased from and administered by a health care provider in a higher-cost place of service will not be covered. However, we have full discretionary authority to allow initial dose(s) of a drug to be administered by a health care
provider in a higher-cost place of service in certain limited circumstances (for example teaching/training purposes).

7. Prescription Legend Drugs and Supplies Exclusions.

The Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

a. Any drug for which you do not have a valid prescription order;

b. More than three fills of a maintenance medication, as determined by us, at a retail pharmacy, unless you have opted-out of the home delivery pharmacy program;

c. Administration of a covered drug by injection or other means other than covered immunizations;

d. Refills of otherwise covered drugs that exceed the number your prescription order calls for;

e. Refills of otherwise covered drugs after one year from the date of the prescription order;

f. Drugs usually not charged for by the health care provider;

g. A drug that is completely administered at the time and place of the health care provider who dispenses it under the prescription order, except for immunizations and drugs for which you receive our prior authorization;

h. Anabolic drugs, unless we determine that they are being used for accepted medical purposes and eligible for coverage under the Policy;

i. Progesterone or similar drugs in any compounded dosage form, except for the purpose of maintaining a pregnancy under the appropriate standard of care guidelines;

j. Costs related to the mailing, sending or delivery of prescription legend drugs;

k. Refill of drugs, medicines, medications or supplies that are lost, stolen, spilled, spoiled, damaged, or otherwise rendered unusable;

l. Any drug or medicine that is available in prescription strength without a prescription order, except as determined by us;

m. More than one fill or refill for the same covered supply, covered drug or therapeutic equivalent medication prescribed by one or more health care practitioner until you have used at least 75% of the previous retail prescription. If the covered supply, drug or therapeutic equivalent medication is dispensed by a home delivery pharmacy, then you must have used at least 75% of the previous prescription;

n. Charges that are reduced by a manufacturer promotion (e.g., coupon or rebate);

o. Any drug used for weight control or whose primary use is weight control, regardless of why the drug is being prescribed to you;

p. Any compounded drug that is substantially like a commercially available product;

q. Any drug delivered to or received from a destination outside of the United States;

r. Any drug for which prior authorization is required but not obtained;

s. Any drug for which step therapy is required but not followed;

t. Drugs dispensed by a person or entity other than a participating pharmacy, home delivery pharmacy, or specialty pharmacy, except for emergencies outside of the geographical service area;

u. Non-legend vitamins, minerals, and supplements even if prescribed by a health care practitioner, except as specifically stated in the Policy;
All medicinal foods, enteral feedings, supplemental feedings, nutritional and electrolyte supplements, and infant formula;

Any drug or agent used for *cosmetic treatment*; for example, wrinkles or hair growth; and

Any drug in unit-dose packaging except as required by law.

**MM. Preventive Care Services**

The following *preventive care services* are covered to the extent required by law. There is no cost sharing on *preventive care services* performed by a *participating provider*.

1. **Covered Preventive Care Services:**

   a. Evidence-based *health care services* that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF). The USPSTF may change its ratings during the year. See [www.uspreventiveservicestaskforce.org](http://www.uspreventiveservicestaskforce.org) for the current recommendations. Currently, the recommendations include:

   1) Routine medical exams, including hearing exams, pelvic exams, pap smears, and any related *preventive care services*, other than routine eye exams. Pelvic exams and pap smears are covered under this Paragraph 1. when directly provided to you by a *health care practitioner*;

   2) Routine medical exams, including hearing exams, and any related *preventive care services* directly provided to a covered *child* in connection with well-baby care. Please see Section 5. XX. (Covered Expenses / Vision Services – Pediatric) for details regarding coverage of pediatric eye exams;

   3) One routine mammogram of a *covered person* per calendar year;

   4) Blood lead tests;

   5) Preventive screenings;

   6) Behavioral interventions to promote breast feeding; comprehensive lactation support and counseling by a trained *health care provider* during pregnancy and/or in the postpartum period;

   7) Annual counseling on sexually transmitted infections;

   8) Counseling for tobacco use;

   9) Prophylactic ocular topical medication for newborns against gonococcal ophthalmia neonatorum;

   10) Annual screening and counseling for *covered persons* for interpersonal and domestic violence;

   11) Healthy diet and physical activity counseling to prevent cardiovascular disease; and

   12) Behavioral counseling for skin cancer.

   b. Other *preventive care services* that are provided on an outpatient basis at a *health care practitioner’s office* or *hospital* and that have been: demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease; and proven to have a beneficial effect on health outcomes. Such covered *preventive care services* include, but are not limited to, the following:

   1) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

   2) With respect to infants, *children* and adolescents, evidence-informed *preventive care services* and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
3) With respect to women, such additional preventive care services and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

2. Preventive Care Services Limitations:

   a. Some laboratory and diagnostic studies may be subject to a deductible and/or coinsurance if we determine they are not part of a routine preventive or screening examination. For example, when you have a symptom or history of an illness or injury, laboratory and diagnostic studies related to that illness or injury are no longer considered part of a routine preventive or screening examination.

3. Preventive Care Services Exclusion:

   This Policy provides no benefit for immunizations for travel purposes. This exclusion applies in addition to the exclusions outlined in Section 6. (General Exclusions).

NN. Prosthetics

1. Covered Prosthetics:

   a. Prosthetic devices and related supplies, including the fitting of such devices, that replace all or part of:

      1) An absent body part (including contiguous tissue); or

      2) The function of a permanently inoperative or malfunctioning body part.

   b. Covered prosthetic devices include, but are not limited to, artificial limbs, eyes, and larynx. Benefits are limited to one purchase no sooner than every three years of each type of the standard model, as determined by us.

   c. Replacement or repairs of prosthetics if we determine that they are medically necessary.

2. Prosthetics Exclusions:

   This Policy provides no benefits for any items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

   a. Prosthetics that we determine to have special features that are not medically necessary.

   b. Dental prosthetics.

   c. Repairs due to abuse or misuse.

OO. Pulmonary Rehabilitation

Outpatient pulmonary rehabilitation therapy limited to 24 visits per covered illness per calendar year. No other benefits for outpatient pulmonary rehabilitation therapy are available under the Policy.

PP. Radiation Therapy and Chemotherapy Services

Radiation therapy and chemotherapy services. Benefits are also payable for charges for x-rays, radium, radioactive isotopes and chemotherapy drugs and supplies used in conjunction with radiation therapy and chemotherapy services.
QQ. Skilled Nursing Care in a Skilled Nursing Facility

1. Covered Skilled Nursing Care:
   a. Skilled nursing care provided to you during the first 30 days of your confinement in a skilled nursing facility if: (1) you are admitted to a skilled nursing facility within 24 hours after discharge from a hospital or surgical center or directly from emergency room care, urgent care, or a health care practitioner’s office; and (2) you are admitted for continued treatment of the same illness or injury.
   b. Each day of your confinement will count towards this 30-day limit, regardless of whether the charges are applied to your deductible or paid by Arise under the Policy.
   c. Benefits are only payable for skilled nursing care which is certified as medically necessary by your attending health care practitioner every seven days.

2. Skilled Nursing Care Exclusions:
   This Policy provides no benefits for any items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).
   a. Skilled nursing care during a skilled nursing facility confinement if health care services can be provided at a lower level of care (e.g. home care, as defined in Section 5.X., (Covered Expenses / Home Care Services), or care in an outpatient setting).
   b. Domiciliary care, such as meals-on-wheels, health visiting, and home help, provided by a welfare agency for people in their own homes.
   c. Maintenance care, supportive care, or custodial care.
   d. Care that is available at no cost to you or care provided under a governmental health care program (other than a program provided under Wis. Stat. Chapter 49).

RR. Surgical Services

This Section 5. RR. does not include surgical services for: (1) covered transplants; (2) pain management procedures; or (3) behavioral health services. Please see Section 5. G. (Covered Expenses / Behavioral Health Services), Section 5. JJ. (Covered Expenses / Pain Management Treatment), and Section 5. VV. (Covered Expenses / Transplants) for this coverage information.

1. Definitions:
   a. Incidental/Inclusive: a procedure or service is incidental/inclusive if it is integral to the performance of another health care service or if it can be performed at the same time as another health care service without adding significant time or effort to the other health care service.
   b. Oral Surgery: surgical services performed within the oral cavity.

2. Covered Surgical Services:
   The following surgical services are covered when provided in a health care practitioner’s office, hospital or licensed surgical center:
   a. Surgical services, other than reconstructive surgery and oral surgery. Covered surgical services include but are not limited to:
      1) Operative and cutting procedures;
      2) Endoscopic examinations, such as: (a) arthroscopy; (b) bronchoscopy; or (c) laparoscopy; and
3) Other invasive procedures such as: (a) angiogram; and (b) arteriogram.

b. **Reconstructive surgery** when the primary purpose of the surgery is to correct *functional impairment* caused by an *illness, injury, congenital abnormality, acute traumatic injury, dislocation, tumors, cancer, obstructive sleep apnea, or temporomandibular joint disorder*. Please note that breast reconstruction following a mastectomy, reconstruction of the non-affected breast to achieve symmetry, and other services required by the Women’s Health and Cancer Rights Act of 1998 are covered under Section 5.DD. (Covered Expenses / Mastectomy Treatment).

c. **Oral surgery**, including related consultation, x-rays and anesthesia, limited to the excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

d. Male sterilization procedures.

e. Tissue transplants (*e.g.*, arteries or veins, corneas, heart valves, skin) placed in the body to aid the function of a body organ or replace tissue lost due to *illness or injury*.

f. Congenital heart disease surgeries.

3. **Surgical Services Exclusions:**

This Policy provides no **benefits** for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

a. **Incidental/inclusive** surgical procedures that are performed in the same operative session as a major covered surgical procedure, which is the primary procedure. **Benefits** for *incidental/inclusive* surgical procedures are limited to the *charge* for the primary surgical procedure with the highest *charge*, as determined by us. No additional **benefits** are payable for *incidental/inclusive* surgical procedures. For example, the removal of an appendix during the same operative session in which a hysterectomy is performed is an *incidental/inclusive* surgical procedure; therefore, **benefits** are payable for the hysterectomy, but not for the removal of the appendix.

b. Reversal of a sterilization procedure.

c. **Oral surgery**, except as specifically stated in Paragraph 2. c. above.

d. **Reconstructive surgery** for purposes other than to correct *functional impairment*.

e. Any **surgical service** that we determine to be *cosmetic treatment*, except as otherwise indicated in the Policy.

f. Magnetic sphincter augmentation (*Linx® System*); transoral incisionless fundoplication procedures.

**SS. Telemedicine**

1. **Definition of Telemedicine**: the delivery of clinical *health care services* via telecommunications technologies, including, but not limited to telephone and interactive audio and video conferencing.

2. **Covered Telemedicine Services**:

   a. **Telemedicine** services provided by a *health care practitioner* to a *covered person* via interactive audio-visual telecommunication to treat a covered *illness or injury*.

   b. Telephone and interactive audio and video conferencing provided by our approved telehealth service providers. Visit [https://secure.wecareforwisconsin.com/members/telehealth](https://secure.wecareforwisconsin.com/members/telehealth) or call the Customer Service telephone number shown on your identification card for additional information about this **benefit**.

3. **Telemedicine Exclusions**:

This Policy provides no **benefits** for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).
a. Telemedicine services that do not include direct contact between the health care practitioner and the covered person.

b. Transmission fees.

c. Website charges for online patient education material.

TT. Temporomandibular Joint (TMJ) Disorder Services

1. Covered TMJ Disorder Services:
   a. Diagnostic procedures and surgical and non-surgical treatment for the correction of TMJ disorders if all of the following apply:
      1) The disorder is caused by congenital, developmental or acquired deformity, illness or injury;
      2) Under the accepted standards of the profession of the health care practitioner providing the service, the procedure is reasonable and appropriate for the diagnosis or treatment of the condition; and
      3) The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.
   b. Non-surgical treatment includes coverage for prescribed intraoral splint therapy devices.

2. TMJ Disorder Services Exclusions:
   This Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).
   a. Elective orthodontic care, periodontic care or general dental care.
   b. Health care services provided in connection with the temporomandibular joint or TMJ disorder, except as specifically stated in Paragraph 1. above.

UU. Therapy Services

1. Definitions:
   a. Habilitative Services: health care services that help a person keep, learn, or improve skills and functioning for activities of daily living. Examples include, but are not limited to, therapy for a child who isn’t walking or talking at the expected age. These health care services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
   b. Rehabilitative Services: health care services that help a person keep, get back or improve skills and functioning for activities of daily living that have been lost or impaired because a person had an illness, injury or was disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.
   c. Therapy Visit: a meeting between you and a health care practitioner, excluding a massage therapist that:
      (1) occurs in the health care practitioner’s office, a medical clinic, convenient care clinic, a free-standing urgent care center, skilled nursing facility, or the outpatient department of a hospital, other than a hospital’s emergency room; and (2) involves you receiving physical, speech, or occupational therapy.

2. Therapy Limitations:
   a. Outpatient therapy is limited as follows:
      1) Physical therapy is limited to 20 therapy visits per covered person per calendar year when billed as rehabilitative services and 20 therapy visits per calendar year when billed as habilitative services. Massage
therapy is covered only when the therapy is billed by a chiropractor, physical therapist or occupational therapist;

2) Speech therapy is limited to 20 therapy visits per covered person per calendar year when billed as rehabilitative services and 20 therapy visits per calendar year when billed as habilitative services; and

3) Occupational therapy is limited to 20 therapy visits per covered person per calendar year when billed as rehabilitative services and 20 therapy visits per calendar year when billed as habilitative services.

b. The therapy visit limits stated above will be reduced by any charges for such therapy visits that are applied to the applicable deductible amounts.

c. All therapy must be expected to provide significant measurable gains that will improve your physical health.

d. All therapy must be performed by a health care practitioner excluding a massage therapist. If a license to perform such therapy is required by law, that therapist must be licensed by the state in which he/she is located and must provide such therapy while he/she is acting within the lawful scope of his/her license.

3. Therapy Exclusions:

This Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).

a. Physical therapy for TMJ disorders, except as specifically stated in Section 5. TT. (Covered Expenses / Temporomandibular Joint (TMJ) Disorder Services).

b. Massage therapy or aquatic therapy, except as specifically stated in Paragraph 2. above.

c. Long-term therapy and maintenance therapy, except as specifically stated in Paragraph 2. above.

VV. Transplants

1. Definitions. The following definitions apply to this Section 5. VV. only:

   a. Covered Transplant Drugs: immunosuppressant drugs prescribed by a physician when dispensed by a health care provider while you are not confined in a hospital. These drugs do not include high dose chemotherapy, except for high dose chemotherapy provided for a covered bone marrow transplant. This includes refills of immunosuppressant drugs.

   b. Designated Transplant Facility: a facility that is (i) approved by us to be the most appropriate facility for your approved transplant services; and (ii) contracted to provide approved transplant services to covered persons pursuant to an agreement with one of our transplant provider networks.

   c. Organ and Tissue Acquisition: the harvesting, preparation, transportation, and storage of human organ and tissue that is transplanted to you. This includes related medical expenses of a living donor.

   d. Transplant Services: approved health care services for which a prior authorization has been received and approved for transplants when ordered by a physician. Such services include, but are not limited to, hospital charges, health care practitioner's charges, organ and tissue acquisition, tissue typing, and ancillary services.

2. Prior Authorization and Cost-Sharing Requirements:

   a. All transplant services require prior authorization. It is your responsibility to obtain a prior authorization for all transplant related services, including but not limited to the initial transplant evaluation. The transplant must meet our medical necessity criteria for such transplant and may not be experimental/ investigative/unproven.

   b. If prior authorization is obtained, we will pay benefits for charges for covered expenses you incur at a designated transplant facility as determined by us during the prior authorization process for an illness or injury.
c. Transplant benefits are subject to any deductibles and coinsurance amounts shown in the Schedule of Benefits.

3. Covered Transplants:
   a. We will cover approved transplant services, including but not limited to organ and tissue acquisition and transplantation, including any post-transplant complications, if you are the recipient; and related medical care, including any post-harvesting complication, if you are a donor.
   b. Covered expenses for transplant services include health care services for approved transplants when ordered by a physician. Health care services include, but are not limited to, hospital charges, physician charges, organ and tissue acquisition, tissue typing, and ancillary services. Covered transplant drugs are payable as described in Section 5. LL. (Covered Expenses / Prescription Legend Drugs and Supplies).
   c. Benefits are payable for any transplant approved by us, including, but not limited to:
      1) Kidney;
      2) Kidney/pancreas;
      3) Liver;
      4) Heart;
      5) Heart/lung;
      6) Lung;
      7) Bone marrow (allogenic and autologous);
      8) Stem cell transplants;
      9) Small bowel transplantation;
      10) Cornea; and
      11) Artificial or mechanical devices, if approved as a bridge to transplant or destination therapy.

4. Transplant Exclusions:
   This Policy provides no benefits for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).
   a. Transplants considered by us to be experimental/investigational/unproven.
   b. Expenses related to the purchase of any organ.
   c. Health care services for, or used in connection with, transplants of human and non-human body parts, tissues or substances, or implants of artificial or natural organs, except as specifically stated in Paragraph 3. above.
   d. Lodging expenses, including meals, unless such expenses are covered under the global fee agreement of your transplant network.

WW.Vision Services - Non-Routine

Please note that vision services for children under the age of 19 are covered in Section 5. XX. (Covered Expenses / Vision Services – Pediatric).
1. **Covered Non-Routine Vision Services:**
   a. Diagnosis and *treatment* of eye pathology.
   b. Eye surgery to treat an *illness* or *injury* to the eye.
   c. Initial pair of eyeglasses or external contact lenses for keratoconus.

2. **Vision Services Exclusions:**
   This Policy provides no *benefits* for any of the items listed below. These exclusions apply in addition to the exclusions outlined in Section 6. (General Exclusions).
   a. Vision therapy;
   b. Refractive eye surgery, such as radial keratotomy;
   c. Orthoptic therapy and pleoptic therapy (eye exercise);
   d. Preparation, fitting or purchase of eye glasses or contact lenses, except as specifically stated in the Policy;
   e. Correction of visual acuity or refractive errors by any means, except as specifically stated in the Policy;
   f. Implantable specialty lenses, including, but not limited to, toric astigmatism-correcting lenses and multifocal presbyopia-correcting intraocular lenses to improve vision following cataract surgery;
   g. Replacement lenses, frames, or contact lenses due to loss, theft, or damage; and
   h. Routine eye exams, except as specifically stated in the Policy.

XX. **Vision Services - Pediatric**

1. Pediatric vision services as listed below for a *covered person* until the last day of the month in which he/she reaches age 19:
   a. Routine eye exams.
   b. Single vision, conventional (lined) bifocal, or conventional (lined) trifocal prescription lenses limited to one pair per *covered person* per *calendar year*. Lenses include the choice of glass, plastic, or polycarbonate and will include scratch resistant coating.
   c. Frames from a selection of covered frames limited to one frame per *covered person* per *calendar year*. The *health care provider* will show you which frames are covered by the Policy.
   d. Contact lenses when purchased in lieu of all other frames and/or lenses. *Benefits* are limited to 48 contact lenses per *covered person* per *calendar year*.

2. The following services, provided you receive our *prior authorization*:
   a. Contact lenses for the following conditions:
      1) Pathological myopia;
      2) Anisometropia;
      3) Aniseikonia;
      4) Aniridia;
      5) Corneal disorders;
      6) Post-traumatic disorders; and
      7) Irregular astigmatism.
b. Low vision services including the following:
   1) One comprehensive low vision evaluation every five years;
   2) Low vision aids, limited to the following: (a) spectacles; (b) magnifiers; and (c) telescopes; and
   3) Follow-up care of four visits in any five-year period.

c. The following lens options and treatments:
   1) Ultraviolet protective coating;
   2) Blended segment lenses;
   3) Intermediate vision lenses;
   4) Standard progressives;
   5) Premium progressives;
   6) Photochromic glass lenses;
   7) Plastic photosensitive lenses;
   8) Polarized lenses;
   9) Standard anti-reflective coating;
   10) Premium anti-reflective coating;
   11) Ultra anti-reflective coating; and
   12) Hi-index lenses.

6. GENERAL EXCLUSIONS

The Policy provides no benefits for any of the following:

1. Health care services that we determine are not medically necessary.

2. Health care services that we determine are experimental/investigational/unproven, except for the following, which are covered under the Policy as described in Section 5. LL. (Covered Expenses / Prescription Legend Drugs and Supplies):
   a. Investigational drugs for the treatment of HIV infection as described in Wis. Stat. § 632.895(9); and
   b. Drugs that by law require a written prescription used in the treatment of cancer that may not currently have the FDA's approval for that specific diagnosis but are listed in recognized off-label drug usage publications as appropriate treatment for that diagnosis.

3. Maintenance care or supportive care.

4. Health care services that we determine to be cosmetic treatment, except as otherwise provided in the Policy.

5. Health care services provided in connection with any injury or illness arising out, or sustained in the course of any occupation, employment, or activity of compensation, profit or gain, for which an employer is required to carry workers' compensation insurance. This exclusion applies regardless of whether benefits under workers' compensation laws or any similar laws have been claimed, paid, waived, or compromised.

6. Health care services furnished by the U.S. Veterans Administration, unless federal law designates the Policy as the primary payer and the U.S. Veterans Administration as the secondary payer.
7. *Health care services* furnished by any federal or state agency or a local political subdivision when you are not liable for the costs in the absence of insurance, unless such coverage under the Policy is required by law.

8. The *amount of benefits* that are covered by, or would have been covered by, Medicare as the primary payer if you are eligible for Medicare. This applies regardless of whether you are actually enrolled in Medicare. See Section 7. H. (Coordination of Benefits / Coverage with Medicare) for additional information.

9. *Health care services* for any *illness or injury* caused by war or act(s) of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to *covered persons* who are civilians injured or otherwise affected by war, any act of war, or terrorism in non-war zones.

10. *Health care services* for any *illness or injury* you sustain: (a) while on active duty in the armed services of any country; or (b) as a result of you being on active duty in the armed services of any country.

11. *Custodial care* except *home health aide services* as covered in Section 5. X. (Covered Expenses / Home Care Services).

12. *Charges* in excess of the *maximum allowable fee* or *maximum out-of-network allowable fee*.

13. *Chelation* therapy, except in the *treatment* of heavy metal poisoning.

14. *Health care services* provided while held, detained or imprisoned in a local, state or federal penal or correctional institution or while in custody of law enforcement officials, except as required under Wis. Stat. § 609.65. This exclusion does not apply to *covered persons* on work-release.

15. *Completion* of forms, including but not limited to claim forms or forms necessary for the return to work or school.

16. An *appointment* you did not attend.

17. *Health care services* for which you have no obligation to pay or which are provided to you at no cost.

18. *Health care services* related to a non-covered *health care service*. When a service is not a covered health care service, all services related to that non-covered health care service are also excluded. This exclusion does not apply to services we would otherwise determine to be a covered health care service if they are to treat complications that arise from the non-covered health care service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing illness and that affects or modifies the prognosis of the original illness. Examples of a "complication" are bleeding or infections, following *cosmetic treatment*, which requires hospitalization.

19. *Health care services* requested or required by a third party for employment, licensing, insurance, marriage, adoption, travel, disability determinations, or court-ordered exams, other than as specifically stated in the Policy or required by law.


21. *Transportation* or other travel costs associated with a *health care service*, except as specifically provided in Section 5. D. (Covered Expenses / Ambulance Services).

22. *Health care services* that are excluded elsewhere in the Policy.

23. *Health care services* not specifically identified as being covered under the Policy, except for those *health care services* approved by us subject to Section 5. C. (Covered Expenses / Alternative Care).

24. *Health care services* provided when your coverage was not effective under the Policy. Please see Section 2. (Enrollment Options) and Section 8. (When Coverage Ends).

25. *Health care services* not provided by a *health care practitioner* or any of the *health care providers* listed in Section 5. (Covered Expenses).

26. The following procedures and any related *health care services*:

   a. Injection of filling material (collagen) other than for incontinence;
b. Salabrasion;

c. Rhytidectomy (face lift);

d. Dermabrasion;

e. Chemical peel;

f. Suction-assisted lipectomy (liposuction);

g. Hair removal;

h. Mastopexy;

i. Mammoplasty, including augmentation or reduction mammoplasty (except for reconstruction associated with a covered mastectomy);

j. Correction of inverted nipples;

k. Sclerotherapy or other treatment for varicose veins less than 3.5 millimeters in size (e.g. telangiectasias, spider veins, reticular veins);

l. Excision or elimination of hanging skin on any part of the body, such as panniculectomy; abdominoplasty and brachioplasty;

m. Mastectomy for gynecomastia;

n. Botulinum toxin or similar products, unless you receive our prior authorization;

o. Any modification to the anatomic structure of a body part that does not affect its function;

p. Labioplasty;

q. Treatment of sialorrhea (drooling or excessive salivation); and

r. Medical and surgical treatment of excessive sweating (hyperhidrosis).

27. Health care services provided at any nursing facility or convalescent home or charges billed by any place that is primarily for rest, the aged, or the treatment of substance use disorders, except as specifically stated in Section 5. G. (Covered Expenses / Behavioral Health Services).

28. Health care services provided: (a) in the examination, treatment or removal of all or part of corns, callosities, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet; (b) in the cutting or trimming of toenails; or (c) in the non-operative partial removal of toenails. This exclusion does not apply to health care services that are associated with a medical diagnosis of diabetes, peripheral vascular disease or peripheral neuropathy.

29. Housekeeping, shopping, or meal preparation services.

30. Health care services provided in connection with: (a) any illness or injury caused by your engaging in an illegal occupation; or (b) any illness or injury caused by your commission of, or an attempt to commit, a felony.

31. Health care services for which proof of claim isn't provided to us as required by the Policy.

32. Health care services not for or related to an illness or injury, other than as specifically stated in the Policy.

33. Sales tax or any other tax, levy, or assessment by any federal or state agency or a local political subdivision.

34. Costs associated with indirect services provided by health care providers such as: creating standards, procedures, and protocols; calibrating equipment; supervising testing; setting up parameters for test results; reviewing quality assurance data; transporting lab specimens; concierge payments; translating claim forms or other records; and after-hours charges.
35. **Treatment** of weak, strained, flat, unstable or unbalanced feet; arch supports; heel wedges; lifts; orthopedic shoes; or the fitting of orthotics to aid walking or running; unless specifically stated otherwise in the Policy.

36. **Health care services** for **treatment** of sexual dysfunction, including impotence, regardless of the cause of the dysfunction. This includes: (a) **surgical services**; (b) devices; (c) penile implants; and (d) sex therapy.

37. **Storage** of blood tissue, cells, or any other body fluids.

38. **Salivary** hormone testing.

39. **Health care services** performed while outside of the United States, except in the case of a **medical emergency**.

40. **Prolotherapy**.

41. **Platelet-rich plasma**.

42. **Coma** stimulation/recovery programs.

43. **Environmental** items including, but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, and vacuum devices.

44. Wigs, toupees, hairpieces, cranial prosthesis, hair implants, or transplants or hair weaving, or hair loss prevention treatments.

45. Car seats.

46. Modifications to your vehicle, home or property including, but not limited to, escalators, elevators, saunas, steam baths, **pools**, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts, chair lifts, grab bars, raised toilet seats, commodes, and ramps.

47. **Health care services** used in educational or vocational training or testing.

48. **Medications** for which the primary purpose is to preserve fertility.

49. **Health care services** for holistic, complementary, alternative or homeopathic medicine or other programs that are not accepted medical practice, as determined by us, including, but not limited to, aromatherapy, herbal medicine, naturopathy, reflexology, and programs with an objective to provide personal fulfillment.

50. **Hypnosis**.

51. **Acupuncture**.

52. **Biofeedback**.

53. **Therapy** services such as recreational therapy (other than recreational therapy included as part of a **treatment** program received during a **confinement** for **treatment** of nervous or mental disorders and/or **substance use disorders**), educational therapy, physical fitness, or exercise programs, except as specifically stated in Sections 5. I. (Covered Expenses / Cardiac Rehabilitation Services) and 5. TT. (Covered Expenses / Therapy Services).

54. **Photodynamic** therapy and laser therapy for the **treatment** of acne.

55. **Vocational** or industrial rehabilitation including work hardening programs.

56. **Sports** hardening and rehabilitation.

57. **Health care services** that are solely for educational, occupational or athletic purposes and not for **treatment** of an illness or injury.

58. **General** fitness programs, exercise programs, exercise equipment, health club or health spa fees, personal trainers, aerobic and strength conditioning, functional capacity exams, physical performance testing, and all material and products related to these programs.

59. **Health care services** provided in connection with a diagnosis of obesity, weight control, or weight reduction, regardless of whether such services are prescribed by a **health care practitioner** or associated with an illness or
injury, except as indicated in Section 5. MM. (Covered Expenses / Preventive Care Services). Services excluded under this provision include, but are not limited to:

a. Gastric or intestinal bypasses;

b. Gastric balloons or banding;

c. Stomach stapling;

d. Wiring of the jaw;

e. Liposuction;

f. Any drug used for weight control or whose primary use is weight control, regardless of why the drug is being prescribed to you;

g. Weight loss programs and nutritional counseling, unless benefits are provided elsewhere in the Policy;

h. Physical fitness or exercise programs or equipment, unless benefits are provided elsewhere in the Policy; and

i. Bone densitometry (DEXA, DXA) scans.

60. Health care services performed by a health care practitioner who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any health care service the provider may perform on himself or herself.

61. Health care services performed by a health care practitioner with your same legal residence.

62. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

63. Respite care, except respite care that is part of hospice care as described under Section 5. Z. (Covered Expenses / Hospice Care).

7. COORDINATION OF BENEFITS (COB)

A. Definitions

The following definitions apply to this Section 7. only:

1. Allowable Expense: a health care service or expense, including deductibles and copayments, that is covered at least in part by one or more plans covering the person for whom the claim is made. When a plan provides benefits in the form of services, the reasonable cash value of each service provided will be considered both an allowable expense and a benefit paid.

2. Claim Determination Period: a calendar year. However, it does not include any part of a year during which a person has no coverage under the Policy or any part of a year before the date this Section 7. or a similar provision takes effect.

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

a. Individual or group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

b. Coverage under a governmental plan or coverage that is required or provided by law. It does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.
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Medical expense benefits coverage in group, group-type and individual automobile “no-fault” contracts but, as to the traditional automobile “fault” contracts, only the medical benefits written on a group or group-type basis are included.

Each contract or other arrangement for coverage under Paragraphs 3. a., b., or c. above is a separate plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

4. Primary Plan/Secondary Plan: Subsection C. (Order of Benefit Determination Rules) below states whether the Policy is a primary plan or secondary plan as to another plan covering the person. When the Policy is a primary plan, its benefits are determined before those of the other plan and without considering the other plan’s benefits. When the Policy is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan’s benefits. When there are more than two plans covering the person, the Policy may be a primary plan as to one or more other plans and may be a secondary plan as to a different plan or plans.

B. Applicability

1. This Section 7. applies when you have health care coverage under the Policy and another plan.

2. If this Section 7. applies, the order of benefit determination rules will be looked at first. The rules determine whether the benefits of the Policy are determined before or after those of another plan. The benefits of the Policy:
   a. Will not be reduced when, under the order of benefit determination rules, the Policy determines its benefits before another plan; but
   b. May be reduced when, under the order of benefit determination rules, another plan determines its benefits first. This reduction is described in Subsection D. (Effect on the Benefits of the Policy) below.

C. Order of Benefit Determination Rules

1. When there is a basis for a claim under the Policy and another plan, the Policy is a secondary plan unless:
   a. The other plan is automobile medical expense benefit coverage or has rules coordinating its benefits with those of the Policy; and
   b. Both those rules and the Policy’s rules described in Paragraph 2. below require that the Policy’s benefits be determined before those of the other plan.

2. The Policy determines its order of benefits using the first of the following rules which applies:
   a. Non-dependent/Dependent. The benefits of the plan which covers the person as an employee, member or subscriber are determined before those of the plan which covers the person as a dependent of an employee, member or subscriber.
   b. Dependent Child/Parents Not Separated or Divorced. Except as stated in Paragraph 2. c. below, when the Policy and another plan cover the same child as a dependent of different persons, called “parents”, the benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in that calendar year; but if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

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

   c. Dependent Child/Separated or Divorced Parents. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

      1) First, the plan of the parent with custody of the child;

      2) Then, the plan of the spouse of the parent with custody of the child; and
3) Finally, the plan of the parent not having custody of the child.

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

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This Paragraph 2. c. does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. Active/Inactive Employee. The benefits of a plan which covers a person as an employee who is neither laid-off nor retired or as that employee’s dependent are determined before those of a plan which covers that person as a laid-off or retired employee or as that employee’s dependent. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this Paragraph 2. d. is ignored. If a dependent is a Medicare beneficiary and if, under the Social Security Act of 1965 as amended, Medicare is secondary to the plan covering the person as a dependent of an active employee, the federal Medicare regulations will supersede this Paragraph 2. d.

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

1) First, the benefits of a plan covering the person as an employee, member or subscriber or as a dependent of an employee, member or subscriber;

2) Second, the benefits under the continuation coverage; and

3) If the other plan does not have the rule described in Subparagraph 1) and 2), and if, as a result, the plans do not agree on the order of benefits, this Paragraph 2. e. is ignored.

f. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member, subscriber or dependent longer are determined before those of the plan which covered that person for the shorter time.

g. None of the Above. If the preceding rules do not determine the primary plan, the allowable expenses will be shared equally between the plans meeting the definition of plan under this provision. In addition, the Policy will not pay more than it would have paid had it been the primary plan.

D. Effect on the Benefits of the Policy

1. When This Subsection Applies. This Subsection D. applies when, in accordance with Subsection C. (Order of Benefit Determination Rules), the Policy is a secondary plan as to one or more other plans. In that event, the benefits of the Policy may be reduced under this Subsection D. Such other plan or plans are referred to as “the other plans” below.

2. Reduction in the Policy’s Benefits. The benefits of the Policy will be reduced when the sum of the following exceeds the allowable expenses in a claim determination period:

a. The benefits that would be payable for the allowable expenses under the Policy in the absence of this section; and

b. The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this section, whether or not a claim is made. Under this provision, the benefits of the Policy will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.
When the benefits of the Policy are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the Policy.

E. Right to Receive and Release Needed Information

We have the right to decide which facts we need to apply these COB rules. We may get needed facts from or give them to any other organization or person without your consent but only as needed to apply these COB rules. Medical records remain confidential as provided by law. Each person claiming benefits under the Policy must give us any facts we need to pay the claim.

F. Facility of Payment

A payment made under another plan may include an amount which should have been paid under the Policy. If it does, we may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under the Policy. We will not have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.

G. Right of Recovery

1. If the amount of the payments we made is more than we should have paid, we may recover the excess from one or more of:
   a. The persons we paid or for whom we paid;
   b. Insurance companies; or
   c. Other organizations.

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

H. Coverage with Medicare

This Policy will coordinate benefits with Medicare in accordance with federal law. A covered person who is eligible for Medicare is considered enrolled in and covered under Medicare Parts A and B, whether or not he/she is actually enrolled in one or both parts of Medicare. This Policy will coordinate benefits as if you were covered by Medicare. For example, if you are eligible to enroll in Medicare Part B but fail to do so, we will still determine benefits that are payable under this Policy as if you had Medicare Part B coverage and Medicare paid Part B benefits, even if Medicare didn’t pay any Part B benefits. You will be responsible for all covered expenses that would have been covered by Medicare.

8. WHEN COVERAGE ENDS

A. General Rules

We may terminate your coverage under the Policy at 11:59 p.m. on the earliest of the following dates:

1. The date we determine that you have performed an act or practice that constitutes fraud or made an intentional material misrepresentation of material fact under the terms of the coverage;

2. The last day of the applicable grace period if the premium required for your coverage has not been paid to us in accordance with this Policy;

3. The day in which you die. If there is a remaining covered spouse, if any, he/she will automatically become the subscriber and covered dependents will continue coverage;

4. The date you enter into military service, other than for assignment of less than 30 days;
5. The last day of the calendar month in which we receive the subscriber’s request to terminate this Policy, unless he/she specifies a later Policy termination date;

6. The last day of the calendar month in which we received the subscriber’s request to terminate coverage for any of his/her dependents, unless he/she specifies a later Policy termination date;

7. For a subscriber’s covered dependent, the date the subscriber’s coverage terminates;

8. For a subscriber’s spouse who is a covered person, the date the subscriber’s spouse is no longer married to the subscriber due to divorce or annulment;

9. For a child who is a covered dependent, the earliest of the following dates, as determined by us:
   a. the last day of the calendar month in which the child reaches age 26, unless he/she is a full-time student returning from military duty or he/she qualifies as an eligible dependent due to his/her disability (see the definition of eligible dependent in Section 14. (Definitions));
   b. for step-children, the date the subscriber’s spouse is no longer married to the subscriber.

A full-time student who attains the limiting age while covered under this Policy will remain eligible for benefits until the last day of the calendar month in which the child ceases to be a full-time student as defined in this Policy.

10. For a child of a covered dependent child, the date the subscriber’s child reaches age 18.

It is the subscriber’s responsibility to notify us of his/her child losing status as an eligible dependent. If he/she does not so notify us, the subscriber will be responsible for any claim payments made during the period of time the child was not an eligible dependent.

You will not be eligible for renewal of this Policy after one of the following events occurs:

1. The subscriber moves outside, or no longer resides in, the geographical service area; or

2. We cease to offer this Policy.

B. Special Rules for Full-Time Students Returning from Military Duty

A full-time student returning from military duty may continue coverage if he/she ceases to be a full-time student due to a medically necessary leave of absence. In order to continue coverage, we must receive written documentation and certification of the medical necessity of the leave of absence from his/her attending health care practitioner.

Coverage will continue for a full-time student returning from military duty on a medically necessary leave of absence until the earliest of the following dates:

1. He/she advises us that he/she does not intend to return to school full-time;

2. He/she becomes employed full time;

3. He/she obtains other health care coverage;

4. He/she marries and is eligible for coverage under his/her spouse’s health coverage;

5. The date coverage of the subscriber through whom he/she has dependent coverage under the Policy is discontinued or not renewed; or

6. One year following the date on which he/she ceased to be a full-time student due to the medically necessary leave of absence if he/she has not returned to school on a full-time basis.

It is the subscriber’s responsibility to notify us of his/her child losing status as an eligible dependent. If he/she does not so notify us, the subscriber will be responsible for any claim payments made on behalf of the child while he/she was not an eligible dependent.
C. Special Rules for Disabled Children

If you have family coverage under the Policy, a child may continue coverage under your family coverage beyond the limiting age if: (1) the child’s coverage under the Policy began before he/she reached age 26; (2) the child is incapable of self-sustaining employment because of intellectual disability or physical handicap; (3) the child is chiefly dependent upon the subscriber for support and maintenance; (4) the child’s incapacity existed before he/she reached age 26; and (5) the subscriber’s family coverage remains in force under the Policy.

Written proof of a child’s disability must be given to us within 31 days after the child turns age 26. Failure to provide such proof within that 31-day period will result in the termination of that child’s coverage. After the child turns 28, we may request proof of disability annually.

It is the subscriber’s responsibility to notify us if his/her child no longer qualifies as an eligible dependent. If he/she does not so notify us, the subscriber will be responsible for any claim payments made on behalf of the child during the period of time he/she was not eligible for coverage under the Policy.

D. Disenrollment from the Plan

Disenrollment means that your coverage under the Policy is revoked. We may disenroll you only for the reasons listed below:

1. Required premiums are not paid by the end of the grace period;
2. You allow a non-covered person to use your identification card to obtain health care services; or
3. You have performed an act or practice that constitutes fraud or made an intentional material misrepresentation of material fact under the terms of the coverage.

9. PREMIUMS, RENEWAL AND GRACE PERIOD

A. Premium Rates

We determine the premium rates for this Policy and all subsequent premiums due for all covered persons under this Policy. Each premium for each payment period after the initial period of coverage must be paid directly to Arise by the premium due date.

For subsequent payment periods, the subscriber's payment of the required premium by the premium due date shall keep this Policy in force for the payment period beginning on the first day of the calendar month following the premium due date for which such premium was paid through the last day of the calendar month, subject to Section 8. (When Coverage Ends) and the payment period's grace period. The subscriber's failure to pay premium due for a payment period shall terminate this Policy in accordance with Section 8. (When Coverage Ends).

We may change the premium rates under this Policy:

1. Annually effective January 1st of each year; and
2. When dependents are added or deleted.

The same rating schedule must apply to all of our policies with this policy form number and to all covered persons in the same actuarial rating classifications.

We will provide written notice of a premium rate change to the subscriber by the earliest of: (1) the first day of the annual open enrollment period; or (2) at least 30 days before any such change takes effect for this Policy. However, when this Policy's premium rate is increased 25% or more for a payment period, we will provide written notice of the new premium rate to the subscriber at least 60 days before any change takes effect. The premium rate change takes effect on the first day of the payment period as described in the required notice.
B. Premium Due Date

The due date of your premium is indicated on your billing statement, which will arrive monthly. In order to keep your coverage in effect, you must pay your premium by the end of the applicable grace period after your premium due date. If we do not receive your premium payment, this Policy will terminate on the last day of the applicable grace period at 11:59 p.m.

The subscriber can terminate this Policy by notifying us prior to his/her next premium due date. After we receive such notice, your Policy will terminate in accordance with Section 8. (When Coverage Ends). You must still pay us the premium for coverage provided during that period. If this Policy ends for any other reason before any paid-up payment period ends, any refunds will be prorated to the termination date from the date of last premium payment.

We're not responsible for notifying you when premiums are due for coverage provided during payment periods under this Policy.

C. Grace Period

Except for your first premium, any premium not paid to us by the due date is in default. However, there is a grace period beginning with the first day of the payment period during which you fail to pay the premium. The grace period is 10 days after the first day of the payment period. This Policy's coverage will remain in force during the grace period. If you don't pay your premium within the applicable grace period, this Policy shall automatically terminate on the last day of the applicable grace period at 11:59 p.m. You are required to pay for coverage we provide during that grace period.

D. Reinstatement (after Policy termination for nonpayment of Premium)

In certain circumstances, you may be able to reinstate your coverage if your Policy is terminated because you did not pay your premium.

To have your coverage reinstated, you must send to us a premium payment for all previously missed months plus payment for the next month. You must send this payment within 60 days of the date your Policy was terminated. If we accept your payment your coverage will be reinstated as of the date your Policy was terminated. We will notify you within 45 days of receiving your payment if we accept. If reinstated, your coverage will continue as if it had never been terminated.

We will only allow you to reinstate this Policy one time per calendar year. You cannot reinstate your Policy if you purchased it through the Health Insurance Marketplace.

10. GENERAL PROVISIONS

A. Your Relationship with Your Health Care Practitioner, Hospital or Other Health Care Provider

We won't interfere with the professional relationship you have with your health care practitioner, hospital or other health care provider. We do not require that you choose any particular health care practitioner, hospital, or other health care provider, although there may be different benefits payable under the Policy depending on your choice of health care practitioner, hospital, or other health care provider. We do not guarantee the competence of any particular health care practitioner, hospital, other health care provider or their availability to provide services to you. You must choose the health care practitioner, hospital, or other health care provider you would like to see and the health care services you wish to receive. We're not responsible for any injury, damage or expense (including attorneys' fees) you suffer as a result of any improper advice, action or omission on the part of any health care practitioner, hospital, or other health care provider, including, but not limited to, any participating provider. We're obligated only to provide the benefits as specifically stated in the Policy.
B. Your Right to Choose Medical Care

The Policy does not limit your right to choose your own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, you still have the right and privilege to receive such health care service at your own personal expense.

C. Health Care Practitioner, Hospital or Other Health Care Provider Reports

1. Health care practitioners, hospitals and other health care providers must release medical records and other claim-related information to us so that we can determine what benefits are payable to you. By accepting coverage under the Policy, you authorize and direct the following individuals and entities to release such medical records and information to us, as required by a particular situation and allowed by applicable laws:
   a. Any health care provider who has diagnosed, attended, treated, advised or provided health care services to you;
   b. Any hospital or other health care facility in which you were treated or diagnosed; and
   c. Any other insurance company, service, or benefit plan that possesses information that we need to determine your benefits under the Policy.

2. This is a condition of our providing coverage to you. It is also a continuing condition of our paying benefits.

D. Assignment of Benefits

This coverage is just for a subscriber and his/her covered dependents. Benefits may be assigned to the extent allowed by the Wisconsin insurance laws and regulations.

E. Subrogation

We have the right to subrogate against a third party or to seek reimbursement from you for the medical expenses necessarily incurred by you and related to an illness or injury caused by a third party. When you receive a benefit under the Policy for an illness or injury, we are subrogated to your right to recover the reasonable value of the services provided for your illness or injury to the extent of the benefits we have provided under the Policy.

Our subrogation rights include the right of recovery for any injury or illness a third party caused or is liable for. “Third party” claims are claims against any insurance company or any person or party that is in any way responsible for providing payment as a result of the illness or injury. These rights also include the right of recovery under uninsured motorist insurance, underinsured motorist insurance, no-fault insurance, and any other applicable insurance. We may pursue our rights of subrogation against any party liable for your illness or injury or any party that has contracted to pay for your illness or injury. In the event you have or may recover for your injury, we have the right to seek reimbursement from you for the actual cash value of any payments made by us to treat such illness or injury.

You or your attorney or other representative agree to cooperate with us in pursuit of these rights and will:

1. Sign and deliver all necessary papers we reasonably request to protect or enforce our rights;
2. Do whatever else is necessary to protect or allow us to enforce our rights including joining us as a party as we may request when you have commenced a legal action to recover for a personal injury; and
3. Not do anything before or after our payment that would prejudice our rights.

Our right to subrogate will not apply unless you have been made whole for loss of payments which you or any other person or organization is entitled to on account of illness or injury. You agree that you have been made whole by any settlement where your claim has been reduced because of your contributory negligence. You also agree that you have been made whole if you receive a settlement for less than the third party’s insurance company's policy limits. If a dispute arises over the question of whether or not you have been made whole, we reserve the right to seek a judicial determination of whether or not you have been made whole.
We will not pay fees or costs associated with any claim or lawsuit without our express written consent. We reserve the right to independently pursue and recover paid benefits.

F. Limitation on Lawsuits and Legal Proceedings

By accepting coverage under the Policy, you agree that you will not bring any legal action against us regarding benefits, claims submitted, the payment of benefits or any other matter concerning your coverage until the earlier of: (1) 60 days after we have received the claim described in Section 11. B. (Claim Filing and Processing Procedures / Filing Claims); or (2) the date we deny payment of benefits for a claim. This provision does not apply if waiting will result in loss or injury to you. However, the mere fact that you must wait until the earlier of the above dates does not alone constitute loss or injury.

By accepting coverage under the Policy, you also agree that you will not bring any legal action against us more than three years after the claim filing deadline outlined in Section 11. B. (Claim Filing and Processing Procedures / Filing Claims).

G. Severability

Any term, condition or provision of the Policy that is prohibited by Wisconsin law will be void and without force or effect. This, however, won't affect the validity and enforceability of any other remaining term, condition or provision of the Policy. Such remaining terms, conditions or provisions will be interpreted in a way that achieves the original intent of the parties as closely as possible.

H. Conformity with Applicable Laws and Regulations

On the effective date of the Policy, any term, condition or provision that conflicts with any applicable laws and regulations will automatically conform to the minimum requirements of such laws and regulations.

I. Waiver and Change

Only our Chief Executive Officer can execute a waiver or make a change to the Policy. No agent, broker or other person may waive or change any term, condition, exclusion, limitation, or other provision of the Policy in any way or extend the time for any premium payment. We may unilaterally change any provision of the Policy if we send written notice to the subscriber at least 30 days in advance of that change. When the change reduces coverage provided under the Policy, we will send written notice of the change to the subscriber at least 60 days before it takes effect.

Any change to the Policy will be made by an endorsement signed by our Chief Executive Officer. Each endorsement will be binding on the subscriber, all covered persons, and us. No error by us, the subscriber, or any covered person will: (1) invalidate coverage otherwise validly in force; (2) continue or reissue coverage validly terminated; or (3) cause us to issue coverage that otherwise would not be issued. If we discover any error, we have full discretionary authority to make an equitable adjustment of coverage, payment of benefits, and/or premium.

J. Refund Requests

If we pay more benefits than what we're required to pay under the Policy, including, but not limited to, benefits we pay in error, we can request a refund from any person, organization, health care provider, or plan that has received an excess benefit payment. If we cannot recover the excess benefit payments from any other source, we can request a refund from you. When we request a refund from you, you agree to pay us the requested amount immediately upon our notification to you. Instead of requesting a refund, we may, at our option, reduce any future benefit payments for which we are liable under the Policy on other claims in order to recover the excess payment amount. We will reduce such benefits otherwise payable for such claims until the excess benefit payments are recovered by us.

K. Quality Improvement

The Arise Health Plan Quality Improvement Committee evaluates and monitors key aspects of service and health care provided to covered persons. The Medical Director directs the Quality Improvement Committee. Various committees consisting of participating providers and Arise Health Plan staff guide, direct, and evaluate quality initiatives. Participating providers are evaluated using nationally accepted criteria prior to joining the network and are reevaluated every three years thereafter.
Health management studies and projects are completed to increase rates of preventive care services and to improve management of acute and chronic diseases. The Quality Improvement Committee is responsible for directing the process of improvement efforts.

L. Your Rights and Responsibilities

We are committed to maintaining a mutually respectful relationship with you that promotes high quality, cost-effective healthcare.

The rights and responsibilities listed below set the framework for cooperation among you, health care providers and us

1. Your Rights as a Health Plan Member
   a. You have the right to receive quality health care that’s friendly and timely.
   b. You have the right to be treated with respect and recognition of your dignity and right to privacy.
   c. You have the right to receive all medically necessary covered services when your health care providers feel they are needed.
   d. You have the right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
   e. You have the right to refuse treatment.
   f. You have the right to participate with health care providers in making decisions about your health care.
   g. You have the right to all information contained in your medical records.
   h. You have the right to receive information about us, our services, and our network of health care providers as well as your rights and responsibilities.
   i. You have the right to make a list of instructions about your health care treatments (called a living will) and to name the person who can make health care decisions for you.
   j. You have the right to have your medical and financial records kept private.
   k. You have the right to voice complaints or appeals about us or the health care coverage we provide.
   l. You have the right to have a resource at Arise that you can contact with any concerns about services and to receive a prompt and fair review of your complaint.
   m. You have the right to make recommendations regarding the member rights and responsibilities policies.

2. Your Responsibilities as a Health Plan Member
   a. You have the responsibility to select a participating primary care practitioner and to communicate with him or her in order to develop a patient-health care practitioners relationship based on trust, respect, and cooperation.
   b. You have the responsibility to know your health plan benefits and requirements.
   c. You have the responsibility to coordinate all non-life-threatening, in-network care through your participating primary care practitioner.
   d. You have the responsibility to review your insurance information upon enrollment and to ask questions to verify that you understand the procedures and explanations that are given.
   e. You have the responsibility to supply information (to the extent possible) that health care providers need in order to provide care and that we need in order to provide coverage.
   f. You have the responsibility to understand your health problems and to participate in developing mutually agreed-upon treatment goals to the degree possible.
g. You have the responsibility to follow the treatment plan and instructions for care that have been agreed on with your health care practitioners.

h. You have the responsibility to give proof of coverage each time you receive services and to update your clinic with any personal changes.

i. You have the responsibility to pay copayments when you receive services and to promptly pay deductibles, coinsurance, and other charges for services not covered by the Policy.

j. You have the responsibility to keep appointments for care or to give early notice if you need to cancel.

M. Incontestability

All statements made in an application or supplemental applications, if any, are representations, not warranties. No statement shall be used by us to: (1) contest or void coverage under this Policy; (2) reduce, limit or deny payment of benefits under this Policy; or (3) defend a claim under this Policy; unless such statement is in writing, a copy of which is supplied to the subscriber.

We will not contest the validity of your coverage under this Policy after your coverage has been in force for two years except for: (1) nonpayment of premium; or (2) a fraudulent statement contained in a document signed by that person or in an application or supplemental application, if any, for that person, a copy of which is supplied to the subscriber.

We shall not use a statement to reduce, limit or deny payment of benefits for a claim incurred by you after the expiration of such two-year period unless it is in a document signed by that person or, if that person is a dependent, in a document, application or supplemental application, if any, signed by the subscriber.

N. Misstatement of Age

Age means your age on your last birthday. If your age has been misstated, we will make an equitable adjustment to your premiums and/or benefits, as permitted by law.

O. Written Notice

Written notice that we provide to an authorized representative of the policyholder will be deemed notice to all affected covered persons and their covered dependents. This provision applies regardless of the notice’s subject matter.

11. CLAIM FILING AND PROCESSING PROCEDURES

A. Definitions

1. Concurrent Care Decision: a decision by us to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by us or a decision with respect to a request by you to extend a course of treatment beyond the period of time or number of treatments that has been approved by us.

2. Correctly Filed Claim: a claim that includes: (1) the completed claim forms that we require; (2) the actual itemized bill for each health care service; and (3) all other information that we need to determine our liability to pay benefits under the Policy, including but not limited to, medical records and reports.

3. Incomplete Claim: a correctly filed claim that requires additional information including, but not limited to, medical information, coordination of benefits questionnaire, and subrogation questionnaire.

4. Incorrectly Filed Claim: a claim that is filed but lacks information which enables us to determine what, if any, benefits are payable under the terms and conditions of the Policy. Examples include, but are not limited to, claims missing procedure codes, diagnosis or dates of service.

5. Post-Service Claim: any claim for a benefit under the Policy that is not a pre-service claim.
6. **Pre-Service Claim:** any claim for a *benefit* with respect to which the terms of the Policy condition receipt of a *benefit*, in whole or in part, on receiving *prior authorization* before obtaining medical care.

7. **Urgent Claim:** any *pre-service claim* for medical care or *treatment* with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or in the opinion of a *health care practitioner* with actual knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or *treatment* that is the subject of the claim.

**B. Filing Claims**

1. **How to File a Claim**

   Either you or your *health care provider* must submit the following information to us within 90 days after receiving a *health care service*:

   a. A fully-completed claim form, including all of the following information:
      
      1) Subscriber name;
      2) Subscriber number;
      3) Provider name;
      4) Provider address;
      5) Provider Tax ID or National Provider Identifier (NPI) Number;
      6) Patient’s name;
      7) Patient’s date of birth;
      8) Date of service;
      9) Procedure code;
      10) Diagnosis code; and
      11) Billed *charges* for each service.

   b. If all sections of the claim form are not completed in full, your claim may be returned to you.

   c. Proof of payment.

   If you receive *health care services* in a country other than the United States, you will need to pay for the *health care services* upfront and then submit the translated claim to us for reimbursement. We will reimburse you for any *covered expenses* in U.S. currency. The reimbursement amount will be based on the U.S. equivalency rate that is in effect on the date you paid the claim or on the date of service if the date of payment is unknown.

   Unless otherwise specifically stated in the Policy, we have the option of paying *benefits* either directly to the *health care provider* or to you. Payments for *covered expenses* for which we are liable may be paid under another group or franchise plan or policy arranged through your employer, trustee, union or association. In that case, we can discharge our liability by paying the organization that has made these payments. In either case, such payments will fully discharge us from all further liability to the extent of *benefits* paid.

2. **Exception to 90-Day Claim Filing Deadline**

   If you do not file the required information within 90 days after receiving a *health care service*, *benefits* will be paid for *covered expenses* if:

   a. It was not reasonably possible to provide the required information within such time; and
b. The required information is furnished as soon as possible and no later than one year following the initial 90-day period. The only exception to this rule is if you are legally incapacitated. If we do not receive written proof of claim required by us within that one-year and 90-day period and you are not legally incapacitated, no benefits are payable for that health care service under the Policy.

3. Pharmacy Prescription Claims

Prescription legend drug claims made after 4:00 p.m. will be logged in and handled on the next business day.

4. How to Appeal a Claim Denial

If a claim is denied, you may appeal the denial by filing a written grievance. Please see Section 12. (Internal Grievance and Appeal Procedures) for more information.

C. Designating an Authorized Representative

You may designate an authorized representative to pursue a claim for benefits or a grievance on your behalf. Such authorized representative will be treated as if he/she is the covered person and we will send our written decision responding to the claim for benefits or grievance to the authorized representative, not you. This written decision will contain personal information about you, including your confidential medical information, if any, that applies to the matter in which you designated the authorized representative to act on your behalf.

No person will be recognized as an authorized representative until we receive written documentation of the designation, on a form approved by us, unless the claim is an urgent claim. An assignment for purposes of payment does not constitute designation of an authorized representative under these claims procedures. Designation of an authorized representative does not constitute assignment for purposes of payment.

In instances of an urgent claim, we will recognize a health care professional with knowledge of your medical condition as your authorized representative unless you specify otherwise.

If you have an authorized representative, any references to “you” or “your” in this Section 11. will refer to the authorized representative.

D. Claim Processing Procedure

Benefits payable under the Policy will be paid after receipt of a correctly filed claim or prior authorization request as follows:

1. Concurrent Care Decisions. We will notify you of a concurrent care decision that involves a reduction in or termination of benefits prior to the end of any prior authorized course of treatment. The notice will provide time for you to file a grievance and receive a decision on that grievance prior to the benefit being reduced or terminated. This will not apply if the benefit is reduced or terminated due to a benefit change or termination of the Policy.

A request to extend a prior authorized treatment that involves urgent care must be responded to as soon as possible, taking into account medical urgency. We will notify you of the benefit determination, whether adverse or not, within 24 hours after receipt of your request provided that the request is submitted to us at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

2. Urgent Claims. We will notify you of our decision on your claim within 72 hours of receipt of an urgent claim or as soon as possible if your condition requires a shorter time frame. You or a health care professional with knowledge of your medical condition may submit the claim to us by telephone, electronic facsimile (i.e. fax) or mail.

We will determine whether a submitted claim is an urgent claim. This determination will be made on the basis of information provided by or on behalf of you. In making this determination, we will exercise our judgment with deference to the judgment of a health care practitioner with knowledge of your condition. As a result, we may require you to clarify the medical urgency and circumstances that support the urgent claim for expedited decision-making.
If the claim is an incorrectly filed claim, we will notify you of the failure to follow the proper procedures as soon as possible, but not later than 24 hours following receipt of the incorrectly filed claim. Such notification will explain the reason why the request failed and the proper procedures for filing an urgent pre-service claim.

If the claim is an incomplete claim, we will notify you of the specific information needed as soon as possible, but no later than 24 hours after we receive the incomplete claim. You will then have 48 hours from the receipt of the notice to provide us with the requested information. We will notify you of our decision as soon as possible, but not later than 48 hours after the earlier of: (a) our receipt of the additional information; or (b) the end of the period of time provided to submit the additional information.

3. **Pre-Service Claims.** If your pre-service claim involves experimental/investigative/unproven treatment, we will notify you of our decision on your claim as soon as possible, but not later than 5 business days after we receive it.

   For all other pre-service claims, we will notify you of our decision on your claim as soon as possible, but not later than 15 days after our receipt of a pre-service claim. However, this period may be extended one time by an additional 15 days if we determine that an extension is necessary due to matters beyond our control. We will notify you of the extension prior to the end of the initial 15-day period, the circumstances requiring the extension, and the date by which we expect to make a decision.

   If the claim is an incorrectly filed claim, we will notify you of the failure to follow the proper procedures as soon as possible, but not later than 5 days following receipt of the incorrectly filed claim. Such notification will explain the reason why the request failed and the proper procedures for filing a pre-service claim.

   If the claim is an incomplete claim, we may extend this time by an additional 15 days, provided that we notify you that an extension is necessary and of the specific information needed prior to the end of the initial 15-day period. You will then have 45 days from the receipt of the notice to provide us with the requested information. Once we have received the additional information, we will make our decision within the period of time equal to the 15-day extension in addition to the number of days remaining from the initial 15-day period. For example, if our notification was sent to you on the fifth day of the first 15-day period, we would have a total of 25 days to make a decision on your claim following the receipt of the additional information. Under no circumstances will the period for making a final determination on your claim exceed 75 days from the date we received the non-urgent pre-service claim.

4. **Post-Service Claims.** We will notify you of our decision on your claim as soon as possible, but not later than 30 days after our receipt of a post-service claim.

   However, this period may be extended one time by an additional 15 days if we determine that an extension is necessary due to matters beyond our control. We will notify you of the extension prior to the end of the initial 30-day period, the circumstances requiring the extension, and the date by which we expect to make a decision.

   If the claim is an incomplete claim, we may extend this time by an additional 15 days, provided that we notify you that an extension is necessary and of the specific information needed prior to the end of the initial 30-day period. You will then have 45 days from the receipt of the notice to provide us with the requested information. Once we have received the additional information, we will make our decision within the period of time equal to the 15-day extension in addition to the number of days remaining from the initial 30-day period. For example, if our notification was sent to you on the fifth day of the first 30-day period, we would have a total of 40 days to make a decision on your claim following the receipt of the additional information. Under no circumstances will the period for making a final determination on your claim exceed 90 days from the date we received the post-service claim.

E. **Claim Decisions**

   If benefits are payable on charges for services covered under the Policy, we will pay such benefits directly to the health care provider providing such services, unless you advise us in writing prior to payment that you have already paid the charges and submitted paid receipts. We will send you written notice of the benefits we paid on your behalf. If you have already paid the charges and are seeking reimbursement from us, payment of such benefits will be made directly to you.

   If the claim is denied in whole or in part, you will receive a written notice from us within the time frames described above. However, notices of adverse benefit determinations involving an urgent claim may be provided to you verbally within the
time frames described above for expedited claim decisions. If verbal notice is given under such circumstances, then written notification will be provided to you no later than 3 days after the verbal notification.

A denial notice will state the specific reason or reasons for the adverse benefit determination, the specific Policy provisions on which the determination is based, and a description of the internal and external review procedures and associated timelines. The notice will include a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.

The denial notice will also disclose any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse benefit determination. A copy of such internal rule, guideline, protocol, or other similar criterion will be provided to you, free of charge, upon request.

If the adverse benefit determination is based on the definition of medically necessary or experimental/investigational/unproven, the denial notice will include an explanation of the scientific or clinical judgment for the determination applying the terms of the Policy to your medical circumstances. Alternatively, the denial notice will include a statement that such explanation will be provided, free of charge, upon your request.

You also have the right to request, free of charge, the diagnosis code with its corresponding meaning and the treatment code with its corresponding meaning along with copies of all documents, records, and other information relevant to your claim for benefits.

12. INTERNAL GRIEVANCE AND APPEALS PROCEDURES

A. General Grievance Information

Situations might occasionally arise when you question or are unhappy with our claims decision or some aspect of service that you received from us. We can resolve most of your concerns without you having to file a grievance. Therefore, before filing a grievance, we urge you to speak with our Customer Service Department to try to resolve any problem, question, or concern that you have by calling the telephone number on your identification card. A customer service representative will record your information and your proposed resolution and consider all information that we have about your concern. If necessary, he/she will then discuss the matter with a supervisor in our Customer Service Department.

We will respond to your proposed resolution in writing by sending you a letter or an Explanation of Benefits that explains the actions we have taken to resolve the matter. If the matter cannot be informally resolved, you have the right to file a grievance in writing with our Grievance/Appeal Committee in accordance with the procedure described below.

You also have the right to appeal an adverse benefit determination by filing a grievance. The grievance procedures described below are the only means through which an adverse benefit determination may be appealed.

B. Grievance Procedures

To file a grievance, you should write down the concerns, issues, and comments you have about our services and mail, fax, or deliver the written grievance along with copies of any supporting documents to our Grievance/Appeal Department at the address shown below.

Arise Health Plan
Attention: Grievance Coordinator
P.O. Box 11625
Green Bay, Wisconsin  54307-1625
Fax: 920-490-6922

Your grievance must be in writing as we cannot accept telephone requests for a grievance. Please deliver, fax, or mail your grievance to us at the address shown above.

For example, if we denied benefits for your claim because we determined that a health care service provided to you was not medically necessary and/or experimental/investigational/unproven, please send us all additional medical information (including copies of your health care provider’s medical records) that shows why the health care service was medically necessary and/or not experimental/investigational/unproven under the Policy.
Any grievance filed by your health care practitioner regarding a prescription legend drug or a durable medical equipment or other medical device should present medical evidence demonstrating the medical reason(s) why we should make an exception to cover and pay benefits for that prescription legend drug, durable medical equipment or medical device that is not covered under the Policy.

We will acknowledge our receipt of your grievance by delivering, faxing, or mailing you an acknowledgment letter within five business days of our receipt of the grievance. If you do not receive this acknowledgement, please contact our Customer Service Department using the telephone number on your identification card.

As soon as reasonably possible after we receive your grievance, our Grievance/Appeal Department will review the information you provided and consider your proposed resolution in the context of any information we have available about the applicable terms, conditions, and provisions of the Policy. If we agree with your proposed resolution, we will notify you by sending a letter explaining our subsequent claims processing action or administrative action that resolves the matter to your satisfaction. If our Grievance/Appeal Department upholds the original claims processing or administrative decision that you challenged, the grievance will be automatically forwarded to our Grievance/Appeal Committee (the “Committee”) for its review and decision in accordance with the grievance procedure explained further below.

You have the right to submit written questions/comments, documents, records, evidence, testimony, and other information relating to the claim for benefits that is the subject of your grievance to the Committee. The Committee will review your grievance and all relevant documents pertaining to the grievance without regard to whether such information was submitted or considered in the initial adverse benefit determination.

You also have a right to appear in person or to participate by teleconference before the Committee to present information to the Committee and to submit written questions to the Committee. The Committee will respond to any submitted written question in its notice to you of its final benefit determination. We will notify you in writing of the time and place of the meeting at least seven calendar days before the meeting. Please remember that this meeting is not a trial where there are rules of evidence are followed. Also, cross-examination of the Committee’s members, its advisors, or Arise employees is not allowed. No transcript of the meeting is prepared, and sworn testimony is not taken by the Committee. However, your presentation to the Committee will be recorded. If you attend the meeting to present reason(s) for the grievance, we expect and require each person who attends the meeting to follow and abide by our established internal practices, rules and requirements for handling grievances effectively and efficiently in accordance with applicable laws and regulations.

For decisions regarding medical judgment, the Committee will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional will not be the same individual who was consulted regarding the initial adverse benefit determination or a subordinate of such individual. You have the right to request, free of charge, the identity of the health care professional whose advice we obtained in connection with the adverse benefit determination, regardless of whether such advice was relied upon in making a decision.

In addition, you have the right to request, free of charge, access to and copies of all documents, records, and other information relevant to your grievance. Furthermore, as part of providing an opportunity for a full and fair review, we will provide you with any new or additional evidence considered, relied upon, or generated by us in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of a final adverse benefit determination is required to be provided to you for purposes of providing you a reasonable opportunity to respond prior to that date.

Before a final adverse benefit determination is made based on a new or additional rationale, we will provide you, free of charge, with the rationale. Such rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse benefit determination is required to be provided to you for purposes of providing you with a reasonable opportunity to respond prior to that date.

In the event the new or additional evidence is received so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, then the deadline for providing a notice of final adverse benefit determination is tolled until such time is reasonable for providing you an opportunity to respond. After you respond or have had a reasonable opportunity to respond but fail to do so, we will notify you of our final decision as soon as we reasonably can, taking into account any medical exigencies.

For a grievance that is not also an adverse benefit determination, we will mail you a letter explaining our decision within 30 days. However, this period may be extended one time by an additional 30 days if we determine that an extension is
necessary. We will notify you of the extension prior to the end of the initial 30-day period, the circumstances requiring the extension, and the date by which we expect to make a decision.

For a grievance that is also an adverse benefit determination, we will notify you of our final decision as soon as possible, but not later than as follows:

1. **Pre-Service Claims.** We will notify you of our final decision as soon as possible, but not later than 30 days after our receipt of your grievance for a pre-service claim.

2. **Post-Service Claims.** We will notify you of our final decision as soon as possible, but not later than 60 days after our receipt of your grievance for a post-service claim.

3. **Concurrent Care.** We will notify you of our final decision to reduce or terminate an initially approved course of treatment before the proposed reduction or termination takes place. We shall decide the appeal of a denied request to extend any concurrent care decision in the appeal time frame for a pre-service claim, urgent claim, or a post-service claim, as appropriate to the request.

4. **Expedited Grievances.** We will notify you of our final decision as soon as possible, but not later than 72 hours after receipt of the expedited grievance. An expedited grievance includes an appeal of an urgent claim.

C. **Expedited Grievance Procedure**

To file an expedited grievance, you or your health care practitioner must submit the concerns, issues, and comments underlying your grievance to us verbally via telephone or in writing via mail, email, or fax using the contact information below. If you contact us initially by phone, you will need to submit copies of any supporting documents via mail, email, or fax:

Arise Health Plan  
Attention: Grievance Coordinator  
P.O. Box 11625  
Green Bay, Wisconsin 54307-1625  
Phone: 920-490-6987 or 1-877-897-4123 (toll-free)  
Fax: 920-490-6922

For example, if we denied benefits because we determined that a health care service provided to you was not medically necessary and/or experimental/investigative/unproven, please send us all additional medical information, including sending us copies of your health care provider’s medical records, that you believe shows that the health care service is medically necessary and/or not experimental/investigative/unproven under the Policy.

Any expedited grievance filed by your health care practitioner regarding a prescription legend drug or durable medical equipment or a medical device should present medical evidence demonstrating the medical reason(s) why we should make an exception to cover and pay benefits for that prescription legend drug, durable medical equipment or medical device that is not covered under the Policy.

As soon as reasonably possible following our receipt of the expedited grievance, our Grievance/Appeal Department will review the expedited grievance. If we agree with the proposed resolution of this matter, we will contact you by phone or fax to explain our decision and then follow up with either a letter or an Explanation of Benefits form explaining how we resolved your expedited grievance. If our Grievance/Appeal Department upholds our original claims processing decision or administrative decision that you disputed, the expedited grievance will be automatically forwarded to our Grievance/Appeal Committee (the “Committee”) for its review and decision in accordance with the procedure explained below. Under no circumstances will the time frame exceed the time period discussed below.

You have the right to submit written questions/comments, documents, records, evidence, testimony, and other information relating to the claim for benefits that is the subject of your expedited grievance. The Committee will review your expedited grievance and all relevant documents pertaining to it without regard to whether such information was submitted or considered in the initial adverse benefit determination.
You also have a right to appear in person or to participate by teleconference before the Committee to present information to the Committee and to submit written questions to the Committee. The Committee will respond to any submitted written question in its notice to you of its final benefit determination. We will notify you of the time and place of the meeting as soon as reasonably possible. Please remember that this meeting is not a trial where there are rules of evidence are followed. Also, cross-examination of the Committee’s members, its advisors, or Arise employees is not allowed. No transcript of the meeting is prepared, and sworn testimony is not taken by the Committee. However, your presentation to the Committee will be recorded. If you attend the meeting to present reason(s) for the expedited grievance, we expect and require each person who attends the meeting to follow and abide by our established internal practices, rules and requirements for handling expedited grievances effectively and efficiently in accordance with applicable laws and regulations.

For decisions regarding medical judgment, the Committee will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional will not be the same individual who was consulted regarding the initial adverse benefit determination or a subordinate of such individual. You have the right to request, free of charge, the identity of the health care professional whose advice we obtained in connection with the adverse benefit determination, regardless of whether such advice was relied upon in making a decision.

In addition, you have the right to request, free of charge, access to and copies of all documents, records, and other information relevant to your expedited grievance. Furthermore, as part of providing an opportunity for a full and fair review, we will provide you with any new or additional evidence considered, relied upon, or generated by us in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of a final adverse benefit determination is required to be provided to you for purposes of providing you a reasonable opportunity to respond prior to that date.

Before a final adverse benefit determination is made based on a new or additional rationale, we will provide you, free of charge, with the rationale. Such rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse benefit determination is required to be provided to you for purposes of providing you with a reasonable opportunity to respond prior to that date.

In the event the new or additional evidence is received so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, then the deadline for providing a notice of final adverse benefit determination is tolled until such time is reasonable for providing you an opportunity to respond. After you respond, or have had a reasonable opportunity to respond but fail to do so, we will notify you of our final decision as soon as we reasonably can, taking into account all medical exigencies.

As expeditiously as your health condition requires, but not later than 72 hours after our receipt of the expedited grievance, the Grievance/Appeal Department will contact you by phone or fax to explain the Committee’s rationale and decision. Not later than 3 days following, the Committee will then mail a detailed decision letter containing all information required by law. The letter will be mailed to the person who filed the expedited grievance using the United States Postal Service.

A notice of a final adverse benefit determination will state the specific reason or reasons for the final adverse benefit determination, the specific Policy provisions on which the determination is based, and a description of the external review procedures and associated timelines. The notice will include a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.

The denial notice will also disclose any internal rule, guideline, protocol or other similar criterion that was relied upon in making the final adverse benefit determination. A copy of such internal rule, guideline, protocol, or other similar criterion will be provided to you, free of charge, upon request.

If the final adverse benefit determination is based on the definition of medically necessary or experimental/investigational/unproven, then the denial notice will provide you with either an explanation of the scientific or clinical judgment for the determination applying the terms of the Policy to your medical circumstances or a statement that such explanation will be provided, free of charge, upon your request.

You also have the right to request, free of charge, the diagnosis code with its corresponding meaning and the treatment code with its corresponding meaning along with copies of all documents, records, and other information relevant to your claim for benefits.

We will retain our records of the expedited grievance for at least six years after we send you notice of our final decision.
You have the right to request, free of charge, copies of all documents, records, and other information relevant to your expedited grievance by sending a written request to the address listed above.

If we continue to deny the payment, coverage, or service requested, or if you do not receive a timely decision, you may be entitled to request an independent external review.

D. Final Claim Decisions

A notice of a final adverse benefit determination will state the specific reason or reasons for the final adverse benefit determination, the specific Policy provisions on which the determination is based, and a description of the external review procedures and associated timelines. The notice will include a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.

The denial notice will also disclose any internal rule, guideline, protocol or other similar criterion that was relied upon in making the final adverse benefit determination. A copy of such internal rule, guideline, protocol, or other similar criterion will be provided to you, free of charge, upon request.

If the final adverse benefit determination is based on the definition of medically necessary or experimental/investigational/unproven, then the denial notice will provide you with either an explanation of the scientific or clinical judgment for the determination applying the terms of the Policy to your medical circumstances or a statement that such explanation will be provided, free of charge, upon your request.

You also have the right to request, free of charge, the diagnosis code with its corresponding meaning and the treatment code with its corresponding meaning along with copies of all documents, records, and other information relevant to your claim for benefits.

We will retain our records of the grievance or expedited grievance for at least six years after we send you notice of our final decision.

You have the right to request, free of charge, copies of all documents, records, and other information relevant to your grievance or expedited grievance by sending a written request to the address listed above.

If we continue to deny the payment, coverage, or service requested, or if you do not receive a timely decision, you may be entitled to request an independent external review.

13. INDEPENDENT EXTERNAL REVIEW

A. Definitions

The following definitions apply to this Section 13. only:

1. Adverse Determination: a determination by Arise to which all of the following apply:
   a. We have reviewed admission to a health care facility, the availability of care, the continued stay or other treatment;
   b. Based on the information provided, the treatment does not meet our requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness; and
   c. Based on the information provided, we reduced, denied or terminated the treatment or payment of the treatment.

An adverse determination also includes the denial of a prior authorization request for health care services from a non-participating provider. The right to an independent external review applies only when you feel the non-participating provider’s clinical expertise is medically necessary and the expertise is not available from a participating provider.

2. Experimental Treatment Determination: a determination by Arise to which all of the following apply:
   a. We have reviewed the proposed treatment;
Based on the information provided, we have determined the treatment is experimental/ investigational/ unproven; and

Based on the information provided, we denied the treatment or payment for the treatment.

3. **Rescission of Coverage Determination**: a determination by Arise to withdraw coverage under the Policy back to your initial date of coverage, modify the terms of the Policy or adjust the premium rate by more than 25% from the premium in effect during the period of contestability.

**B. Independent External Review Process**

You may be entitled to an independent external review by an Independent Review Organization (IRO) if you have received an experimental treatment determination, adverse determination or a rescission of coverage determination.

In general, you must complete all grievance/appeal options described above before requesting an independent external review. This includes waiting for our determination on your grievance/appeal. However, if we agree with you that the matter should proceed directly to independent review, or if you need immediate medical treatment and believe that the time period for resolving an internal grievance will cause a delay that could jeopardize your life or health, you may ask to bypass our internal grievance process. In these situations, your request will be processed on an expedited basis.

If you or your authorized representative wish to file a request for an independent external review, your request must be submitted in writing to the address listed below and received within four months of the decision date of your grievance.

Arise Health Plan  
Attention: Grievance Coordinator  
P.O. Box 11625  
Green Bay, Wisconsin 54307-1625  
Fax: 920-490-6955

Your request for an independent external review must include:

1. Your name, address and telephone number;
2. An explanation of why you believe that the treatment should be covered;
3. Any additional information or documentation that supports your position;
4. If someone else is filing on your behalf, a statement signed by you authorizing that person to be your representative; and
5. Any other information we request.

Within five days of our receipt of your request, an accredited IRO will be assigned to your case through an unbiased random selection process. The assigned IRO will send you a notice of acceptance within one business day of receipt, advising you of your right to submit additional information within ten business days of your receipt of the notice from the IRO. The assigned IRO will also deliver a notice of the final external review decision in writing to you and Arise within 45 calendar days of their receipt of the request. Some of the information you provide to the IRO may be shared with appropriate regulatory authorities.

The IRO’s medical director or other medical professional will review your request and decide if an immediate review is needed. If so, it will review your dispute on an expedited basis and make a decision within 72 hours. If the IRO decides that your illness or injury does not require its immediate review of your dispute, it will notify you that you must first complete our internal grievance and appeals process.

Unless your case involves the rescission of the Policy, the IRO’s decision is binding for both you and Arise. You are not responsible for costs associated with the independent external review.

**14. DEFINITIONS**

In this Policy, all italicized terms have the meanings set forth below, regardless of whether they appear as singular or plural.
Activities of Daily Living (ADL): the following, whether performed with or without assistance:

1. Bathing which is the cleansing of the body in either a tub or shower or by sponge bath;
2. Dressing, which is to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;
3. Toileting which is to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene;
4. Mobility, which is to move from one place to another, with or without assistance of equipment;
5. Eating, which is getting nourishment into the body by any means other than intravenous; and
6. Continence, which is voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene.

Adverse Benefit Determination: any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of your eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization management, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental/investigational/unproven or not medically necessary or appropriate.

An adverse benefit determination includes any rescission of coverage, which is a cancellation or discontinuance of coverage that has a retroactive effect, regardless of whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.

Ambulance Services: ground and air transportation: (1) provided by a licensed ambulance service using its licensed and/or certified vehicle, helicopter, or plane which is designed, equipped, and used to transport you when you are sick or injured; and (2) which is staffed by emergency medical technicians, paramedics, or other certified medical professionals.

Authorized Representative: a person designated to file a claim for benefits or a grievance on your behalf and/or to act for you in pursuing a claim for benefits under the Policy.

Behavioral Health Services: health care services for the treatment of substance use disorders and nervous or mental disorders.

Benefit: your right to payment for covered health care services that are available under the Policy. Your right to benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including the Schedule of Benefits and any attached endorsements.

Calendar Year: the period of time that starts with your applicable effective date of coverage shown in our records, as determined by us, and ends on December 31st of such year. Each following calendar year will start on January 1st of that year and end on December 31st of that same year.

Charge: an amount billed by a health care provider for a health care service. Charges are incurred on the date you receive the health care service.

Child/Children: any of the following:

1. A biological child of a subscriber.
3. A legally adopted child or a child placed for adoption with the subscriber.
4. A child under the subscriber’s (or his/her spouse’s) legal guardianship as ordered by a court. To be initially eligible for coverage, the child must be under the age of 18 and you must have sole and permanent guardianship of both the child and his/her estate. See Section 2. E. (Enrollment Options / Court Order).
5. A child placed in foster care with a subscriber.
Coinsurance: your share of the costs of a covered health care service, calculated as a percent of the charge for a covered expense.

Confinement/Confined: the period starting with your admission on an inpatient basis to a hospital or other licensed health care facility for treatment of an illness or injury. Confinement ends with your discharge from the same hospital or other facility.

Convenient Care Clinic: a medical clinic that: (1) is located in a retail store, supermarket, pharmacy or other non-traditional, convenient, and accessible setting; and (2) provides covered health care services performed by health care practitioners acting within the scope of their respective licenses.

Copayment: a specific dollar amount that you are required to pay to the health care provider towards the charge for certain covered expenses. Please note that for covered health care services, you are responsible for paying the lesser of the following: (1) the applicable copayment; or (2) the charge for the covered expense.

Cosmetic Treatment: any health care service used solely to: (1) change or improve your physical appearance or self-esteem; or (2) treat a condition that causes no functional impairment or threat to your health.

Covered Dependent: an eligible dependent who has properly enrolled and been approved by us for coverage under the Policy.

Covered Expenses: any charge, or any portion thereof, that is eligible for full or partial payment under the Policy.

Covered Person: a subscriber and/or his/her covered dependent(s).

Custodial Care: services that are any of the following:

1. Non-health-related services, such as assistance in activities of daily living.
2. Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function unless eligible for habilitative benefits (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
3. 24-hour supervision for potentially unsafe behavior.
4. Supervision of medication which usually can be self-administered.
5. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Services may still be considered custodial care by us even if:

1. You are under the care of a health care practitioner;
2. The health care practitioner prescribes health care services to support and maintain your physical and/or mental condition;
3. Services are being provided by a nurse; or
4. Such care involves the use of technical medical skills if such skills can be easily taught to a layperson.

Deductible: the specified amount you are required to pay for covered expenses in a calendar year before benefits are payable under the Policy.

Delegate: a vendor we contract with to perform services on our behalf. This includes any vendors the contracted vendor uses in providing services to us.

Developmental Delay: any disease or condition that interrupts or delays the sequence and rate of normal growth and development in any functional area and is expected to continue for an extended period of time or for a lifetime. Functional areas include, but are not limited to, cognitive development, physical development, communication (including speech and hearing), social/emotional development, and adaptive skills. Developmental delays can occur even in the absence of a
documented identifiable precipitating cause or established diagnosis. Developmental delays may or may not be congenital (present from birth).

**Durable Medical Equipment**: an item that we determine meets all of the following requirements: (1) it can withstand repeated use; (2) it is primarily used to serve a medical purpose with respect to an illness or injury; (3) it is generally not useful to a person in the absence of an illness or injury; (4) it is appropriate for use in your home; (5) it is prescribed by a health care practitioner; and (6) it is medically necessary. *Durable medical equipment* includes, but is not limited to: wheelchairs; oxygen equipment (including oxygen); and hospital-type beds.

**Eligible Dependent**: an individual who falls into one or more of the five categories below and who is not on active military duty for longer than 30 days:

1. A subscriber’s legal spouse.
2. A subscriber’s child, under the age of 26.
3. A full-time student returning from military duty.
4. A subscriber’s child over age 26 if all of the following criteria are met:
   a. The child’s coverage under the Policy began before he/she reached age 26;
   b. The child is incapable of self-sustaining employment because of intellectual disability or physical handicap;
   c. The child is chiefly dependent upon the subscriber for support and maintenance;
   d. The child’s incapacity existed before he/she reached age 26; and
   e. The subscriber’s family coverage remains in force under the Policy.
5. A natural child of a subscriber’s child if the subscriber’s child is under 18 years old.

**Emergency Medical Care**: health care services to treat your medical emergency.

**Emergency Room Visit**: a meeting between you and a health care practitioner that: (1) occurs at the emergency room; and (2) includes only the charges for the emergency room fee billed by the facility for use of the emergency room.

**Expedited grievance**: a grievance to which any of the following conditions apply:

1. The duration of the standard resolution process will result in serious jeopardy to your life or health or your ability to regain maximum function.
2. A health care practitioner with knowledge of your medical condition believes that you are subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.
3. A health care practitioner with knowledge of your medical condition determines that the grievance will be treated as an expedited grievance.

**Experimental/Investigational/Unproven**: as determined by our Corporate Medical Director, any health care service or facility that meets at least one of the following criteria:

1. It is not currently recognized as accepted medical practice;
2. It was not recognized as accepted medical practice at the time the charges were incurred;
3. It has not been approved by the United States Food and Drug Administration (FDA) upon completion of Phase III clinical investigation;
4. It is being used in a way that is not approved by the FDA or listed in the FDA-approved labeling (i.e. off-label use), except for off-label uses that are accepted medical practice;
5. It has not successfully completed all phases of clinical trials, unless required by law;
6. It is based upon or similar to a treatment protocol used in on-going clinical trials;

7. Prevailing peer-reviewed medical literature in the United States has failed to demonstrate that it is safe and effective for your condition;

8. There is not enough scientific evidence to demonstrate or make a convincing argument that (a) it can measure or alter the sought-after changes to your illness or injury or (b) such measurement or alteration will affect your health outcome; or support conclusions concerning the effect of the drug, device, procedure, service or treatment on health outcomes; or

9. It is associated with a Category III CPT code developed by the American Medical Association.

The above list is not all-inclusive.

A health care service or facility may be considered experimental/investigational/unproven even if the health care practitioner has performed, prescribed, recommended, ordered, or approved it, or if it is the only available procedure or treatment for the condition.

We have full discretionary authority to determine whether a health care service is experimental/investigational/unproven. In any dispute arising as a result of our determination, such determination will be upheld if it is based on any credible evidence. If our decision is reversed, your only remedy will be our provision of benefits in accordance with the Policy. You will not be entitled to receive any compensatory damages, punitive damages, or attorney's fees, or any other costs in connection therewith or as a consequence thereof.

Family Coverage: coverage that applies to a subscriber and his/her covered dependents.

Full-Time Student: a child in regular full-time attendance at an accredited secondary school, accredited vocational school, accredited technical school, accredited adult education school, accredited college or accredited university. Such school must provide a schedule of scholastic courses and its principal activity must be to provide an academic education. An apprenticeship program is not considered an accredited school, college or university for this purpose. Full-time student status generally requires that the student take 12 or more credits per semester; however, the exact number of credits per semester depends on the manner in which the school defines regular full-time status for its general student body; this may vary if the school has trimesters, quarters, or another type of schedule for its general student body. Proof of enrollment, course load and attendance is required upon our request. Full-time student status includes any regular school vacation period (summer, semester break, etc.).

Full-Time Student Returning From Military Duty: an adult child of a subscriber who meets all of the following criteria:

1. The child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education;

2. The child was under the age of 27 when called to federal active duty;

3. Within 12 months after returning from federal active duty, the child returned to an institution of higher education on a full-time basis, regardless of age; and

4. The adult child must: (1) attend an accredited school for the number of credits, hours, or courses required by the school to be considered a full-time student; (2) attend two or more accredited schools for credits toward a degree, which, when combined equals full-time status at one of the schools; or (3) participate in either an internship or student teaching during the last semester of school prior to graduation, if the internship or student teaching is required for his/her degree. The adult child continues to be a full-time student during periods of vacation or between term periods established by the school.

Functional Impairment: a significant and documented loss of use of any body structure or body function that results in a person’s inability to regularly perform one or more activity of daily living or to use transportation, shop, or handle finances.

Genetic Testing: testing that involves analysis of human chromosomes, DNA, RNA, genes and/or gene products (e.g., enzymes, other types of proteins, and selected metabolites) which is predominantly used to detect potential heritable disorders, screen for or diagnose genetic conditions, identify future health risks, predict drug responses (pharmacogenetics), and assess risks to future children. Genetic testing may also be applied to gene mutations that occur in cells during a person’s lifetime.
**Genetic testing** includes, but is not limited to: (1) gene expression and determination of gene function (genomics); (2) analysis of genetic variations; (3) multiple gene panels: (4) genetic bio-markers; (5) biochemical biomarkers: (6) molecular pathology; (7) measurements of gene expression and transcription products; (8) cytogenetic tests; (9) topographic genotyping; (10) microarray testing; (11) whole genome sequencing; and (12) computerized predictions based on the results of the genetic analysis.

**Grievance:** any dissatisfaction with us or our administration of your health *benefit plan* that you express to us in writing. For example, you might file a *grievance* about our provision of services, our determination to reform or rescind a policy, our determination of a diagnosis or level of service required for *evidence-based treatment* of *autism spectrum disorders*, or our claims practices.

**Geographical Service Area:** the region in which Arise operates and your plan is available, as determined by us. Please see [www.arisehealthplan.com](http://www.arisehealthplan.com) for more information.

**Health Care Practitioner:** one of the following licensed practitioners who perform services payable under this Policy: a Doctor of Medicine (MD), a Doctor of Osteopathy (DO), a Doctor of Podiatric Medicine (DPM); a Doctor of Dental Surgery (DDS), a Doctor of Dental Medicine (DMD); a Doctor of Chiropractic (DC); a Doctor of Optometry (OD); a physician assistant (PA); a nurse practitioner (NP); a certified nurse midwife (CNM); a psychologist (Ph.D., Psy.D.), a licensed mental health professional, including but not limited to clinical social worker, marriage and family therapist or professional counselor; a physical therapist; an occupational therapist; a speech-language pathologist; an audiologist; or any other licensed practitioner that is acting within the scope of their license and performing a service that would be payable under the Policy.

**Health Care Provider:** any physician, *health care practitioner*, hospital, pharmacy, clinic, *skilled nursing facility*, surgical center or other person, institution or other entity licensed by the state in which he/she/it is located to provide *health care services*.

**Health Care Services:** diagnosis, *treatment*, hospital services, *surgical services* as defined in Section 5.RR. (Covered Expenses / Surgical Services), maternity services, *medical services*, procedures, drugs, medicines, devices, *supplies*, or any other service directly provided to you by a *health care provider*.

**Health Insurance Marketplace:** a resource established and operated by the State or the Department of Health and Human Services where qualified consumers can learn about and purchase *Qualified Health Plans*.

**High-Technology Imaging:** including, but not limited to: magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET), single photon emission computed tomography (SPECT), computed tomography (CT) imaging, and nuclear stress testing for high-end imaging.

**Hospital:** a facility providing 24-hour continuous service to a *confined covered person*. Its chief function must be to provide diagnostic and therapeutic facilities for the surgical and medical diagnosis, *treatment* and care of injured or sick persons. A professional staff of licensed *health care practitioners* and surgeons must provide or supervise its services. It must provide general *hospital* and major surgical facilities and services. A *hospital* also includes a specialty *hospital* approved by us and licensed and accepted by the appropriate state or regulatory agency to provide diagnosis and short term *treatment* for patients who have specified medical conditions. A *hospital* does not include, as determined by us: (1) a convalescent or extended care facility unit within or affiliated with the *hospital*; (2) a clinic; (3) a nursing, rest or convalescent home; (4) an extended care facility; (5) a facility operated mainly for care of the aged; (6) sub-acute care center; or (7) a health resort, spa or sanitarium.

**Illness:** a *physical illness*, a *substance use disorder*, or a *nervous or mental disorder*.

**Incarcerated:** serving a term in prison or jail. It does not mean living at home or in a residential facility under supervision of the criminal justice system, or living there voluntarily. In other words incarceration does not include being on probation, parole or home confinement. You are not considered *incarcerated* if you are in jail or prison pending disposition of charges. In other words, being held but not convicted of a crime.

**Injury:** bodily damage caused by an accident. The bodily damage must result from the accident directly and independently of all other causes.
**Maintenance Care:** health care services provided to you after the acute phase of an illness or injury has passed and maximum therapeutic benefit has occurred. Such care promotes optimal function in the absence of significant symptoms.

**Maximum Allowable Fee:** the maximum amount of reimbursement allowed for a covered health care service. For a covered health care service provided by a participating provider, the maximum allowable fee is the rate negotiated between us and the participating provider. For a covered health care service provided by a non-participating provider, the maximum allowable fee is the maximum out-of-network allowable fee.

If you submit a written or oral request for our maximum allowable fee for a health care service and if you provide us with the appropriate billing code that identifies the health care service (for example, CPT codes, ICD 10 codes or hospital revenue codes) and the health care provider’s estimated fee for that health care service, we will provide you with any of the following:

1. A description of our specific methodology, including, but not limited to, the following:
   a. The source of the data used, such as our claims experience, an expert panel of health care providers, or other sources;
   b. The frequency of updating such data;
   c. The geographic area used;
   d. If applicable, the percentile used by us in determining the maximum allowable fee; and
   e. Any supplemental information used by us in determining the maximum allowable fee.
2. The maximum allowable fee determined by us under our guidelines for the specific health care service you identified. This may be in the form of a range of payments or maximum payment.

**Maximum Out-of-Network Allowable Fee:** the benefit limit established by us for a covered health care service provided by a non-participating provider. The benefit limit for a particular health care service is based on a percentage of the published rate allowed for Wisconsin by the Centers for Medicare and Medicaid Services (CMS) for the same or similar health care service. When there is no CMS rate available for the same or similar health care service, the benefit limit is based on an appropriate commercial market fee for the covered health care service, as determined by us.

**Medical Emergency:** a medical condition involving acute and abnormal symptoms of such severity (including severe pain) that a prudent and sensible person who possesses an average knowledge of health and medicine would reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

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

**Medically Necessary:** a health care service that we determine to be:

1. Consistent with and appropriate for the diagnosis or treatment of your illness or injury;
2. Commonly and customarily recognized and generally accepted by the medical profession in the United States as appropriate and standard of care for the condition being evaluated or treated;
3. Substantiated by the clinical documentation;
4. The most appropriate and cost effective care that can safely be provided to you. Appropriate and cost effective does not necessarily mean the least expensive;
5. Proven to be useful or likely to be successful, yield additional information, or improve clinical outcome;
6. Not primarily for the convenience or preference of the covered person, his/her family, or any health care provider; and
7. A health care service may not be considered medically necessary even if the health care provider has performed, prescribed, recommended, ordered, or approved the service, or if the service is the only available procedure or treatment for your condition.

Medical Services: health care services recognized by a health care practitioner to treat your illness or injury.

Medical Supplies: items that we determine to be: (1) used primarily to treat an illness or injury; (2) generally not useful to a person in the absence of an illness or injury; (3) the most appropriate item that can be safely provided to you and accomplish the desired end result in the most economical manner (4) not primarily for the patient's comfort or convenience; and (5) prescribed by a health care practitioner.

Miscellaneous Hospital Expenses: regular hospital costs (including take-home drug expenses) that we cover under the Policy for treatment of an illness or injury requiring either: (1) inpatient hospitalization; or (2) outpatient health care services at a hospital. For outpatient health care services, miscellaneous hospital expenses include charges for: (1) use of the hospital's emergency room; and (2) emergency medical care provided to you at the hospital. Miscellaneous hospital expenses do not include room and board, nursing services, and ambulance services.

Nervous or Mental Disorders: clinically significant psychological syndromes that: (1) are associated with distress, dysfunction or physical illness; and (2) represent a dysfunctional response to a situation or event that exposes you to an increased risk of pain, suffering, conflict, physical illness or death. Behavior problems, learning disabilities, autism or developmental delays are not nervous or mental disorders.

Non-Participating Provider: a health care provider that has not entered into a written agreement with us to provide covered services to you as of the date upon which the services are provided.

Obesity: a body mass index (BMI) of 30 or greater. BMI is calculated by dividing your weight in kilograms by the square of your height in meters.

Observation Care: Clinically appropriate outpatient hospital services, which include ongoing short term treatment, assessment, and reassessment prior to your health care practitioner determining if you will require further treatment as a hospital inpatient or if they can discharge you from the hospital.

Office Visit: either of the following:

1. For health care services other than behavioral health services, a meeting between you and a health care practitioner that: (a) occurs at the health care practitioner's office, a medical clinic, convenient care clinic, an ambulatory surgical center, a free-standing urgent care center, skilled nursing facility, the outpatient department of a hospital, other than an emergency room or in your home; and (b) includes you receiving medical evaluation and health management services (as defined in the latest edition of Physician's Current Procedural Terminology or as determined by us) or manipulations by a health care practitioner, other than services related to physical therapy.

2. For behavioral health services, a meeting between you and a health care practitioner licensed to provide nonresidential services for the treatment of nervous or mental disorders and/or substance use disorders that: (a) occurs in the health care practitioner's office, a medical clinic, a free-standing urgent care center, skilled nursing facility, outpatient treatment facility, the outpatient department of a hospital, other than an emergency room or in your home; and (b) involves you receiving psychotherapy, psychiatric diagnostic interviews, medication management, electro-shock therapy, behavioral counseling, or neuropsychological testing.

Out-of-Pocket Limit: the maximum amount that you are required to pay each calendar year for covered expenses. This limit is shown in the Schedule of Benefits. Any of the following costs will count towards your out-of-pocket limit: (1) deductible; (2) copayments; and (3) coinsurance amounts you pay for covered expenses associated with health care services. In determining whether you've reached your out-of-pocket limit, the following amounts will not count: (1) amounts you pay for non-covered health care services; and (2) amounts you pay that exceed the maximum allowable fee.

Participating Provider: a health care provider that has entered into a written agreement with us to provide covered services to you as of the date upon which the services are provided. A health care provider's participation status may change from time to time. Please refer to our on-line directory or contact us for a listing of participating providers.
Physical Illness: a disturbance in a function, structure or system of the human body that causes one or more physical signs and/or symptoms and which, if left untreated, will result in deterioration of health status or of the function, structure or system of the human body. Physical illness includes pregnancy and complications of pregnancy. Physical illness does not include substance use disorders or nervous or mental disorders.

Physician: a person who:

1. Received one of the following degrees in medicine from an accredited college or university: Doctor of Medicine (M.D.); Doctor of Osteopathy (D.O); Doctor of Dental Surgery (D.D.S); Doctor of Dental Medicine (D.D.M.); Doctor of Podiatric Medicine (D.P.M.); Doctor of Optometry (O.D.); or Doctor of Chiropractic (D.C.);

2. Is a medical doctor or surgeon holding a license or certificate of registration from the medical examining board in the state in which he/she is located; and

3. Practices medicine within the lawful scope of his/her license.

Placed for Adoption / Placement for Adoption: any of the following:

1. The Wisconsin Department of Children and Families, a county department under Wis. Stat § 48.57(1)(e) or (hm), or a child welfare agency licensed under § 48.60 places a child in a subscriber’s home for adoption and enters into an agreement under § 48.63(3)(b)4. or § 48.833(1) or (2) with the subscriber;

2. The Wisconsin Department of Children and Families, a county department under Wis. Stat. § 48.57 (1)(e) or (hm), or a child welfare agency under § 48.837(1r) places, or a court under § 48.837(4)(d) or (6)(b) orders, a child placed in a subscriber’s home for adoption;

3. A sending agency, as defined in Wis. Stat. § 48.988(2)(d), places a child in a subscriber’s home under § 48.988 for adoption, or a public child placing agency, as defined in § 48.99(2)(r), or a private child placing agency, as defined in § 48.99(2)(p), of a sending state, as defined in § 48.99(2)(w), places a child in the subscriber’s home under § 48.99 as a preliminary step to a possible adoption, and the subscriber takes physical custody of the child at any location within the United States;

4. The person bringing the child into this state has complied with Wis. Stat. § 48.98, and the subscriber takes physical custody of the child at any location within the United States; or

5. A court of a foreign jurisdiction appoints a subscriber as guardian of a child who is a citizen of that jurisdiction, and the child arrives in the subscriber’s home for the purpose of adoption by the subscriber under Wis. Stat. § 48.839.

Prescription Legend Drug: any medicine whose label is required to contain the following or similar wording: “Caution: Federal Law prohibits dispensing without prescription.” Prescription legend drug also includes investigational drugs used to treat the HIV virus as described in Wis. Stat. § 632.895(9), insulin and other exceptions as designated by us.

Preventive Care Services: health care services that are not for the diagnosis or treatment of an illness or injury and that are designed to: (1) evaluate or assess health and well-being, (2) screen for possible detection of unrevealed illness, (3) improve health, or (4) extend life expectancy.

Primary Care Practitioner: a participating provider who is a health care practitioner who directly provides or coordinates a range of health care services for a patient. A primary care practitioner’s primary practice must be Family Practice, Internal Medicine, General Practice, Obstetrics/Gynecology and Pediatrics.

Prior Authorization: written approval that you must receive from us before you visit certain health care providers or receive certain health care services. Each prior authorization will state the type and extent of the treatment or other health care services that we have authorized.

Qualified Health Plan: a health plan that is certified to meet the standards issued or recognized by the Health Insurance Marketplace through which the plan is offered.

Reconstructive Surgery: surgery performed on abnormal structures of the body caused by: (1) congenital defects; (2) development abnormalities; (3) trauma; (4) infection; (5) tumors; or (6) disease.

Respite care: services provided to give a primary caregiver temporary relief from caring for an ill individual.

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**Single Coverage:** coverage that applies only to a **subscriber**.

**Skilled Nursing Care:** health care services that: (1) are furnished pursuant to a health care practitioner's orders; (2) require the skills of professional personnel such as a registered nurse or a licensed practical nurse; and (3) are provided either directly by or under the direct supervision of such professional personnel. Patients receiving skilled nursing care are usually quite ill and often have been recently hospitalized. In the majority of cases, skilled nursing care is only necessary for a limited time period. After that, most patients have recuperated enough to be cared for by "nonskilled" persons such as spouses, children, or other family or relatives. The following examples are generally considered care that can be provided by "nonskilled" persons, and therefore do not qualify as skilled nursing care: range of motion exercises, strengthening exercises, simple wound care, ostomy care, tube and gastrostomy feedings, administration of basic medications, maintenance of urinary catheters, assistance with performing activities of daily living, and supervision for potentially unsafe behavior.

**Skilled Nursing Facility:** an institution or a designated part of one, including but not limited to, a sub-acute or rehabilitation facility that:

1. Is operating pursuant to state and federal law;
2. Is under the full-time supervision of a health care practitioner or registered nurse;
3. Provides services seven days a week, 24 hours a day, including skilled nursing care and therapies for the recovery of health or physical strength;
4. Is not a place primarily for custodial or maintenance care;
5. Requires compensation from its patients;
6. Admits patients only upon a health care practitioner’s orders;
7. Has an agreement to have a health care practitioner’s services available when needed;
8. Maintains adequate records for all patients; and
9. Has a written transfer agreement with at least one hospital.

**Specialty Health Care Practitioner:** a participating provider who is a health care practitioner whose primary practice is other than one of the following: Family Practice, Internal Medicine, General Practice, Obstetrics/Gynecology and Pediatrics.

**Subscriber:** an individual who has: (1) been properly enrolled and approved for coverage under this Policy; (2) paid the appropriate premium in accordance with this Policy; and (3) been issued an identification card from Arise identifying him/her as the subscriber.

**Substance Use Disorder:** a disorder that is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-5). According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

**Supplies:** medical supplies, durable medical equipment or other materials provided directly to you by a health care provider, as determined by us.

**Supportive Care:** health care services provided to a covered person whose recovery has slowed or ceased entirely so that only minimal rehabilitative gains can be demonstrated with continuation of such health care services.

**Surgical Services:** (1) an operative procedure performed by a health care practitioner that we recognize as treatment of an illness or injury; or (2) those services we identify as surgical services, including male sterilization procedures and preoperative and postoperative care.

**Treatment:** management and care directly provided to you by a health care practitioner for purposes of diagnosing, healing, curing, and/or combating an illness or injury, as determined by us.

**Urgent Care:** care received for an illness or injury with symptoms of sudden or recent onset that require medical care the same day.
15. WISCONSIN DEPARTMENT OF INSURANCE CONTACT INFORMATION


You may also contact the OFFICE OF THE COMMISSIONER OF INSURANCE, a state agency which enforces Wisconsin's insurance laws, and file a complaint.

You can file a complaint electronically with the OFFICE OF THE COMMISSIONER OF INSURANCE at its website at http://oci.wi.gov/, or by writing to:

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

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