Certificate of Coverage - POS

WPS Health Plan, Inc. d/b/a Arise Health Plan
421 Lawrence Drive · De Pere, WI 54115

IMPORTANT NOTICE: You are covered under a point of service ("POS") policy issued by Arise Health Plan. This Certificate is not the entire contract of insurance; it is merely evidence of insurance provided under the Group Master Policy (the "Policy") we issued to the *policyholder*. This Certificate describes the essential features of such insurance.

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 Certificate of Coverage (the "Certificate") 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, WPS Health Plan, Inc. d/b/a 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 *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.

In performing its obligations under the Policy, Arise is acting only as a health insurer with respect to the Policy. We are not in any way acting as a *plan* administrator, a *plan* sponsor or a *plan* trustee for purposes of the Employee Retirement Income Security Act of 1974 (ERISA) or any other law.

The Policy is issued by Arise and delivered to the *policyholder* in Wisconsin. All terms, conditions, and provisions of the 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 Certificate, your completed application for this insurance, and applicable laws and regulations.

WPS Health Plan, Inc.

Michael F. Hamerlik

Michael F. Hamerlik
President and Chief Executive Officer

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1. GENERAL INFORMATION

A. General Description of Coverage

Arise has issued a Group Master Policy to the *policyholder*. The Group Master Policy forms a contract between us and your employer under which we provide health insurance coverage for certain employees and their dependents. This Certificate describes the health insurance *benefits* you are entitled to receive as a *covered person*. We provide the *benefits* described in this Certificate under the terms, conditions, and provisions of the Group Master Policy.

This Certificate describes the two benefit levels. One benefit level applies 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*.

This Certificate replaces and supersedes any certificates we issued to the *policyholder* before the effective date of the Group Master Policy and any written or oral representations that we or our representatives made.

B. Entire Contract

The entire contract between you and us is made up of the Group Master Policy, the *policyholder's* group application, any supplemental *policyholder* applications, this Certificate, the Schedule of Benefits, any endorsements, your application, and any supplemental applications. These documents are collectively referred to as "the Policy."

C. How to Use This Certificate

You should read this Certificate, including its Schedule of Benefits and all endorsements, carefully and completely. The provisions of this Certificate 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 Certificate 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 Certificate, the terms "you" and "your" refer to any *covered person.* The terms "we", "us", and "our" refer to Arise.

D. 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*.

E. 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.

F. 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 Certificate, you agree to cooperate fully with those persons or entities in the performance of their responsibilities.

2. ELIGIBILITY, ENROLLMENT, AND EFFECTIVE DATE

A. Employee Eligibility

An individual who meets the definition of *eligible employee* is eligible for coverage under the Policy as stated in Section 2. D., E. or F. unless the *policyholder's* application for coverage indicates a *waiting period*.

An individual who ceases to qualify as an *eligible employee* may continue coverage under the Policy in certain circumstances. See Section 8. D. (When Coverage Ends / Extension of Benefits) for more details.

B. Dependent Eligibility

Any family members that meet the definition of *eligible dependent* will become eligible for coverage under the Policy when the *eligible employee* becomes eligible for coverage. *Subscribers* may also enroll new *eligible dependents* who join their family because of birth, legal adoption, *placement for adoption*, marriage, legal guardianship, or court or administrative order. See Section 2. F. (Special Enrollment Periods) for more information about these special enrollment opportunities. Once a *subscriber* enrolls his/her first *eligible dependent*, his/her *single coverage* will switch to *family coverage.*

C. How to Enroll

In order to obtain coverage under the Policy, an *eligible dependent* or *eligible employee* must complete and submit the enrollment form provided by the *policyholder* to us **within 31 days** after becoming eligible. If an *eligible employee* or *eligible dependent* does not enroll for coverage within this period and he/she is not otherwise eligible for a special enrollment period, as outlined below, he/she must wait to enroll for coverage during the next annual enrollment period.

D. Initial Enrollment Period

When the group purchases coverage under the Policy, the initial enrollment period is the first period of time when *eligible employees* can enroll themselves and their *eligible dependents*. Coverage begins on the date identified in the Policy as long

as we receive the completed enrollment form and any required premium **within 31 days** after the employee and any dependents become eligible to enroll.

If an *eligible employee* is not actively at work for reasons other than *illness* or *injury* on the date his/her coverage would begin, his/her health coverage will not be effective until the day he/she returns to active work.

E. Annual Enrollment Period

Each year there will be an enrollment period during which any *eligible employee* and/or *eligible dependents* can enroll under the Policy. The annual enrollment period also provides an opportunity for a *subscriber* to change to a different health insurance *plan*, if available. Any coverage selected will be effective on the first day of the month following the annual enrollment period.

If an *eligible employee* or *eligible dependent* does not request enrollment during the annual enrollment period, he/she must wait to enroll for coverage during the next annual enrollment period unless he/she becomes eligible for a special enrollment period.

The annual enrollment period will be the month prior to the *policyholder's* anniversary date. The application for coverage must be received prior to *policyholder's* anniversary date.

F. Special Enrollment Periods

Certain life events or other circumstances may trigger a special enrollment period during which an *eligible employee* and/or *eligible dependent* will be able to enroll in the Policy outside the annual enrollment period. These circumstances are explained in subsections 1. – 7. below.

Except as noted below, we generally must receive an enrollment form from the *eligible employee* listing all individuals he/she wants to enroll **within 31 days** after the *eligible employee* or *eligible dependent* experiences the special late enrollment circumstance (*e.g.*, birth, marriage, loss of coverage).

If an *eligible employee* has completed any *waiting period* required by the *policyholder*, he/she may enroll himself/herself and his/her *eligible dependents* if the *eligible employee* acquires an *eligible dependent* through marriage, birth, or adoption or *placement for adoption*.

If we timely receive an enrollment form, coverage for the *eligible employee* and/or his/her *eligible dependents* will begin on the first day of the calendar month following the date of marriage or on the date the *eligible employee* experiences the special late enrollment circumstance due to birth, adoption or *placement for adoption* of a *child*, or by court order. If we do not receive the enrollment form within this time period, you may have to wait until the next annual enrollment period to add or change your coverage.

1. Eligibility for Premium Assistance Subsidy under Medicaid

If an *eligible employee* or *eligible dependent* previously declined coverage under the Policy, but later becomes eligible for a premium assistance subsidy under Medicaid, including BadgerCare Plus or the Children's Health Insurance Program (CHIP), the *eligible employee* or *eligible dependent* may enroll in the Policy by submitting an enrollment form **within 60 days** after they are determined to be eligible for the subsidy.

2. Loss of Other Health Care Coverage

If an *eligible employee* or *eligible dependent* initially declined enrollment in the Policy because of other health care *coverage*, the *eligible employee* or *eligible dependent* may enroll in the Policy if they lose eligibility for that other coverage. A special enrollment period is not available to an *eligible employee* or *eligible dependent* if the other health care coverage was terminated for cause or because premiums were not paid on a timely basis.

In *order* to qualify for a special enrollment period due to loss of other health care coverage, all of the following must be true:

a. The *eligible employee* submitted an enrollment form within 31 days of his/her initial date of eligibility and waived coverage for himself/herself and/or his/her *eligible dependents* because the *eligible employee* and/or *eligible dependents* had other health care coverage;

b. The *eligible employee* and/or his/her *eligible dependents* had other health care coverage when the *eligible employee* initially waived coverage under the Policy; and

c. The *eligible employee* and/or *eligible dependents* lost the other health care coverage that they had when they waived the *benefits* of the Policy because of any of the following:

1) Loss of eligibility;

2) Contributions made on your behalf towards your other health care coverage ended;

3) COBRA continuation coverage ended;

4) The *eligible employee* and/or *eligible dependent* no longer lives or works in the *plan*'s *geographical service area* and no other *benefit* option is available;

5) The *plan* no longer offers *benefits* to a class of individuals that includes the *eligible employee* and/or *eligible dependent*;

6) The *eligible employee* and/or *eligible dependent* incurs a claim that would exceed a lifetime limit on all *benefits;* or

7) The *eligible employee* and/or *eligible dependent* loses eligibility for Medicaid, including BadgerCare Plus or the Children's Health Insurance Program (CHIP).

If health care coverage is lost for one of the reasons outlined in subsections c. 1) – 6) above, coverage for the *eligible employee* and/or his/her *eligible dependents* under the Policy will begin on the first day following the date the *eligible employee*'s other health coverage ended if we receive an enrollment form **within 31 days** after the loss of other health care coverage. If health care coverage is lost for the reason outlined in subsection c. 7) (*loss* of eligibility for Medicaid), coverage for the *eligible employee* and/or his/her *eligible dependents* under the Policy will begin on the first day following the date the *eligible employee*'s or *eligible dependent's* other health coverage ended if we receive an enrollment form **within 60 days** after the loss of other health care coverage. Otherwise, the *eligible employee* and/or *eligible dependents* may not be added until the next annual enrollment period.

3. Marriage

If a *subscriber* acquires one or more *eligible dependents* through marriage, he/she may enroll any *eligible dependents*. If we receive an enrollment form **within 31 days** after the date of marriage, the *eligible dependents*' coverage will be effective on the date of marriage. Otherwise, the spouse and other *eligible dependents* may not be added until the next annual enrollment period.

If the *subscriber* previously had *single coverage*, enrolling a spouse or any other *eligible dependents* will switch him/her to *family coverage.*

4. Birth of a Child

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

If a *subscriber* has *single coverage*, coverage is provided for a newborn natural *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.

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.

5. Adoption of a Child or a Child Placed for Adoption

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

If a *subscriber* has *single coverage* and wishes to change to *family coverage* because of his/her adoption of a *child* or a *child placed for adoption*, we must receive an enrollment form listing the *child(ren)* the *subscriber* wants to enroll within 60 days after the date of the adoption or *placement for adoption*. The effective date for such *family coverage* will be one of the following: (a) the date a court makes a final order granting adoption of the *child* by the *subscriber*; (b) the date that the *child* is *placed for adoption* with the *subscriber*; or (c) a later date elected by the *subscriber*. If we receive the enrollment form after the 60-day enrollment period ends, the *child(ren)* may not be added until the next annual enrollment period.

If the adoption of a *child* who is *placed for adoption* with the *subscriber* is not finalized, the *child's* coverage will terminate *when* the *child's placement for adoption* with the *subscriber* terminates.

6. Child Support Order

We will provide coverage in accordance with a Qualified Medical Child Support Order (QMCSO), National Medical Support Order (NMSN), or Child Support Order ("Child Support Order") pursuant to the applicable requirements under § 609 of the Employee Retirement Income Security Act (ERISA) and § 1908A of the Social Security Act and any other applicable laws. It is the *policyholder's* responsibility to determine whether a medical child support order is qualified.

Upon receipt of a medical child support order issued by an appropriate court or governmental agency, the policyholder will follow its established procedures for determining whether the medical child support order is qualified. The *policyholder* will provide us with notice of a Child Support Order and a copy of the order along with an application for coverage within the greater of 31 days after issuance of the order or the time in which the *policyholder provides* notice of its determination to the persons specified in the order.

Where a Child Support Order requires coverage to be provided under the Policy and an *eligible employee's child* is not already a *covered dependent*, then such *child* will be provided a special enrollment period. If the *eligible employee* whose *child* is the subject of the Child Support Order is not enrolled at the time enrollment for the *child* is requested, then the *eligible employee* must also enroll for coverage under the Policy during the special enrollment period. The effective date of coverage will either be the date the Child Support Order is issued or pursuant to another coverage date set forth in the Child Support Order.

Where a *Child* Support Order requires coverage to be provided for under the Policy for an *eligible employee's child* who is already a *covered dependent*, such *child* will continue to be provided coverage under the Policy pursuant to the terms of the Child Support Order.

7. Adding a Domestic Partner (if applicable)

If a *subscriber* wishes to add a *domestic partner* and his/her *domestic partner's eligible dependent children*, if any, the *subscriber* must apply for coverage within 31 days of the date the *subscriber* registers such partner as a *domestic partner* with us. To register a *domestic partner,* we must receive a completed "Declaration of Domestic Partnership Affidavit" on a form approved by us.

The effective date of the *domestic partner's* and the *domestic partner's children's*, if applicable, coverage will be the first of the month following our receipt of the completed enrollment form. If we receive an enrollment form after that 31-day period ends, the *domestic partner* and the *domestic partner's eligible children*, if any, may not be added until the next annual open enrollment period.

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 *coinsurance* amounts.

D. Prior Authorization

1. **What is Prior Authorization?** *Prior authorization* is the process we use to determine if a prescribed *health care service* 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* 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, high-cost *durable medical equipment*, *genetic testing*, 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?** 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 only accept *prior authorization* requests from the ordering *health care provider* (e.g. your *physician*); we will not accept *prior authorization* requests from the laboratory that will perform the genetic services.

4. **What Happens After My Provider Submits the Prior Authorization Request?** After we receive your *health care provider's* request, we 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 Section 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 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 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, a *health care service* is 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 overturn the *prior authorization* penalty and 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:

   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* amount; (2) *coinsurance*; (3) the applicable *copayment* amount; (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*, most *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* annual *deductible* amount 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 *copayment* amounts (if applicable) 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. KK. (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 annual *deductible* and *coinsurance* amounts of the Policy. See Section 5. T. (Emergency Medical Care.

D. Out-of-Pocket Limits

Your *out-of-pocket limits* are set forth in your Schedule of Benefits. 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 must be ***medically necessary*** as determined by us to be a covered expense.

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. A. (Obtaining Services / Prior Authorization) for detailed information about our *prior authorization*s. Additionally, all *benefits* are subject to the *deductible* and *coinsurance* amounts, *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. 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* as long as they are *medically necessary* to treat your *illness* or *injury*.

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

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*;

Non-emergency transports may require *prior authorization*. See www.arisehealthplan.com

d. From a *hospital* or a *skilled nursing facility* to your home for hospice care; or

e. From your home for *hospice care* covered under Section 5. Z. (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. 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 subsection 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 <u>not</u> subject to the exclusions in Section 6. (General Exclusions). The only exclusions that apply to this Section are outlined below in Subsection 2 below (Autism Services Exclusions).

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.

5) 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.

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.

Benefits are payable up to the maximum benefit limit set forth in the Schedule of Benefits.

2. Autism Services Exclusions:

Section 5. F. is only subject to the following exclusions. The 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;

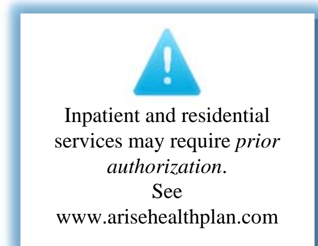
m. claims that have been determined by us to be fraudulent;

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*; and

o. prescription drugs and durable medical equipment.

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 o*utpatient 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 i. through vii. 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

c. Transitional *treatment*

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:

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. RR. (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 certain facilities or in connection with certain *treatment* programs including, but not limited to, wilderness programs, boot camps, therapeutic boarding schools, or 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*;

b. 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:

a. Cardiac rehabilitation beyond Phase II.

b. Behavioral or vocational counseling.

J. Chiropractic Services

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

1. **Covered Chiropractic Services**:

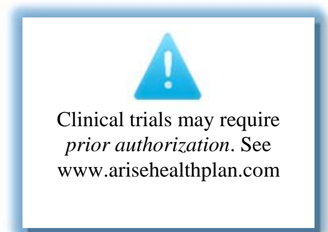
   Medically necessary services and diagnostic tests provided by a chiropractor.

2. **Chiropractic Services Exclusions:**

Some chiropractic services may be considered *maintenance care* or *supportive care*, which are both excluded under this Policy. See Section 6. (General Exclusions).

K. Clinical Trials

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



   a. **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.

   b. **Qualifying Clinical Trial:** With respect to cancer or other life-threatening diseases or 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 disease or condition and which meets any of the criteria in the bulleted list below.

   - 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:
     - National Institutes of Health (NIH), including the National Cancer Institute (NCI).
     - Centers for Disease Control and Prevention (CDC).
     - Agency for Healthcare Research and Quality (AHRQ).
     - Centers for Medicare and Medicaid Services (CMS).
     - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA).
     - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
     - 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:
       - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health.
       - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
   - The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
   - 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 is covered under the Policy.

c. **Routine Patient Care Costs:** costs associated with any of the following:

1) *health care services* that are typically covered under the Policy absent a clinical trial;

2) 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;

3) reasonable and necessary *health care services* used to diagnose and treat complications arising from your participation in a *qualifying clinical trial*; or

4) covered *health care services* needed for reasonable and necessary care arising from the provision of a trial *health care service*.

Routine patient care costs do not include costs associated with:

1) *experimental/investigational/unproven health care services* with the exception of:

a) certain Category B devices;

b) certain promising interventions for patients with terminal *illnesses*; and

c) other *health care services* that meet specified criteria in accordance with our medical policy guidelines;

2) *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;

3) *health care services* provided by the research sponsors at no *charge* to any person enrolled in the trial; or

4) *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, 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 trial protocol.

L. Cognitive Rehabilitation Therapy

Outpatient cognitive rehabilitation therapy following a post-traumatic brain *injury* or cerebral vascular accident.. 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. LL. (Covered Expenses / Preventive Care Services). Diagnostic colorectal cancer tests are covered under Section 5. Q. (Covered Services / Diagnostic Services) and Section 5. RR. (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. KK. (Covered Expenses / Prescription Legend Drugs and Supplies) and male sterilization procedures are covered under Section 5. PP. (Covered Expenses / Surgical Services).

O. Dental Services

1. **Definition of sound natural teeth:** teeth that: (1) are organic and formed by the natural development of the human body; (2) are not manufactured; (3) have not been extensively restored; (4) have not become extensively decayed or involved in periodontal disease; and (5) are not more susceptible to *injury* than whole organic teeth.

2. **Covered Dental Services**:

   a. Dental repair or replacement of your *natural teeth* due to an *injury* if *treatment* begins within six months of the *injury*.

   b. Extraction of teeth: 1) in preparation of the jaw for radiation treatment of neoplastic disease; or 2) in preparation of a covered transplant.

   c. Sealants on existing teeth to prepare the jaw for chemotherapy treatment of neoplastic disease.

   d. *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 **<u>any</u>** 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;

      3) You have a medical condition that requires hospitalization or a medical condition that requires general anesthesia for dental care.

3. **Dental Services Exclusions:**

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

   b. *Injuries* or damage to teeth (natural or otherwise) that result from or are caused by the chewing of food or similar substances.

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

d. Orthognathic surgery or any surgical procedure performed to correct deformities of the mandible or maxilla, correction of malocclusion, or orthodontic *treatment* (e.g. braces), except as specifically stated in Section 5. PP. (Covered Expenses / Surgical Services).

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

f. *Cosmetic treatment* or elective orthodontic care, periodontal care, *oral surgery* as defined in Section 5. PP. (Surgical Services) for bony impacted wisdom teeth or general dental 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. 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, diabetic test strips, alcohol pads, dextrose (tablets and gel), blood glucose monitors, auto injectors, auto blood samplers, and glucose control solution are dispensed by a pharmacy, *benefits* are payable according to Section 5. KK. (Covered Expenses / Prescription Legend Drugs and Supplies).

c. Medical eye exams (dilated retinal examinations).

d. Preventive foot care for *covered persons* with diabetes.

e. Diabetic self-management education programs.

f. Diabetic shoes when *medically necessary.*

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

Q. Diagnostic Services (for genetic services, see Section 5. U. Genetic Services)

1. **Covered Diagnostic Services:**

a. Diagnostic x-rays;

b. Radiology; and

c. Laboratory services.

The services must be directly provided to you and related to a covered *physical illness* or *injury*.

2. **Diagnostic Services Exclusions:**

a. *Charges* for computer-aided detection (except for screening mammogram interpretation).

b. *Charges* for imaging studies for purposes of 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*.

S. Durable Medical Equipment

1. Covered Durable Medical Equipment:

Certain *durable medical equipment may* require *prior authorization*. See www.arisehealthplan.com

a. Rental of 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. Breastfeeding equipment must be provided by a *participating provider*.

2. Durable Medical Equipment Limitations:

a. *Benefits* will be limited to the standard models, as determined by us.

b. 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:

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; home pneumatic compression devices for DVT (deep vein thrombosis) prevention; cold therapy (application of low temperatures for the skin) including, but not limited to, cold packs, ice packs, cryotherapy; and home automatic external defibrillator (AED).

d. *Durable medical equipment* that we determine to have special features.

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, or 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 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.

j. Light boxes for behavioral conditions.

k. Devices and computers to assist in communication and speech.

l. Enuresis alarms.

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 fee billed for use of the emergency room. If you receive *health care services* from an *urgent care* facility within an *emergency room*, the emergency room *copayment* will also apply. We will waive the emergency room *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 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.

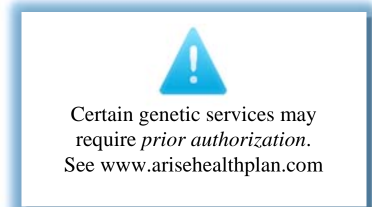
b. *Emergency medical care* received in a *health care practitioner's* office, *urgent care* facility, or any place of service other than a emergency room will be payable as shown in the Schedule of Benefits.

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*.

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*.

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 only accept *prior authorization* requests from the ordering *health care provider* (*e.g.* your *health care practitioner*); we will not accept *prior authorization* requests from the laboratory that will perform the genetic services.

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 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 without cost-sharing; and

i. All other *genetic testing* for which you receive our *prior authorization*.

2. **Genetic Services 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.

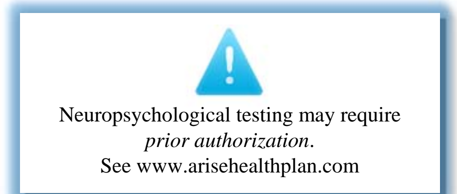
V. Health and Behavior Assessments

1. **Covered Health and Behavior Assessments:**

a. Health and behavior assessments and reassessments;

b. Diagnostic interviews;

c. Neuropsychological testing.



Neuropsychological testing may require *prior authorization*.
See www.arisehealthplan.com

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

2. **Health and Behavior Assessments 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 Device*s*, and Related Treatment

This Section 5. W. (Covered Expenses / Hearing Aids, Implantable Hearing Devices and Related Treatment) only applies to covered dependent *children* who are under age 18.

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 the *covered dependent child* is under age 18 and certified as deaf or hearing impaired by a *health care practitioner,* and the *hearing aids* and/or devices are prescribed by a *health care practitioner* in accordance with accepted professional medical or audiological standards:

Bone anchored hearing aids and cochlear implants may require *prior authorization*. See www.arisehealthplan.com

a. One *hearing aid* (including fitting and testing), per ear, 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*.

d. Post-*cochlear implant* aural therapy.

3. **Hearing Services Exclusions:**

a. Hearing protection equipment.

b. *Hearing aid* batteries and cords.

c. *Hearing aids, implantable hearing devices* and related treatment provided to a *covered person* age 18 or over.

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*.

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*; 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.

3. **Home Care Exclusions and Limitations:**

a. *Home care* that is not ordered by a *health care practitioner*

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.

c. *Benefits* are limited to 40 *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.

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.

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 will 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:**

   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. Please see Section 5. TT. (Transplants) for this coverage information. This section does not include *charges* for outpatient physical, speech, or occupational therapy. Please see Section 5. RR. (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. Please see Section 5. G. (Behavioral Health Services) for these coverage details.

1. **Covered Hospital Services:**

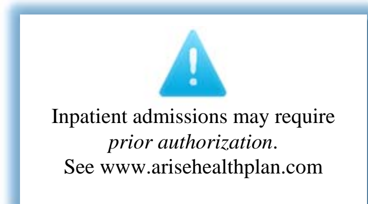
   a. **Inpatient Hospital Services.** *Benefits* are payable for the following inpatient *hospital* services for a *physical illness* or *injury*:

      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 stays at a *hospital* if care could safely and effectively be provided to you in a less acute setting.

BB. 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.TT. (Transplants).

CC. 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.

DD. 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) due to a lethal fetal anomaly; and (c) the abortion procedure is permitted by and performed in accordance with law. "Lethal fetal anomaly" is defined as an anomaly which predictably results in fetal demise either in utero or shortly (within 72 hours) after delivery.
   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:**
   a. Birthing classes, including Lamaze classes.
   b. Abortion procedures, except as specifically stated 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.

EE. 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 do not include *health care services* covered elsewhere in the Policy, including *home care* services covered under Section 5. X. (Home Care Services).

FF. 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;

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

d. Elastic stockings or supports when prescribed by a *physician* and required in the treatment of an *illness* or *injury*. We may establish reasonable limits on the number of pairs allowed per covered person per calendar year;

e. enteral therapy supplies; and

f. urinary catheters and supplies.

2. Medical Supplies 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. Ace bandages, gauze and dressings.

GG. 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 .LL. (Preventive Care Services).

HH. 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. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered *durable medical equipment* and are covered *health care services*. Please see Section 5. S. (Durable Medical Equipment).

3) Cervical collars;

4) Corsets (back and special surgical).

c. Orthotic devices or appliances to support the foot when they are a permanent part of an orthopedic leg brace or when custom-molded to fit the *covered person*.

d. Orthopedic shoes limited to one pair per *covered person* per calendar year.

e. 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:

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.

c. Over-the-counter orthotic devices and appliances to support the foot.

II. Pain Management Treatment

Pain management *treatment* including injections and other procedures to manage your pain related to an *illness* or *injury*. Pain management *treatments* include, but are not limited to, the following:

1. Medial branch neuroablation (denervation) of the facet joint nerves (spinal radiofrequency neuroablation, facet neurotomy);
2. Facet joint injections and medial branch nerve blocks; and
3. Epidural injections, including spinal selective nerve blocks.

JJ. 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.

KK. Prescription Legend Drugs and Supplies

1. Definitions. The following definitions apply to this Subsection KK. only:

a. **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*.

b. **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* will also include over-the-counter drugs that we determine to be covered drugs.

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

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

e. **Preferred Drug(s):** any *generic drug* or *brand-name drug* named on our list of *preferred drugs*, which is available at www.arisehealthplan.com/members/formulary/view_drug_formulary. The list of *preferred drugs* may change from time to time.

f. **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.

g. **Preventive Drugs:** drugs that we are required by law to define as preventive drugs, including, but not limited 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; and (8) immunizations. This definition of *preventive drugs* may change during the course of the year. Please see www.uspreventiveservicestaskforce.org.

h. **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.

i. **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 otherwise 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/investigative/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. specialty drugs;

e. injectable insulin;

f. *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;

g. an immunization that is not excluded elsewhere in the Policy;

h. oral chemotherapy drugs; and

i. *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;

c. diabetic test strips;

d. alcohol pads;

e. dextrose (tablets and gel);

- **f.** blood glucose monitors;
- **g.** auto injector;
- **h.** auto blood sampler; and
- **i.** 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 *copayment*, or *deductible* if applicable, for any *preventive drug*. All other covered drugs and *supplies* are subject to any *copayment* and/or *deductible* 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* or *deductible* 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 a claim for reimbursement. Your claim must include 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 requested 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 liable for the *copayment*, or *deductible* if applicable, and any difference between our *benefit* payment 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 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.

e. **Use of Brand-Name Drugs When Equivalent Generic Drugs Are Available.** If you obtain a *brand-name drug* and we determine that an equivalent *generic drug* is available, you must pay the difference in cost between the equivalent *generic drug* and the *brand-name drug* plus the *brand-name drug copayment* and/or *deductible* amount. Except as stated below, this limitation applies regardless of *medical necessity* or

your *health care practitioner's* instructions, including any instruction that you use only the *brand-name drug*.

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.

f. **Quantity Limits.** The following quantity limits apply to all *prescription legend drug benefits* under this subsection. 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.

Item	**Quantity Limit**
Prescription legend drugs or *supplies* dispensed by a *participating pharmacy*	30-day supply per fill or refill
Prescription legend drugs (other than *specialty drugs*) or *supplies* dispensed by a *home delivery pharmacy*	90-day supply per fill or refill
Preventive drugs used for Tobacco Cessation	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*
Specialty drugs	30-day supply per fill or refill, except as noted above
Blood glucose monitor dispensed by a *participating pharmacy*	One per *covered person* per *calendar year*

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

h. **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, *i.e.* a *participating pharmacy* where the drug can be obtained for self-administration, *benefits* for such *prescription legend drugs* purchased from and administered by a *health care provider* in a higher-cost place of services 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 (*e.g.* for 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, 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 used for sexual dysfunction or to enhance sexual activity, regardless of why the drug is being prescribed to you.

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

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

u. 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*;

v. Non-legend vitamins, minerals, and supplements even if prescribed by a *health care practitioner*, except as specifically stated in the Policy;

w. All medicinal foods, enteral feedings, supplemental feedings, over-the-counter nutritional and electrolyte supplements, including infant formula;

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

y. Medications, drugs, or hormones to stimulate human biological growth, unless there is a laboratory-confirmed *health care practitioner's* diagnosis of your growth hormone deficiency;

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

LL. Preventive Care Services

The following *preventive care services* are covered to the extent required by law. Your *deductible* and *coinsurance* do not apply to *preventive care services*; they are covered without cost-sharing from day one.

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 (please see www.uspreventiveservicestaskforce.org), including but not limited to:

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

2) Routine medical exams, including eye exams, hearing exams, and any related *preventive care services* directly provided to a covered *child* in connection with well-*child* care.

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 opthalmia neonatorum;

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

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

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.

c. screening for colorectal cancer, including fecal occult blood testing, limited to routine sigmoidoscopy or colonoscopy, including related *health care services*, once every five years, in accordance with the most current guidelines of the United States Preventive Services Task Force. Any additional routine sigmoidoscopies or colonoscopies performed within that five-year period shall be payable under Section 5. PP. (Covered Expenses / Surgical Services) subject to applicable deductible and coinsurance provisions;

d. Advanced care planning office consultations limited to one initial consultation and two follow-up consultations.

2. Preventive Care Services Limitations and Exclusions:

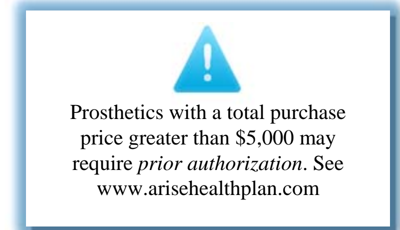
a. Some laboratory and diagnostic studies may be subject to a *deductible* and/or *coinsurance* if we determine they are not part of a routine preventive or screening examination. For example, when you have a

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;

b. We will not cover immunizations for travel purposes.

MM. 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.

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.

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

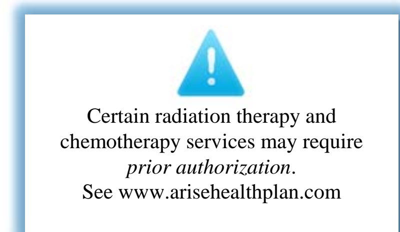
2. Prosthetics Exclusions:

a. Prosthetics that we determine to have special features.

b. Dental prosthetics.

c. Repairs due to abuse or misuse.

NN. 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.

OO. 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: (i) 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 (ii) 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 payable only for the *skilled nursing care* that continues to treat the same *illness* or *injury* for which you were treated at the *hospital* prior to your admission to that *skilled nursing facility*.

d. *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:

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 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).

PP. Surgical Services

This Subsection PP. does not include *surgical services* for: (1) covered transplants; (2) pain management procedures; or (3) *behavioral health services*. Please see Section 5. G. (Behavioral Health Services), Section 5. II. (Pain Management Treatment), and Section 5. TT. (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.

c. **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.

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; (b) arteriogram; or (c) tap or puncture of brain or spine.

b. *Reconstructive surgery* when the primary purpose of the surgery is to treat an *illness* or *injury* or to correct *functional impairment* caused by an *illness*, *injury*, or congenital abnormality, acute traumatic *injury,* dislocation, tumors, cancer or 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.CC. (Mastectomy Treatment).

c. *Oral surgery*, including related consultation, x-rays and anesthesia, limited to the following procedures:

1) surgical removal of impacted, sound natural unerupted teeth

2) excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

3) surgical procedures to correct injuries to the jaws, cheeks, lips, tongue, roof and floor of the mouth;

4) apicoectomy (excision of the apex of the tooth root);

5) root canal therapy, if performed simultaneously with an apicoectomy;

6) excision of exostosis (bony outgrowth) of the jaws and hard palate;

7) frenotomy (incision of the membrane connecting the tongue to the floor of the mouth;

8) incision and drainage of cellulitis (tissue inflammation) of the mouth;

9) incision of accessory sinuses, salivary glands or ducts;

10) x. gingivectomy (excision of gum tissue to eliminate infection), but not including restoration of gum tissue or soft tissue Allograft;

11) alveolectomy; and

12) orthognathic surgery.

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 Limitations and 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 the sole *treatment* of a psychological condition (*e.g.* psychological reaction to appearance or fear of disease) or *reconstructive surgery* for purposes other than those stated in paragraph 2. b. above.

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.

QQ. Telemedicine

1. Definitions. The following definitions apply to this Subsection QQ. only:

a. Distant site: the location of the *health care practitioner* at the time he/she is furnishing *telemedicine* services.

b. Interactive audio-visual telecommunication: Telecommunication that allows medical information to be communicated in real-time via interactive audio and video communications. The real-time audio and video communication is between the patient and a distant *health care practitioner* furnishing the *health care services*. The patient must be present and participating throughout the communication. Telephone calls do not qualify as *interactive audio-visual telecommunication* because they are non-face-to-face medical discussions that do not include direct, in-person contact between the patient and the *health care practitioner*.

c. **Originating site:** the location of the patient at the time he/she is receiving *telemedicine* services.

d. **Telemedicine:** the delivery of clinical *health care services* via telecommunications technologies, including but not limited to, telephone, interactive audio and video conferencing, and email. *Telemedicine* does not include teleradiology.

2. **Covered Telemedicine Services:**

a. *Telemedicine* services provided by a *health care practitioner* at a *distant site* to a *covered person* at an *originating site* via *interactive audio-visual telecommunication*. The *originating site* and the *distant site* must be:

1) A *health care practitioner*'s office;

2) A *convenient care clinic*;

3) A *hospita*l; or

4) A *skilled nursing facility*.

b. Phone and internet consultations provided by our approved telehealth service provider, Teladoc. Visit www.arisehealthplan.com/members/telehealth or call the Customer Service telephone number shown on your identification card for additional information about this *benefit.*

3. **Telemedicine Exclusions:**

a. *Telemedicine* services that do not include direct, in-person contact between the *health care practitioner* and the *covered person*.

b. Telephone evaluation and management services.

c. Transmission fees.

d. Website charges for online patient education material.

e. Online medical evaluations.

RR. Temporomandibular Joint (TMJ) Disorder Services

1. **Covered TMJ 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 Services Exclusions:**

a. Elective orthodontic care, periodontic care or general dental care.

b. *Health care services* provided in connection with the temporomandibular joint or TMJ syndrome, except as specifically stated in paragraph 1. above.

SS. 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 was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

c. **Therapy Visit:** a meeting between you and a *health care practitioner*, licensed physical, speech, or occupational therapist or any other *health care provider* approved by us that: (1) occurs in the provider'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. Covered Therapy Services:

a. Outpatient therapy, limited as follows:

1) Physical therapy when billed as *rehabilitative services* or *habilitative services*. Massage therapy is covered only when the therapy is billed by a chiropractor, physical therapist or occupational therapist;

2) Speech therapy when billed as *rehabilitative services* or as *habilitative services*; and

3) Occupational therapy when billed as *rehabilitative services* or as *habilitative services.*

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

c. All therapy must be performed by a *health care practitioner* excluding a massage therapist, unless approved by us. 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:

a. Physical therapy for temporomandibular (TMJ) disorders, except as specifically stated in Section 5. RR. (Temporomandibular (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.

TT. Transplants

1. Definitions. The following definitions apply to this Section 5. TT. 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*; (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/investigational/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. KK. (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.

d. We will notify you if a second opinion is required at any time during the determination of benefits period. If you are denied a transplant procedure by the *designated transplant facility*, we will refer you to a second *designated transplant facility* for evaluation. If the second facility determines, for any reason, that you are an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant related services and supplies even if a third *designated transplant facility* or any non-d*esignated transplant facility* accepts you for the procedure.

4. Transplant 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, 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.

UU. Vision Services - Non-Routine

1. Covered Non-Routine Vision Services:

a. Diagnosis and *treatment* of eye pathology.

b. Eye surgery to cure an *illness* or heal an *injury* to the eye.

c. Initial pair of eyeglasses or external contact lenses for aphakia, keratoconus, or following cataract surgery.

2. Vision Services Exclusions:

a. Vision therapy;

b. Refractive eye surgery, such as radial keratotomy.

c. Orthoptic therapy and pleoptic thereapy (eye exercise);

d. Preparation, fitting or purchase of eye glasses or contact lenses, except as specifically stated above;

e. Correction of visual acuity or refractive errors by any means, except as specifically stated above; and

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.

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. KK. (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 of, 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 worker's compensation laws or any similar laws have been claimed, paid, waived, or compromised. See Section 10. M. (Worker's Compensation) for additional information.

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 that would be covered by, Medicare as the primary payer if you are eligible to enroll. This applies, regardless of whether or not you 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 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* resulting or arising from complications of, or incidental to, any *health care service* not covered under the Policy, except for complications of, or services incidental to, a *subscriber*'s or his/her spouse's or domestic partner's elective abortion.

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.

20. Private duty nursing.

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. (Eligibility, Enrollment, and Effective Date) 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* approval;
- **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's primarily for rest, for the aged, or for 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* and *prescription legend drugs* provided in connection with *substance use disorders* or *nervous or mental disorders*, except as specifically stated in: Section 5. AA. (Covered Expenses / Hospital Services), which is limited to inpatient *hospital* services for detoxification; Section 5. G. (Covered Expenses /

Behavioral Health Services); Section 5. GG. (Covered Expenses / Nutritional Counseling); Section 5. KK. (Covered Expenses / Prescription Legend Drugs and Supplies); and Section 5. OO. (Covered Expenses / Skilled Nursing Care in a Skilled Nursing Facility).

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

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

35. Costs associated with indirect services provided by *health care providers* such as: creating standards, procedures, and protocols; calibrating equipment; supervising the 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*.

36. *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; except as specifically stated Section 5. P. (Diabetes Services) and HH. (Orthotic Devices and Appliances).

37. *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; (d) and sex therapy.

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

39. Salivary hormone testing.

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

41. Prolotherapy.

42. Platelet-rich plasma.

43. Coma stimulation/recovery programs.

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

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

46. Car seats.

47. 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, or ramps.

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

49. Medications for which the primary purpose is to preserve fertility.

50. *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.

51. Hypnosis.

52. Acupuncture.

53. Biofeedback, except for fecal/urinary incontinence.

54. Therapy services such as recreational therapy (other than recreational therapy included as part of a *treatment* program received during an inpatient *hospital 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 Section 5. I. (Covered Expenses / Cardiac Rehabilitation Services) and Section 5. RR. (Covered Expenses / Therapy Services).

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

56. Vocational or industrial rehabilitation including work hardening programs.

57. Sports hardening and rehabilitation.

58. *Health care services* that are for purposes of educational, occupational or athletic enhancement.

59. 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.

60. *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. LL. (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.

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

62. *Health care services* performed by a provider with your same legal residence.

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

64. *Respite care*. This exclusion does not apply to *respite care* that is part of an integrated *hospice care* program of services provided to a terminally ill person by a licensed *hospice care* agency for which *benefits* are provided as described under Section 5. Z. (Covered Expenses / Hospice Care).

65. Health care services associated with expenses for infertility or fertility treatment, including assisted reproductive technology, regardless of the reason for the treatment.

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

67. Evaluation of habitual abortions (three consecutive documented spontaneous abortions in the first or second trimesters) when not pregnant.

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

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 or a similar provision takes effect.
3. **Custodial Parent:** a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the *child* resides more than one half of the *calendar year* without regard to any temporary visitation.
4. **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.

   c. 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 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*.

5. **Primary Plan/Secondary Plan:** Subsection C. below (Order of Benefit Determination Rules) 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).

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 subsection 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 (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 or *domestic partner* 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 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 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 rule 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 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.

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 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 primary.

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. 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 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

If you or a *covered dependent* are receiving *benefits* under both this Policy and Medicare, federal law may require this Policy to be primary over Medicare. For example, this Policy will pay as the *primary plan* and Medicare will pay as the *secondary plan* under the following circumstances:

1. If the *covered person* (employee or the employee's spouse) is age 65 or older and is covered under an employer group health *plan* of an employer that employs at least 20 persons (including part time employees) for a minimum of 20 weeks during the current or preceding *calendar year* and has not elected to have Medicare as the sole source of medical protection.

2. If the *covered person* is: under age 65; covered under an employer group health *plan* of an employer with at least 100 employees because he/she or a covered family member is working as an employee, is the employer (including self-employed persons) or is an individual associated with the employer in a business relationship; and receiving Medicare benefits due to his/her disability. In this case, the employer must have at least 100 people actively employed 50 percent or more of the regular business days in the preceding *calendar year.*

3. If the *covered person* is covered under an employer group health *plan*, and has end-stage renal disease (ESRD). If an ESRD patient has health insurance coverage under an employer group health *plan*, Medicare is the *secondary plan* for 30 months from entitlement to, or eligibility for, Medicare based on ESRD.

When this Policy is not primary, this Policy will coordinate *benefits* with Medicare in accordance with federal law.

Per Section 6. (General Exclusions), paragraph 8., if you are eligible for Medicare as your *primary plan*, this Policy will not cover any expense that Medicare would cover regardless of whether you are actually enrolled in 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 the Policy terminates.

2. The last day of the calendar month in which you die.

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

4. The date you enter into military service, other than for an assignment of less than 30 days.

5. The last day of the calendar month in which the *subscriber's* employment terminates.

6. The last day of the calendar month in which we determine the *subscriber* no longer meets the definition of *eligible employee*. However, the employee's coverage under the Policy may continue if the *subscriber* is:

a. granted an approved leave of absence protected by the Family and Medical Leave Act of 1993 (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA), or any workers' compensation leave of absence. In this case, the *subscriber's* coverage will continue until the last day of the calendar month in which we determine the *subscriber* fails to return to work from that leave of absence; or

b. granted a leave of absence under the *policyholder's* established leave of absence policy. In this case, the *subscriber's* coverage will continue no longer than three consecutive months unless a later date is

specifically stated in the employer's leave of absence policy. Such leave of absence policy and any supporting documentation must be provided to us upon our request; or

c. subject to a collective bargaining agreement (CBA). In this case, the *subscriber's* coverage will continue as stated in the CBA. The CBA and any supporting documentation must be provided to us upon our request.

The *policyholder* must continue to pay the required premiums during any period of continued coverage stated in this paragraph 6.

7. The last day of the month in which we receive the *policyholder's* request to terminate a *covered person's* coverage, unless the *policyholder* specifies a later coverage termination date.

8. For a *subscriber's covered dependent*, the date the *subscriber's* coverage terminates under the Policy.

9. For a *subscriber's* spouse or *domestic partner* who is a *covered person*: (a) the day the *subscriber's* spouse is no longer married to the *subscriber* due to divorce or annulment; or (b) the day the *domestic partner* no longer meets the definition of *eligible dependent*.

10. 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*;

c. For a *child* of a *domestic partner*, the date the *subscriber's domestic partner* no longer meets the definition of an *eligible dependent*.

11. For a child of a *covered dependent child*, the date the *covered dependent child* reaches age 18.

12. For any *covered dependent*, the last day of the calendar month in which the individual no longer meets the definition of *eligible dependent.*

It is the *subscriber's* responsibility to notify us of his/her *dependent* 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 *dependent* was not an *eligible dependent*.

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 poof 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. Extension of Benefits

This Section 8. D. only applies when (1) the Policy is not replaced by another group health insurance policy, group health plan, or self-insured group health benefits plan; and (2) we determine that Wis. Admin. Code Ins 6.51 (6) and (7) require that we provide an extension of coverage.

1. **Definition of totally disabled / total disability:** being unable due to *illness* or *injury* to perform the essential functions of any job or, for *eligible dependents* and retirees, to carry on most of the normal activities of a person of the same age and sex, as determined by us. You are not *totally disabled* if you are working on either a full-time or part-time basis for wage or profit for anyone, including working for yourself. To qualify as a *totally disabled* person, you must be under the regular care of a *health care practitioner*. We have the right to examine any *covered person* who claims that he/she is *totally disabled* as often as reasonably required for us to determine whether or not that person meets this definition. Such examinations may include, having *health care providers* or vocational experts examine that person.

2. **Conditions That Trigger an Extension of *Benefits*.** On the day the Policy ends for all *covered persons*, *benefits* will continue for each *covered person* who, on the date the Policy ends, is:

   a. Totally disabled; or

   b. Confined in a hospital.

   An extension of *benefits* provided under this subsection will end on the earliest of the following dates:

   c. The day you are no longer *totally disabled* or no longer *confined* in a *hospital*;

   d. The day on which 12 consecutive months have passed since the date the Policy ended; or

   e. The day on which coverage for the condition(s) causing your *total disability* or *confinement* is provided under similar coverage, other than temporary coverage required by Wis. Admin. Code Ins 6.51 (7m) (b) under another group health plan.

   An extension of *benefits* under this section does <u>not</u> provide coverage for dental services, uncomplicated pregnancies or for any *injury* or *illness* other than the covered *illness* or *injury* causing the *covered person's total disability* or *confinement*.

E. 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. CONTINUATION COVERAGE

A. Wisconsin Law

1. In certain cases, you may be eligible to continue coverage that would otherwise end under Section 8. (When Coverage Ends) in accordance with Wis. Stat. § 632.897. Those who are eligible to purchase continuation coverage are:

a. *Subscribers* who are no longer eligible for coverage under the Policy through the *policyholder*, except if their employment is terminated for misconduct; or

b. A *subscriber's covered dependent* who is no longer eligible for coverage under the Policy through the *policyholder* due to divorce, annulment or death of the *subscriber*. In either case, you must be covered under the Policy through the *policyholder* for at least three consecutive months immediately prior to the termination date of your coverage in order to qualify for continuation coverage.

2. Within five days of the *policyholder's* receiving notice to end your coverage or notice that you are eligible under paragraph 1. a. or 1. b.) above, the *policyholder* must notify you of:

a. Your option to continue your coverage;

b. The monthly premium amount you must pay to continue your coverage. The premium amount for continuation coverage will be at the premium rate that we require for such coverage;

c. The manner in which and the place to which you must make premium payments; and

d. The time by which you must pay the premiums required for continuation coverage.

3. If you are eligible to purchase continuation coverage under Wis. Stat. § 632.897 and timely elect to continue your coverage and pay to the *policyholder* the required premium within 30 days after receiving the notice described above from the *policyholder*, the *policyholder* must notify us of your election of continuation coverage as soon as reasonably possible in the manner required by us. Your continuation coverage under the Policy may be continued until the earliest of the following dates:

a. The date you become eligible for other similar group health care coverage or the same coverage under the Policy;

b. For a *subscriber's* former spouse, the date the *subscriber* is no longer eligible for coverage under the Policy;

c. The date the Policy terminates;

d. The date you move out of Wisconsin;

e. The end of the last coverage period for which you paid the required premium; or

f. 18 consecutive months after you elect continuation coverage.

4. If any of the six events described above applies to a *covered person* with continuation coverage, the *covered person* whose continuation coverage terminated under the Policy due to that event must give written notice of that

event to the *policyholder* and us as soon as reasonably possible. The *policyholder* must also notify us of that event as soon as reasonably possible after becoming aware of that event.

5. The continuation coverage described above is made available by us only to the limited extent that we're required to provide such coverage under Wis. Stat. § 632.897. Nothing in this Section 9. A. provides, or will be interpreted or construed to provide, any coverage in excess of, or in addition to, the continuation coverage required to be provided by us under Wis. Stat. § 632.897.

B. Federal Law

A *covered person* who is no longer eligible for coverage under the Policy, such as a *covered person* whose employment ends with the *policyholder*, certain *children* who qualify as *eligible dependents*, or a divorced or surviving spouse and his/her *children*, may be eligible to purchase continuation coverage under the Policy in accordance with the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), as amended.

You must contact the *policyholder* within 60 days of a divorce or a *child* losing status as an *eligible dependent* under the Policy in order to be eligible for COBRA continuation. You have 60 days following the termination date to elect to continue coverage under COBRA.

If you are eligible to purchase continuation coverage under COBRA, please see the *policyholder* for further information.

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 are 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;

   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 dependent*s. *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 *policyholder* 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 *policyholder* 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 *policyholder*, all *covered persons*, and us. No error by us, the *policyholder*, 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 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 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 *treatment*s (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 *health care practitioner* and to communicate with him or her in order to develop a patient-*health care practitioner* 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 care through your participating *health 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. Workers' Compensation

The Policy is not issued in lieu of nor does it affect any requirements for coverage by workers' compensation insurance. *Health care services* for injuries or *illness*es that are job, employment, or work related, and for which *benefits* are provided or payable under any workers' compensation or occupational disease act or law, are excluded from coverage under the Policy. If a *covered person* receives *benefits* under the Policy for *charges* that are later determined to be eligible for coverage under any workers' compensation insurance, workers' compensation act, or employer liability law, the *covered person* will reimburse us in full to the extent that *benefits* were paid by us under the Policy for such *charges*. We reserve the right to recover against you even though:

1. The workers' compensation benefits are in dispute or are made by means of settlement or compromise;
2. No final determination is made that the *illness* or *injury* was sustained in the course of or resulted from employment;
3. The medical or health care *benefits* are specifically excluded from the workers' compensation settlement or compromise; or
4. The workers' compensation settlement or compromise purports to be limited to lost wages or other recovery other than medical expenses.

N. 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. **Incomplete Claim:** a *correctly filed claim* that requires additional information including, but not limited to, medical information, coordination of benefits questionnaire, or subrogation questionnaire.
3. **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.
4. **Post-Service Claim:** any claim for a *benefit* under the Policy that is not a *pre-service claim*.
5. **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.

6 **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

11) Billed *charges* for each service

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

b. 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

P*rescription legend drug* claims made after 4:00 PM 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 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, including a statement of your right to bring a civil action under ERISA § 502(a), if applicable. 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 *medical 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/investigative/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/investigative/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 30 days after our receipt of your *grievance* for a *post-service claim*. 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.

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, including a statement of your right to bring a civil action under ERISA § 502(a), if applicable. 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 *medical 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, including a statement of your right to bring a civil action under ERISA § 502(a), if applicable. 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 *medical 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;

   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*;

   b. based on the information provided, we have determined the *treatment* is *experimental/ investigational/ unproven*;

   c. 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: IRO 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 Certificate, 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 this Certificate, 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*.
2. A step-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.
5. A *child* who is considered an alternate recipient under a qualified medical child support order. See Section 2. F. 6. for additional information about child support orders.
6. The *child* of a *subscriber's domestic partner* provided that:
   - **a.** the *domestic partner* is enrolled as a *covered person* under the Policy; and
   - **b.** the *domestic partner* is the biological parent or has a court-appointed legal relationship with the *child* (i.e. through adoption).

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*.

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.

Cosmetic Treatment: any *health care service* used solely to: (1) change or improve your physical appearance or self-esteem; or (2) treatment of 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.

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).

Domestic Partner: a person who occupies the same dwelling unit with a *subscriber* if all of the following conditions are met:

1. The person is in a committed relationship (relationship of mutual support, caring and commitment and intend to remain in such a relationship in the immediate future) with the *subscriber*;

2. Each partner is 18 years of age or older;

3. Neither partner is married or legally separated in marriage, or has been a party to an action or proceeding for divorce or annulment within six months of registration, or, if one has been married, at least six months have lapsed since the date of the judgment terminating the marriage;

4. Each partner is competent to contract;

5. Neither partner is currently registered in another domestic partnership, and if either party has been in such a registered relationship, at least six months have lapsed since the effective date of termination of that registered relationship;

6. There are no blood ties between the *subscriber* and his/her partner closer than that permitted for marriage or for *domestic partner* registration;

7. The relationship of the *subscriber* and his/her partner is not merely temporary, social, political, commercial or economic in nature (i.e., there must be mutual financial interdependency); and

8. The *subscriber* has registered his/her partner as a *domestic partner* with the *policyholder* and Arise by providing proof that, for at least the six-month period immediately preceding the date of registration, the *subscriber* either had obtained a domestic partnership certificate from the city, county or state of residence or from any other city, county or state offering the ability to register a domestic partnership or has any three of the following with respect to the partner:

a. joint lease, mortgage or deed;

b. joint ownership of a vehicle;

c. joint ownership of checking account (demand deposit) or credit account;

d. designation of the partner as a beneficiary of the *subscriber's* will;

e. designation of the partner as a beneficiary for the *subscriber's* life insurance or retirement benefits;

f. designation of the partner as holding power of attorney for health care; or

g. shared household expenses.

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 six 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.
6. If shown in the *policyholder's* current application for coverage as being applicable, a *subscriber's domestic partner*.

Eligible Employee: a person who is either (1) employed by the *policyholder* on a permanent, full-time basis for the required number of hours per week as shown in the *policyholder's* current Arise application for coverage; or (2) identified by the *policyholder* as a person that must be covered pursuant to the Patient Protection and Affordable Care Act.

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

Emergency Room Visit: a meeting between you and a *health care practitioner:* (1) occurs at the emergency room or any other facility *charged* as an extension of the emergency room including *urgent care* rooms; (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.
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*. When referred to in this Certificate, *family coverage* also includes *limited family coverage*.

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

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*; or (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 deviation, loss, or 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 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.PP. (Surgical Services), maternity services, *medical services*, procedures, drugs, medicines, devices, *supplies*, or any other service directly provided to you by a *health care provider*

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.

Home 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 in your home; and (b) involves 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 *healthcare practitioner* licensed to provide nonresidential services that: (a) occurs in your home; and (b) is for the *treatment* of *nervous or mental disorders* and/or *substance use disorders*; and (c) involves you receiving psychotherapy, psychiatric diagnostic interviews, medication management, behavioral counseling, and neuropsychological testing.

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 practitioner s* 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) a facility operated mainly for *treatment* of *nervous or mental disorders* and/or *substance use disorders*; (7) sub-acute care center; or (8) a health resort, spa or sanitarium.

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

Injury: bodily damage caused by an accident. The bodily damage must result from the accident directly and independently of all other causes.

Limited Family Coverage: coverage that applies to: (1) a *subscriber* and his/her eligible spouse or *domestic partner* who is a *covered dependent*; or (2) a *subscriber* and his/her *children* who are *covered dependents*.

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 i*s 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*.

Upon written or oral request from you 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 a specific *health care service* provided to you. That 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; and
6. Not primarily for the convenience or preference of the *covered person*, his/her family, or any *health care provider*.

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; and (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 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 the health care network selected by the *policyholder* or *covered person* 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*, or the outpatient department of a *hospital*, other than an emergency room; 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 or the outpatient department of a *hospital*, other than an emergency room; 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) the *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 the network shown on your Arise identification card as of the date upon which the services are provided. Please refer to our on-line directory or contact us for a listing of *participating providers*. A *health care provider's* participating status may change from time to time so you should check it frequently. You may be required to pay a larger portion of the cost of a covered health care service if you see a *non-participating provider*.

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. 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.

Policyholder: the employer or other organization that purchased the Group Master Policy pursuant to which this Certificate was issued.

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.

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.

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 Care Practitioner: a *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 *eligible employee* who has properly enrolled and been approved by us for coverage under the Policy.

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*.

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.

Waiting Period: a period of time that must pass before an individual is eligible to be covered for *benefits* under the provisions of the Policy.

15. WISCONSIN DEPARTMENT OF INSURANCE CONTACT INFORMATION

You may resolve your problem by taking the steps outlined in Sections 11. (Claim Filing and Processing Procedures), 12. (Internal Grievance and Appeal Procedures), and 13. (Independent External Review).

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 contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** using any of the following:

For regular mail by the United States Postal Service:

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

For Federal Express, UPS or Overnight Mail:

Office of the Commissioner of Insurance
Complaints Department
125 South Webster Street
Madison, WI 53703-3474

By electronic mail: ocicomplaints@wisconsin.gov

By phone: (608) 266-3585 or Toll Free (800) 236-8517