



Limitations and Exclusions

How to Voice a Complaint or File a Grievance

We want to make sure the plan is working for you and welcome your feedback. If you have a complaint or want to file a grievance on a decision that affects you, please contact our Member Services Department locally at (920) 490-6900 or toll-free at 1-888-711-1444.

We strive to resolve all complaints verbally. However, you have the option to submit a formal grievance in writing if your complaint is not handled to your satisfaction. The Grievance Procedure is used to resolve all complaints regarding plan administration or benefit denials.

Your grievance will be considered by a review panel consisting of Arise Health Plan representatives, a clinical medical representative, and a member representative.

Exclusions and Limitations

The plan does not cover the following services. Please see your Certificate of Coverage for more specific information.

Services, supplies, facilities, or equipment that are not medically necessary or that are experimental or investigational, as determined by us.

Services furnished by a federal, state, county, municipal, or other governmental agency.

An illness or injury caused by any military related act or incident of declared or undeclared war, riots, insurrection, or terrorism.

An illness or injury as a result of the armed services of any country that occurred while on active duty or as a result of being on active duty.

Medical care received during a stay in a hospital owned or operated by a federal, state, province, or political unit, unless required by law.

Custodial or maintenance care.

Charges in excess of the usual and customary charge.

Services performed by a close relative.

General fitness programs, exercise programs, exercise equipment, and health club memberships.

Drugs, medicines, procedures, services, and supplies for sex transformation surgery.

Treatment or therapy that is court ordered, ordered as a condition of parole, probation, or custody evaluation, except as required by law.

Telephone consultations or completion of claim forms or forms necessary for return to work or school.

Services provided during a pre-existing conditions waiting period, including any complications of such conditions.

Charges for a missed appointment.

Telemedicine, except teleradiology.

Services the covered person would not be obligated to pay in the absence of this plan or that are provided at no charge.

Services, supplies, facilities, or equipment for complications resulting from an elective surgery.

Service or treatment requested by a third party.

Cranial banding.

Private duty nursing.

Personal comfort or convenience items.

Marriage counseling.

Reversal of voluntary sterilization.

Travel and transportation for a consultation or to receive treatment.

Bereavement counseling, unless provided as part of hospice coverage.

All services not specifically identified as being covered.

Services provided before the covered person's effective date.

Services provided after the covered person's termination date.

Services and/or supplies provided without a required pre-service authorization or if pre-service authorization was denied.

Functional capacity or physical performance testing.

Cosmetic surgery or treatment or any portion thereof.

Dental services, except as stated in the Certificate.

Over-the-counter drugs, non-prescription vitamins, minerals, and supplements, all enteral feedings, supplemental feedings, over-the-counter nutritional supplements, and related supplies.

Treatment for sexual dysfunction or to increase sexual function.

Modifications to your vehicle, home, or property.

Medical supplies and durable medical equipment for comfort, personal hygiene, or convenience.

Environmental items such as air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, or vacuum devices.

Wigs, toupees, hairpieces, cranial prosthesis, hair implants or transplants, or hair weaving.

Routine or periodic maintenance of durable medical equipment or replacement of batteries.

Genetic counseling, studies, and testing, except as stated in the Certificate.

Hearing services, except as stated in the Certificate.

Hospital services if care could be provided in a less acute setting.

Infertility or fertility treatment.

Birthing classes, abortions, and home births.

Reconstructive surgery, except as stated in the Certificate.

Vocational or industrial rehabilitation, work hardening programs, cardiac rehabilitation beyond Phase II, habilitative services, and sports hardening and rehabilitation.

Physical, occupational, and speech therapy for conditions such as attention deficit hyperactivity disorder, sensory or auditory defensiveness, mental retardation and related conditions, hearing therapy for communication delay, or therapy for perceptual disorders.

Massage or aquatic therapy, except as stated in the Certificate.

Hypnosis, acupuncture treatment, holistic, or homeopathic medicine.

Sex therapy.

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

Biofeedback.

Charges or services for birth to three program.

Services of an athletic trainer.

Long-term and maintenance therapy.

Organ transplants that are not listed in the Certificate as approved transplant services.

Vision services other than annual routine exam(s).

Services, supplies, equipment, or facilities for obesity, morbid obesity, weight control, or weight reduction including, but not limited to, gastric or intestinal bypasses, gastric balloons, stomach stapling, wiring of the jaw, liposuction, weight loss drugs or programs, and physical fitness or exercise programs or equipment.

Any immunization or vaccination other than those recommended by the Advisory Committee on Immunization Practices.

Wellness services received from a non-participating provider.

Waiting Period for Pre-Existing Conditions

This plan has a waiting period for any illness or injury for which medical advice, diagnosis, care, or treatment was recommended or received within six months prior to a member's enrollment date. Benefits for pre-existing conditions and any complications are not payable under the plan for 12 consecutive months (18 months for late enrollees) from the enrollment date. Charges incurred after the waiting period for the condition are eligible for benefits as provided under this plan.

The waiting period may be shorter if there was previous qualifying coverage and no lapse in coverage greater than 63 days.

The pre-existing condition waiting period does not apply to pregnancy and complications of pregnancy. It also does not apply to genetic information in the absence of a diagnosis of an illness related to such information.

Children under the age of 19 will not be subject to a pre-existing conditions waiting period.

Eligible Group

In order for a group to be eligible for coverage with Arise Health Plan, the group must employ two or more full-time employees, must have been formed other than for the purpose of securing insurance, must be located in the service area of the plan, and must meet all participation and contribution requirements.

Eligible Employee

For an employee to be considered eligible to participate in the group health plan, he or she must be actively at work full-time for a minimum of 30 hours per week. This does not include temporary or leased employees, members of a board of directors, or independent consultants or contractors to the group.

Eligible Dependents

Dependent Children are eligible until age 26. An unmarried adult child age 26 and older who is a full-time student will continue to be eligible regardless of age if that child meets all of the following requirements:

1. The child was called to federal active duty in the national guard or in a reserve component of the United States armed forces while the child was a full-time student; and
2. The child was under the age of 27 when called to federal active duty.

Premium and Renewal Terms

We determine your group's premium based on a number of factors. These include your group's characteristics and the various benefit design options that are selected. You may renew coverage by paying your premium on time. A member's coverage depends on his or her eligibility under the terms and conditions of your group's policy.

Wellness Care and Routine Physicals

Wellness care includes routine evaluation, assessing health and well-being, screening for possible detection of an unrevealed illness, or improving health when there are no symptoms, illnesses, or diagnosis.

Wellness care must be provided by a participating provider.

Quality Improvement

The Arise Health Plan Quality Improvement Committee evaluates and monitors key aspects of service and health care provided to members. The medical director directs the Quality Improvement Committee. Various committees consisting of Participating Providers and Arise Health Plan staff guide, direct, and evaluate quality initiatives. Participating Providers are evaluated using nationally accepted criteria prior to joining the network and are reevaluated every three years thereafter.

Health management studies and projects are completed to increase rates of preventive services and to improve management of acute and chronic diseases. The Quality Improvement Committee is responsible for directing the process of improvement efforts.

Pharmacy Benefit Information

Arise Health Plan contracts with the national company Express Scripts to administer pharmacy benefits. Employers have the option of using Express Scripts or selecting another pharmacy benefits manager for their employees. If your employer selected Express Scripts, they will process your pharmacy claims, issue your drug benefit identification cards, and provide mail order pharmacy services.

Most Arise Health Plan insurance plans come with a drug formulary. A drug formulary is a list used by practitioners to identify drugs that offer the greatest overall value. A committee of physicians, nurse practitioners, and pharmacists maintain the formulary.

The formulary may be accessed from our website at www.WeCareForWisconsin.com or you may contact a Member Services representative locally at (920) 490-6900 or toll-free at 1-888-711-1444. If your prescription is not on the formulary, you may still have coverage. To promote the most appropriate utilization, selected high-risk or high-cost medications require prior authorization by the health plan to be eligible for coverage. Practitioners initiate the prior authorization by providing the necessary medical information to the health plan. Please refer to your Certificate of Insurance for additional details about your pharmacy benefit and applicable deductibles, copays, and/or coinsurance.