

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 Pre-Existing Conditions

There is a waiting period if within 12 months prior to the Covered Person's effective date, the Covered Person:

- A. Had an illness or injury diagnosed; or
- B. Received care, medical services, or treatment for an illness or injury.

Benefits are not payable for expenses incurred as a result of that illness or injury and any complications of any such illness or injury for a period of 12 months after the effective date of coverage.

We will not pay benefits for charges for treatment, services, supplies, or other expenses incurred during the pre-existing conditions waiting period for any such illness or injury and any complications of any such illness or injury.

If a dependent child is born or is legally adopted by the policyholder while covered under the policy, the child does not have a pre-existing conditions waiting period for such illness or injury.

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

This plan does not cover the following services. Please see your policy for more specific information.

Services, procedures, or supplies provided in connection with an illness or injury arising out of, or sustained in the course of, any occupation, employment, or activity of compensation, profit or gain, whether or not benefits are available under Workers' Compensation. This exclusion does not apply to services, procedures, or supplies received by a covered person who qualifies as a sole proprietor, officer, or partner under state law and such benefits are not covered under any Workers' Compensation plan, provided he or she is not engaged in the following professions or activities of compensation as defined

by the National Council on Compensation Insurance, Inc. (NCCI): aircraft or helicopter operation, asbestos, athletic team, atomic energy, farm, fire, fireworks, hay baling and drivers, mining NOC, police officers and drivers, salvage operation, sawmill, and trucking.

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.

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.

Illness or injury as a result of an illegal occupation.

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 policy 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.

Sterilization procedures and 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 policy.

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.

Any smoking cessation drugs or supplies.

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 prostheses, 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 required by federal law.

Hearing services, except as stated in the policy.

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

Infertility or fertility treatment.

Maternity services.

Services and treatment for nervous and mental disorders, alcoholism, and drug abuse, except as required by federal law.

Reconstructive surgery, except as stated in the policy.

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 policy.

Hypnosis, acupuncture treatment, and 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 policy as approved transplant services.

Vision services other than annual routine exam.

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.

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.

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.