

**It's all about choice.** A Point of service (POS) plan offers the best of both worlds. To maximize cost-effectiveness, health care costs are efficiently managed through primary care physicians (PCPs). Plus, members enjoy the benefit of freedom of choice. Each participant chooses a primary care physician. When care is provided in network, through the coordination of the member's PCP, a higher level of benefits is available. However, members have the choice to use providers outside of the network and still receive benefits at a lower level.



| Deductible    |               | Coinsurance |     |        | Out-of-Pocket |               |
|---------------|---------------|-------------|-----|--------|---------------|---------------|
| In            | Out           | In          | Out | Max    | In            | Out           |
| Single/Family | Single/Family |             |     |        | Single/Family | Single/Family |
| 250/750       | 500/1,500     | 80%         | 60% | 5,000  | 1,250/2,750   | 2,500/5,500   |
| 250/750       | 500/1,500     | 80%         | 60% | 10,000 | 2,250/4,750   | 4,500/9,500   |
| 500/1,500     | 1,000/3,000   | 80%         | 60% | 5,000  | 1,500/3,500   | 3,000/7,000   |
| 500/1,500     | 1,000/3,000   | 80%         | 60% | 10,000 | 2,500/5,500   | 5,000/11,000  |
| 1,000/3,000   | 2,000/6,000   | 100%        | 80% | 5,000  | 1,000/3,000   | 3,000/8,000   |
| 1,000/3,000   | 2,000/6,000   | 90%         | 70% | 10,000 | 2,000/5,000   | 5,000/12,000  |
| 1,000/3,000   | 2,000/6,000   | 80%         | 60% | 5,000  | 2,000/5,000   | 4,000/10,000  |
| 1,000/3,000   | 2,000/6,000   | 80%         | 60% | 10,000 | 3,000/7,000   | 6,000/14,000  |
| 1,500/4,500   | 3,000/9,000   | 100%        | 80% | 5,000  | 1,500/4,500   | 4,000/11,000  |
| 1,500/4,500   | 3,000/9,000   | 90%         | 70% | 10,000 | 2,500/6,500   | 6,000/15,000  |
| 1,500/4,500   | 3,000/9,000   | 80%         | 60% | 5,000  | 2,500/6,500   | 5,000/13,000  |
| 1,500/4,500   | 3,000/9,000   | 80%         | 60% | 10,000 | 3,500/8,500   | 7,000/17,000  |
| 2,500/7,500   | 5,000/15,000  | 100%        | 80% | 5,000  | 2,500/7,500   | 6,000/17,000  |
| 2,500/7,500   | 5,000/15,000  | 80%         | 60% | 10,000 | 4,500/11,500  | 9,000/23,000  |
| 5,000/15,000  | 10,000/30,000 | 100%        | 80% | 5,000  | 5,000/15,000  | 11,000/32,000 |

| Individual Lifetime Maximum Benefit   | \$5,000,000                                     |  |
|---|---|--|
| Summary of Services   | Participating Providers (In-Network)            | Non Participating Providers (Out-of-Network) |
| <b>Wellness Services</b> (no calendar year maximum) <ul style="list-style-type: none"> <li>Routine Physical Exams</li> <li>Routine Labs</li> <li>Routine Mammograms (40+) and Pap Tests</li> <li>Routine Vision and Hearing Exams</li> <li>Immunizations and Vaccinations (except for travel)</li> <li>Well-baby Care</li> <li>Blood Lead Tests to Age 5</li> <li>Routine Colonoscopy (50+)</li> </ul>  | 100%<br>+ Waiver of Deductible                  | Not Covered                                  |
| <b>Hospital Services</b> <ul style="list-style-type: none"> <li>Room and Board, Miscellaneous Hospital Expenses, and Intensive Care Unit (prior approval required*)</li> <li>Outpatient Facility Fees</li> <li>Outpatient Radiology, Pathology, and Lab Services</li> </ul>   | Deductible & Coinsurance                        | Deductible & Coinsurance                     |
| <b>Emergency Services</b> <ul style="list-style-type: none"> <li>Emergency Room Facility Fees</li> <li>Emergency Room Care (including physician charges &amp; miscellaneous expenses)</li> <li>Ambulance (up to \$2,000 ground/\$10,000 air; prior approval required for non-emergency transport*)</li> </ul>   | Participating Provider Deductible & Coinsurance |  |
| <b>Transplants</b><br>Covered Expenses include, but are not limited to, hospital charges, Practitioner charges, Organ and Tissue Acquisition, tissue typing, and ancillary services at a Designated Transplant Facility that are Medically Necessary.   | Deductible & Coinsurance                        | Deductible & Coinsurance                     |
| <b>Kidney Transplants and Dialysis Treatments</b><br>(Maximum benefit of \$30,000 per year; prior approval required*)   | Deductible & Coinsurance                        | Deductible & Coinsurance                     |
| <b>Professional Services</b> <ul style="list-style-type: none"> <li>Office Visits (including chiropractors)</li> <li>Maternity Services (prenatal, delivery, and postnatal care)</li> <li>Medical and Surgical Services</li> <li>Corneal Transplants, Bone and Skin Grafts</li> <li>Therapy and Physical Medicine (Occupational, physical, speech, and respiratory therapy; \$750 max per calendar year)</li> <li>Radiation and Chemotherapy Services</li> <li>Cardiac Rehabilitation Services</li> </ul> | Deductible & Coinsurance                        | Deductible & Coinsurance                     |
|   | Not Covered                                     | Not Covered                                  |
|   | Deductible & Coinsurance                        | Deductible & Coinsurance                     |
|   | Deductible & Coinsurance                        | Deductible & Coinsurance                     |

| Summary of Services (Continued)  | Participating Providers (In-Network) | Non Participating Providers (Out-of-Network) |
|--|--------------------------------------|--|
| <b>Professional Services (Continued)</b>   |                                      |  |
| • Oral Surgery and Dental Repair (due to injury)   | Deductible & Coinsurance             | Deductible & Coinsurance                     |
| • X-ray and Lab Services   | Deductible & Coinsurance             | Deductible & Coinsurance                     |
| • Independent Anesthesiologist, Pathologist, and Radiologist Services  | Deductible & Coinsurance             | Deductible & Coinsurance                     |
| <b>Home Health Care</b>  |                                      |  |
| • Home Health Services (up to 40 visits per year; prior approval required*)  | Deductible & Coinsurance             | Deductible & Coinsurance                     |
| • Home IV Therapy and Supplies (prior approval required*)  |                                      |  |
| <b>Other Health Care Services</b>  |                                      |  |
| • Breast Reconstruction (following a mastectomy)   | Deductible & Coinsurance             | Deductible & Coinsurance                     |
| • Durable Medical Equipment (DME costing more than \$500 requires prior approval)  |                                      |  |
| • Diabetic Equipment and Self-management Education Programs  |                                      |  |
| • Temporomandibular Joint (TMJ) Disorders (diagnosis and non-surgical treatment up to \$1,250 per year)  |                                      |  |
| • Skilled Nursing Care Facility (up to 30 days per confinement)  |                                      |  |
| <b>Prescription Drugs</b> (subject to a \$500 annual deductible) (including insulin and disposable diabetic supplies; prior approval required for certain drugs*)  |                                      |  |
| <b>Retail**</b>  |                                      |  |
| • Generic  | 30% Coinsurance After Deductible     | Not Covered                                  |
| • Brand  | 30% Coinsurance After Deductible     | Not Covered                                  |
| • Non-Formulary  | 60% Coinsurance After Deductible     | Not Covered                                  |
| <b>Mail Order**</b>  |                                      |  |
| • Generic  | 25% Coinsurance After Deductible     | Not Covered                                  |
| • Brand  | 25% Coinsurance After Deductible     | Not Covered                                  |
| • Non-Formulary  | 50% Coinsurance After Deductible     | Not Covered                                  |
| *Prior approval required when receiving certain benefits; without prior approval, benefits may be denied or substantially limited. Note: All benefits are subject to the applicable limitations and exclusions as defined in the policy. Annual benefit limitations apply per calendar year.   |                                      |  |
| **Maximum retail out of pocket \$200 per prescription after prescription drug deductible has been met. Maximum mail order out of pocket \$400 per prescription after prescription drug deductible has been met.  |                                      |  |
| IMPORTANT: This plan summary provides only a general description of benefits and limitations. You can find a detailed description of coverage in the applicable policy. Coverage is subject to all terms and conditions of the policy and any endorsements or amendments. If there is ever a disagreement between the policy and this brochure, the policy has final authority. This plan summary must be used in conjunction with the additional plan information inserts which include limitations and exclusions. In-network and out-of-network deductibles track separately. |                                      |  |

## 100% Wellness Benefit

Routine physicals, immunizations, mammograms, and other preventive services are covered 100%, with no annual dollar limit when received from a Participating Provider.

## Buy-Up Options

(available for POS and HMO plans only)

Choose our Buy-Up option to make your individual plan look and act more like a group insurance plan.

By choosing the Buy-Up option:

- Your drug deductible is waived (your prescription benefit remains 30%/30%/60% for retail and 25%/25%/50% for mail order)
- Any covered in-network office visits are paid at 100% after you pay a \$30 copayment (Applies to office visit charge only.\*)

\*See plan for details.

### 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 unit at (920) 490-6900 (local) or call 1-888-711-1444 (toll-free).

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:

- Had an Illness or Injury diagnosed,
- Received care, medical services or, treatment of an Illness or Injury,
- Had symptoms of an Illness or Injury which would cause a person to seek diagnosis, care, medical services, or treatment; or
- Had Illness or injury for which a kidney transplant procedure is being considered.

Benefits are not payable for expenses incurred as a result of that Illness or Injury and any complications of any such Illness or Injury until:

- The Covered Person has no treatment, services, supplies, or other expenses incurred for that Illness or Injury for a period of 12 months in a row after the effective date of coverage; or
- The Covered Person has been insured under this Policy for 18 months in a row; whichever, happens first.

We will not pay benefits for charges for treatment, services, supplies, or other expenses incurred during the Waiting Period for any such Illness or Injury and complications of any such Illness or Injury.

If a Dependent child is born or is legally adopted by the Policyholder while covered under this Policy, the child does not have a waiting period for such Illness or Injury.

#### Transplants

The waiting period for a covered transplant, other than kidney, is 24-months starting on the effective date of the policy.

#### The plan does not cover the following services. Please see the policy for specifics.

Services, supplies, facilities, or equipment that are not medically necessary or are experimental or investigational.

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, or insurrection.

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

Custodial or maintenance care.

Charges in excess of the usual and customary charge.

Services performed by a close relative.

Services for pervasive developmental disorders.

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.

Services provided during any waiting periods.

Telemedicine, except teleradiology.

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.

Services for smoking cessation program, treatment, or supply.

Travel and transportation for a consultation or to receive treatment.

Bereavement counseling.

Services provided before the effective date.

Services provided after the termination date.

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

