HEALTHY 1 ENGAGE

Stay Healthy. Stay Engaged.

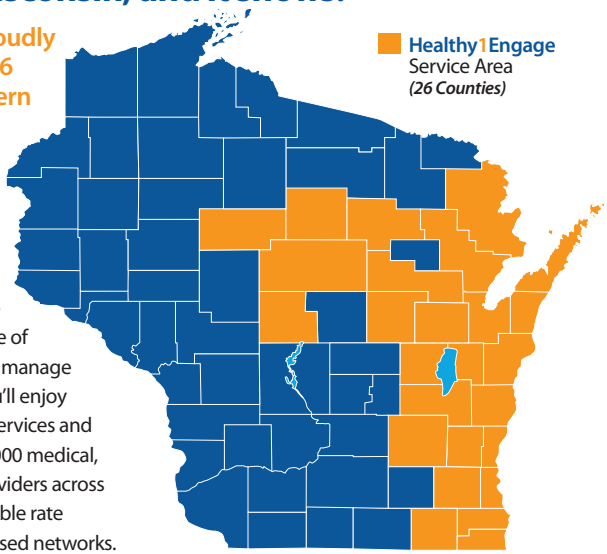
Free Preventive Care – To help you stay Healthy, Arise Health Plans include first dollar, 100% coverage for preventive services such as annual exams, well-child visits, screenings, and immunizations when performed by a participating provider.

Fitness Program Reimbursement – To help you stay Engaged, Arise members have full access to a robust network of fitness locations with a wide range of amenities.

Transparency – Arise members gain access to the Arise Transparency Site, where you can find up to the minute pricing and quality information on common health care procedures.

We Care for Wisconsin, and it shows!

Arise Health Plan proudly services families in 26 counties across eastern and northcentral Wisconsin.



FIND A DOCTOR *(Click Here)*

What is an HMO?

Arise Healthy1Engage HMO (health maintenance organization) plans are one of the most effective ways to manage your health care costs. You'll enjoy convenient access to the services and programs of more than 3,000 medical, hospital, and specialty providers across Wisconsin, all at an affordable rate made possible by our focused networks.

Our Mission, Our Pledge to You.

Arise Health Plan, health insurance carrier of the Green Bay Packers, is a local health plan dedicated to:

Providing exceptional personalized service.

Partnering with the area's best health care providers.

Delivering competitive rates and the most value for our members.

HMO SIlver $2,500 30% to $5,000 OOP
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WPS Health Plan, Inc. - ADV-BRO-0279 13-09

ABOUT THIS HEALTH PLAN

METAL LEVEL: SILVER

AVAILABLE ON MARKETPLACE? ✓
(Available on and off the exchange)

SPECIAL BONUS!
3 FREE PRIMARY CARE VISITS PER MEMBER PER YEAR!

DEDUCTIBLE:
$2,500 *In Network*

CO-INSURANCE:
30% *In Network*

MAXIMUM OUT-OF-POCKET:
$5,000 *In Network*

OFFICE VISIT CO-PAYS: *In Network*

Retail	Primary	Specialist	ER
Co-Ins*	Co-Ins*	Co-Ins*	Co-Ins*

** After deductible is met.*

PRESCRIPTION CO-PAYS:

Generic	Formulary	Brand	Specialty
$20	$50	$75	25% to $500

Arise HEALTH PLAN
www.WeCareForWisconsin.com

Limitations and Exclusions (Click Here)

2014 INDIVIDUAL & FAMILY PLANS

HEALTHY 1 ENGAGE

BACK TO PLAN OVERVIEW

BENEFIT DEFINITIONS

Deductible

The amount that you, either by yourself or in combination with other covered family members, pay for covered in-network services each year before your plan pays for specified services is your deductible.

For example, if your deductible is $1,000, services subject to the deductible will be paid by you until the $1,000 deductible is met. If you have more than 1 person on your plan, your family or group total, is twice the individual deductible. In our example, your family deductible would be $2,000. Family Member #1 has a separate $1,000 deductible and Family Member #2 has a separate $1,000 deductible - which equals the $2,000 family deductible. If there is a Family Member #3 or more, they would not be subject to the deductible requirement if the family deductible has already been met ($2,000 in our example).

Note - Deductible may not apply to all services, such as Free Preventive Services and services where Co-Pays apply.

Deductible (HSA qualified plan version)

The amount that you, either by yourself or in combination with other covered family members, pay for covered in-network services each year before your plan pays for specified services is your deductible.

For example, if your deductible is $1,000, services subject to the deductible will be paid by you until the $1,000 deductible is met. If you have more than 1 person on your plan, your family or group total, is twice the individual deductible. In our example, your family deductible would be $2,000, **in which family members would share responsibility. One member could satisfy the entire deductible or a combination of family members could satisfy the $2,000. The family deductible, or group total, must be met before this plan pays benefits.** If there is a Family Member #3 or more, they would be subject to the same shared family deductible requirement ($2,000 in our example).

Note - Deductible may not apply to all services, such as Free Preventive Services.

Co-Insurance

After you pay your plan deductible, you may still be responsible for a percentage of the charges for services received. This type of cost sharing is called coinsurance. For example, if your health plan pays 80% of billed charges, your coinsurance payment is the remaining 20%.

Maximum Out-of-Pocket

This is the most money you will be required to pay within a calendar year for deductibles, coinsurance and co-pays.

Prescription Co-Pays

The flat amount you pay to a pharmacy at the time of service. Copays accumulate to your Maximum Out-of-Pocket.

Office Visit Co-Pays

The flat amount you pay to a healthcare provider at the time of service. Co-pays accumulate to your Maximum Out of Pocket.

Metal Level

The Affordable Care Act categorizes coverage levels as "metal levels", specified as Bronze, Silver, Gold and Platinum. Bronze plans are generally less expensive and have more consumer cost-sharing, while Platinum plans are generally more expensive and have less consumer cost-sharing.

HEALTHY 1 ENGAGE

BACK TO PLAN OVERVIEW

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.

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.

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, for which an employer is required to carry workers' compensation insurance. If you are covered by workers' compensation insurance, this exclusion applies regardless of whether benefits under workers' compensation laws or any similar laws have been claimed, paid, waived, or compromised.

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.

An illness or injury as a result of the armed services of any country that occurred as a result of or 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 maximum allowable fee.

Services performed by a close relative or someone who ordinarily lives in the covered person's home.

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

Drugs, medicine, procedures, services, and supplies for or leading to 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.

Charges for missed appointments.

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 in connection with or for complications resulting from an elective surgery or other health care service that is excluded under this policy.

Services or treatments requested by a third party for employment, licensing, insurance, marriage, adoption, travel, disability determinations, or court ordered exams.

Cranial banding.

Private duty nursing.

Personal comfort or convenience items.

Marriage counseling.

Reversal of sterilization procedures.

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.

Services performed by someone who is not a licensed practitioner, except as stated in the policy.

Injection of filling material (collagen) other than for incontinence, salabrasion, rhytidectomy (face lift), dermabrasion, chemical peel, suction-assisted lipectomy (liposuction), electrolysis, mastopexy, mammoplasty, augmentation, reduction mammoplasty, correction of inverted nipples, sclerotherapy for spider veins, panniculectomy, mastectomy for male gynecomastia, botox, and all related services, supplies, or treatment.

Non-emergency services performed outside of the United States.

Educational services.

Routine foot care, except for preventive foot care for covered persons with diabetes.

Cosmetic surgery or treatment or any portion thereof, as determined by us.

Dental services, including tooth extraction, 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.

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.

Shoe orthotics, shoes, shoe inserts, or arch supports.

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

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

Repairs due to abuse or misuse of durable medical equipment.

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

Hearing services, except as stated in the policy.

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

Infertility or fertility treatment, direct attempts to achieve pregnancy or increase chances of achieving pregnancy, and evaluation and treatment of habitual abortions when not pregnant.

Birthing classes.

Abortions, unless the mother's life would be in danger, as determined by us.

Home births.

Reconstructive surgery performed only to achieve a normal or nearly normal appearance or any portion thereof, as determined by us, unless required by law.

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

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.

Expenses related to the purchase of any organ.

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

Vision services, except as stated in the policy.

Services, supplies, equipment, or facilities for obesity, morbid obesity, 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.