

# Health Tradition Health Plan

*A Mayo Health System Choice in Wisconsin*



Premier

Member Handbook

EASE

# **Member Handbook: A Guide to Using Health Tradition Premier**

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*This handbook serves as your guide for accessing healthcare services under the Health Tradition Premier healthcare plan. Keep it in a convenient location, and refer to it when you have questions about your plan.*

**Note:** *This handbook provides an overview of the Plan and is not intended to provide full details about plan benefits. Refer to the official plan documents for detailed information about your covered benefits, exclusions and limitations. If there is any discrepancy between this handbook and the plan documents, the plan documents will be relied upon for plan administration.*

*This plan is administered by Health Tradition Health Plan, whose offices are located in Onalaska, Wisconsin. Health Tradition is a managed care organization specifically designed to meet the healthcare needs of our region.*

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# Who to Contact when You Need Help

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*Health Tradition Premier offers a range of healthcare resources when you need assistance.*

When you need assistance, there are a variety of places to turn. Use the general guidelines below to help determine who to contact:

**Network healthcare provider** When you have any type of healthcare problem, unless it is life-threatening, call your network healthcare provider first. Based on your symptoms and condition, your network healthcare provider will work with you to decide how to best treat your condition.

**Ask Mayo Clinic** Ask Mayo Clinic nurses are available 24 hours a day, 365 days a year for answers to your healthcare questions. The nurses will provide you with reliable information or direct you to another resource. Simply call **1-877-817-0936** (toll-free).

**Urgent Care Clinics** Urgent care clinics are available to take care of healthcare problems that are not emergencies, but do require immediate medical attention (for example, stomach flu, skin conditions, twisted ankle, minor cuts and burns). Usually, it's best to start by calling your network healthcare provider — he or she can help you decide if you need to visit an urgent care clinic. Refer to the Health Tradition Provider Directory for a list of the Plan's urgent care clinic locations.

## Who to Contact when You Need Help, *continued*

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**Emergency Room** Emergency Rooms are available 24 hours a day to handle life-threatening medical problems. Prior authorization is not required for Emergency Room visits.

**Health Tradition Customer Service** Health Tradition Customer Service Representatives are available at **1-877-832-1823** (*toll-free*) from 7 a.m. to 7 p.m., Monday through Friday, to answer routine questions about claims, eligibility, enrollment, your membership card, plan benefits or the healthcare provider network. A 24-hour voice response unit also is available when you may not need to speak directly with a Customer Service Representative or for calls after hours.

**Health Tradition Member Advocate** Contact the Health Tradition Member Advocate at **1-888-459-3020** (*toll-free*) or **608-783-9505** if you have questions about unresolved claims, billing issues or need assistance with complaints.

**Health Tradition Referral Coordinator** If you have a question about a referral or prior authorization issue, contact the Health Tradition Referral Coordinator at **608-781-9692** or **1-888-459-3020** (*toll-free*).

**[www.healthtradition.com](http://www.healthtradition.com)** This Web site provides access to a variety of information about your health plan benefits.

# Your Membership Card

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*Carry your card at all times and present it whenever you visit a provider, clinic, hospital or pharmacy.*


Your membership card is important because it identifies you as a member of Health Tradition Premier. Show your card when you receive any healthcare services or fill a prescription.

If you choose single or family coverage, you will receive two cards. When you receive your card, please discard any previous health plan or pharmacy cards. Be sure to verify that your name and other information printed on the card are correct. If any part is incorrect or you need additional cards, please call Customer Service at **1-877-832-1823** (toll-free).

**Health Tradition Health Plan**  
*A Mayo Health System Choice in Wisconsin*

**Premier**

HTW12345601 SAMPLE, JOSEPH Q  
HTW12345602 SAMPLE, SUSAN  
HTW12345603 SAMPLE, BRANDON  
HTW12345604 SAMPLE, JESSICA  
HTW12345605 SAMPLE, PEGGY  
HTW12345606 SAMPLE, ANN  
HTW12345607 SAMPLE, KIM  
Group #: XXXX                      Group Name: Your Group Name Here  
Plan Type: Medical/Pharmacy  
RX Group: MCL    PCN: SXC    RX Bin: 610593



Never lend your card to someone else. If your card is lost or stolen, please notify Customer Service immediately at **1-877-832-1823** (toll-free).

**Note:** Your membership card is valid only as long as you are enrolled in the Plan. Possession of a card does not guarantee the benefits of plan membership.

# Healthcare Provider Network

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*The Health Tradition network offers a wide range of network healthcare providers.*

Health Tradition Premier is a comprehensive healthcare plan offering access to Franciscan Skemp Healthcare and other network healthcare providers, clinics and hospitals throughout the region. Under Health Tradition, you can visit Mayo Clinic only when you receive prior approval from the Plan.

The Health Tradition network includes healthcare providers in Wisconsin, Minnesota and Iowa. *A network is a specific group of healthcare providers under contract with Health Tradition.* Although many healthcare providers are included in the network, please check your *Health Tradition Provider Directory* to make sure your healthcare provider is listed. The Health Tradition healthcare provider network is continually updated so please call Health Tradition Customer Service at **1-877-832-1823** (toll-free) if you have a question about a specific healthcare provider.

Enrolling in Health Tradition does not guarantee services by a particular healthcare provider on the list of network healthcare providers. When a healthcare provider is no longer part of Health Tradition, you must choose among remaining Health Tradition network healthcare providers. Under certain circumstances, however, you may continue to visit that healthcare provider for a specified period of time to complete treatment.

Services provided by Health Tradition may not be covered if they are not provided by participating Health Tradition network healthcare providers or prior authorized by Health Tradition. The *Certificate of Coverage* fully defines what services are covered and describes procedures you must follow to obtain coverage.

# Accessing an Individual Healthcare Provider

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*We encourage you to choose a network healthcare provider and visit him or her for routine care.*

A healthcare provider gives you personalized, comprehensive care over time. He or she will get to know you, your medical history, your family and your lifestyle. This healthcare provider is usually your first contact with the healthcare system. A healthcare provider has knowledge about a variety of different medical disciplines and manages your total health needs. This includes arranging any referrals, inpatient stays or out-patient procedures.

Once you choose a healthcare provider, we encourage you to visit him or her for routine care. This continuity helps you feel more comfortable with your healthcare provider, and it helps your healthcare provider counsel and care for you more effectively. Serious illness often can be prevented if you are receiving quality healthcare on a regular basis from someone who knows your medical history and lifestyle. And if you do become ill, early detection and careful management of disease are important.

## **Accessing an Individual Healthcare Provider,** *continued*

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A few things to remember about choosing a healthcare provider:

- Network healthcare providers in family practice, general internal medicine, pediatrics, OB/GYN and Center for Women's Health offer primary care services.
- Take some time to carefully consider who will be your healthcare provider — it is important that you feel comfortable with your healthcare provider.
- Each family member can choose his or her own network healthcare provider.
- If you choose a new healthcare provider, we encourage you to make an appointment and give the healthcare provider an opportunity to establish an understanding of your overall health.

# Specialty Care

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*If you need specialty care, your network healthcare provider will work with you to help decide what is best for you.*

When you and your network healthcare provider decide you need specialty care, your network healthcare provider can assist you by coordinating all of your care. You can make a direct appointment with an in-network specialist. Your network healthcare provider will need to send a referral request to Health Tradition if the specialist is out-of-network. You must receive Plan authorization before visiting an out-of-network provider. If there is an appropriate specialist within your network, you will be referred to that specialist.

If a specialist refers you to another specialty care provider, you may make a direct appointment if the provider is an in-network specialist. If the specialist is out-of-network, the specialist or your network healthcare provider must send the referral request to Health Tradition. The Plan will determine if the referral is necessary prior to your visit.

If you visit a mental health/substance abuse provider for an initial assessment or a chiropractic network healthcare provider, you do not need to obtain a referral from your network healthcare provider. However, you must visit a network healthcare provider listed in the *Health Tradition Provider Directory* to receive coverage.

# Mental Health and Substance Abuse

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*Mental health and substance abuse services do not require authorization from a network healthcare provider.*

Outpatient psychotherapy services at Franciscan Skemp Behavioral Health, Family and Children's Center, or other mental health/substance abuse providers listed in the *Health Tradition Provider Directory* do not require a referral from your network healthcare provider.

After your initial assessment and treatment visits, your provider will submit a plan of care to Health Tradition for approval of continuing services. If you are seeking treatment at an out-of-network mental health provider, it is your responsibility to seek the approval for continuing care after the initial visits.

Prior authorization is required for the following types of psychological services:

- Psychological testing
- Group services
- Inpatient psychiatric and substance abuse care
- Day treatment services
- Out-of-network care

The Plan will determine if authorization is necessary prior to your visit. Although your therapist may assist you in obtaining prior authorization, Health Tradition encourages you to obtain it. Proof of a Plan-approved authorization is necessary for proper payment of a claim.

For more information on mental health and substance abuse services, please contact Health Tradition at **608-781-9692** or **1-800-459-3020** (*toll-free*).

# Referrals and Prior Authorization

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*You must receive prior authorization from the Plan for certain services to receive plan benefits.*

Certain services are covered only upon referral. Under Health Tradition Premier, you must obtain a written referral and receive the Plan's authorization *before* you visit an out-of-network specialist. It is your responsibility for making sure the referral is obtained. All referrals to non-Health Tradition healthcare providers and for certain services must be authorized by Health Tradition to be covered.

Your in-network healthcare provider is responsible for completing and signing a referral authorization request form and forwarding it to Health Tradition. You must have Plan authorization before you receive specialty care outside the network or for certain other services. In certain instances, the care may be limited to a specific type, frequency or range of dates. You will receive written confirmation indicating what services have been authorized by the Plan. Amounts exceeding the usual and customary payments will be the responsibility of the member.

Certain services, such as experimental treatments/drugs or some durable medical equipment, require prior authorization. The *Certificate of Coverage* fully defines services requiring referrals or prior authorizations to obtain coverage.

## **Referrals and Prior Authorization,**

*continued*

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In certain circumstances, you and your provider may decide you need a standing referral. Your provider is responsible for contacting the Plan to receive authorization.

If you have questions about prior authorization or referrals, please contact the Health Tradition Referral Coordinator at **608-781-9692** or **1-888-459-3020** (*toll-free*). If you have questions about who is an out-of-network healthcare provider, call Customer Service at **1-877-832-1823** (*toll-free*).

# Ask Mayo Clinic

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*Call Ask Mayo Clinic toll-free at 1-877-817-0936 (toll-free) for answers to your health questions anytime day or night.*

As a member of Health Tradition Premier, you and your family can call *Ask Mayo Clinic*, a toll-free nurse line, 24 hours a day, 365 days a year. *Ask Mayo Clinic* nurses are available to answer your health questions, help you decide what to do and give you information that helps protect your health.

*Ask Mayo Clinic* is staffed by professional, caring registered nurses. These nurses are trained to handle telephone inquiries, and they use the latest online healthcare references to answer your questions. Moreover, *Ask Mayo Clinic* only uses the most reliable medical information.

You can call *Ask Mayo Clinic* anytime. However, *Ask Mayo Clinic* does not diagnose conditions or serve as a substitute for 911.

When you call *Ask Mayo Clinic*, a nurse may:

- Ask for your name and phone number
- Ask about your symptoms and help you decide if you should visit your primary care provider, an urgent care clinic or the Emergency Room
- Give you information and instructions for how to care for yourself or a sick family member
- Answer your general health questions about conditions, medications and treatments
- Make a follow-up call for further evaluation and information, if appropriate

# Urgent Care

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*Urgent care situations are conditions that will worsen if you delay medical attention until the next available appointment, but are not life-threatening emergencies. Whenever possible, try to contact Ask Mayo Clinic or your healthcare provider and follow their directions for urgent care services.*

Show your membership card as soon as medically possible.

Urgent care clinics are available to take care of healthcare problems that are not emergencies, but do require immediate medical attention. Conditions evaluated in an urgent care clinic include:

- Upper respiratory problems
- Stomach flu
- Vaginal and urinary tract infections
- Ear infections
- Some forms of minor trauma such as sprains, strains, scrapes, cuts and minor burns

At most urgent care clinics, patients are registered on a first-come, first-served basis. The staff will make every attempt to see you as soon as medically possible after you arrive. However, as in any unscheduled care area, those who are more seriously ill or injured must be seen first.

Services at out-of-network urgent care clinics are subject to usual and customary charges. Please refer to your *Health Tradition Provider Directory* for a list of the Plan's urgent care clinics.

# Emergency Care

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*In the case of an emergency, go to the nearest hospital Emergency Room immediately or call 911.*

Show your membership card as soon as medically possible.

Emergency care is covered 24 hours a day, 7 days a week, no matter where you are or when it's needed. Prior authorization is not required for emergency care services.

*Emergency care is medical treatment required unexpectedly and immediately because of an accidental injury or emergency illness. An emergency exists when a member's symptoms are severe enough to lead a prudent layperson to reasonably conclude that immediate medical attention is necessary. It does not include elective medical treatment for an illness or injury (including follow-up care from an Emergency Room visit) for which the need for care could reasonably have been foreseen. If you receive emergency care outside of the service area and are hospitalized, please notify Health Tradition Utilization Management at **1-888-459-3020** (toll-free) within 48 hours or as soon as medically possible. If you cannot call, please have someone call for you.*

Emergency symptoms are severe and often occur unexpectedly. For example, go to the nearest Emergency Room immediately if you experience conditions such as:

- Sudden severe headache, paralysis, seizure or stroke symptoms
- Loss of consciousness
- Heavy bleeding from any source

## Emergency Care, *continued*

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- Major trauma or motor vehicle accidents
- Breathing difficulty of any type
- Chest pain or pressure
- Severe pain
- Head or neck injuries
- Fractures

Emergency care does not include elective medical treatment for an illness or injury for which the need for care could reasonably have been foreseen or follow-up care after an emergency.

Services at out-of-network providers are subject to usual and customary charges. Please refer to your *Health Tradition Provider Directory* for a list of the Plan's emergency care facilities.

# Hospitalization

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*You may be admitted to any Health Tradition hospital. Your healthcare provider will coordinate your hospital admission.*

When you need hospital care, you may go to any Health Tradition network hospital. Your network healthcare provider will coordinate your hospital admission. Your healthcare provider may make a request to the Plan to use an out-of-network hospital if the service is not provided in the network. If you are admitted to a hospital for an elective procedure, please contact Utilization Management at **1-888-459-3020** (toll-free) or **608-781-9692** at least two days prior to the admission.

If you are admitted to a hospital as a result of an emergency, please contact Utilization Management at **1-888-459-3020** (toll-free) or **608-781-9692** within 48 hours or as soon as medically possible. If you are not able to call, please ask a family member or your healthcare provider to call for you. Failure to notify the Plan may result in claims being denied for payment.

Present your membership card when you arrive at the hospital. Please refer to your *Health Tradition Provider Directory* for a listing of Health Tradition network hospitals.

# Preventive Care

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*Health Tradition Premier provides comprehensive coverage for preventive care.*

Preventing illness is one of the best ways to improve your quality of life. Preventive care programs are part of the plan, which includes coverage at in-network providers for:

- Preventive physical exams
- Lab and x-rays per current Preventive Guidelines
- Well-child care (frequency determined by your network healthcare provider)
- Well-woman gynecological exams, including Pap smears
- Mammograms
- Adult and child immunizations
- Hearing exams (one exam per calendar year)
- Vision exams (one exam per calendar year)

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### Some helpful definitions

**Physical exam:** A preventive physical exam includes a health history, medical examination, associated counseling and certain preventive x-ray and lab tests. If you have a current illness or chronic condition that requires ongoing monitoring and related tests, this portion of your exam will **not** be considered preventive.

**Immunizations:** Routine preventive immunizations for children and adults are covered under Health Tradition Premier. Immunizations for foreign travel are **not** covered.

**Hearing exam:** A hearing exam includes an initial history, hearing exam, associated counseling and discussion of exam results.

**Preventive care:** Medical care emphasizing prevention and early detection by performing periodic, regular testing and other services.

**Vision exam:** A vision exam includes a refractive eye exam and glaucoma screening. The fitting and repair of glasses or contacts and surgeries to correct vision are **not** covered under Health Tradition Premier.

# Filing Claims

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*You do not need to file paper claims if you receive care within the Plan's network.*

When you visit a Health Tradition network healthcare provider (as outlined in your *Provider Directory*), you do not need to file any healthcare claims — your network healthcare provider will file them for you. Please inform your Health Tradition network healthcare provider that you are a Health Tradition member.

When you visit healthcare providers outside the network, simply present your membership card for billing. Information for filing a claim is located on the back of your card. You usually do not have to file claims. However, an out-of-network provider may not file a claim and bill you immediately instead.

If there is a situation where you need to pay for healthcare services and then file a claim to be reimbursed, follow these simple steps:

- Obtain an itemized bill and receipt from the healthcare provider. Each bill should include items such as the patient's full name, date(s) of service, type(s) of service, diagnosis, network healthcare provider's name and address and itemized charges.
- Record your ID number from the front of your membership card on the bill.
- Submit the original itemized bill and receipt of payment to:

**Health Tradition Health Plan**  
**c/o MMSI**  
**4001 41st Street N.W.**  
**Rochester, MN 55901-8901**

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## **Filing Claims**, *continued*

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After the claim has been processed, your reimbursement will be mailed to the healthcare provider, unless you provide proof of payment.

If you have questions about this process, please call Customer Service at **1-877-832-1823** (*toll-free*).

# Prescription Drug Plan

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*You have a national network of nearly 55,000 pharmacies where you can conveniently obtain prescriptions.*

Health Tradition has contracted with SXC Health Solutions, Inc. to provide you with a national network of nearly 55,000 pharmacies. This allows you to obtain prescriptions conveniently in your community, or across the country, for the same copayment amount. Simply present your membership card to your pharmacist to verify whether the pharmacy participates in the SXC network. If you have questions about whether a specific pharmacy is in the network, please call Customer Service at **1-877-832-1823** (toll-free).

If you receive a prescription from a non-SXC pharmacy, you will only receive benefits in an emergency situation. To receive a reimbursement, please contact Customer Service.

Your prescription drug plan is based on the *Health Tradition Formulary*. The formulary is a list of Health Tradition-approved drugs that your health plan will cover. If you have a prescription for a drug that is on the *Health Tradition Formulary* and covered under Health Tradition Premier, you pay either the generic or brand name copayment amount. If a drug is not listed on the formulary or not covered under the Plan, you either will be responsible for a larger copayment or the entire cost of the medication, depending on your plan. Please consult with your healthcare provider to consider switching to an alternate medication listed on the formulary — all network healthcare providers have access to the *Health Tradition Formulary*. You can be assured that these prescription drugs have been through a rigorous approval process to ensure the highest quality.

### **How This Plan Works**

Under Health Tradition Premier, you pay a single copayment for up to a 34-day supply, excluding diabetic supplies. You may receive a generic drug or a brand name drug without a generic equivalent for a single copayment. The generic copayment generally is a lower amount than the brand name copayment. If you receive a brand name drug when a generic equivalent is available, you pay the generic copayment *plus* the difference in price between the brand name and generic drug. Health Tradition encourages you to discuss your prescription options with your healthcare provider. Please refer to your *Summary of Benefits* for exact copayment amounts.

Certain insulin and anti-migraine medications have monthly limitations per copayment. Self-injectable medications must be purchased at an SXC pharmacy. These medications will be subject to a coinsurance percentage, identified in your *Summary of Benefits*, until the drug maximum out-of-pocket limit is reached, if applicable.

You may visit the [www.healthtradition.com](http://www.healthtradition.com) Web site to learn more about your pharmacy benefits or to view the abridged *Health Tradition Formulary*.

# Coordination of Benefits

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*If you or one of your family members has coverage with more than one health plan, Health Tradition will work with you to coordinate the benefits.*

If both Health Tradition Premier and another health plan cover you or your family, these plans will coordinate benefits and share the responsibility for paying your eligible healthcare costs. You may not, however, be reimbursed for more than the cost of any healthcare service you receive.

Coverage with more than one health plan most often occurs when two spouses work for different employers and each enrolls the other and/or children in their health plan. When this occurs, one health insurance plan becomes primary and one becomes secondary.

- If Health Tradition Premier is primary, you will need to file your Explanation of Benefits (EOB) forms with your secondary insurance plan. *An EOB is a form sent to you after a claim has been processed outlining how much money the Plan paid and the amount you are personally responsible for paying.*
- If Health Tradition Premier is secondary, you will need to file your primary insurance plan's EOB forms or Medicare Summary of Notice with Health Tradition. It is your responsibility to provide us with complete information about your other health insurance plan(s). If we do not have complete information, we cannot process your claims correctly.

If you have questions about this process, please contact Customer Service at **1-877-832-1823** (toll-free).

# Complaints

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*Our Customer Service Representatives and Member Advocates are available to address your complaints.*

If you have a complaint about any aspect of Health Tradition Premier, you may take the following steps:

1. Contact Customer Service at **1-877-832-1823** (*toll-free*). Our Customer Service Representatives will help you try to solve the problem on an informal basis and will document your oral complaint.
2. If you are unable to work out the complaint through Customer Service, please contact our Member Advocate at **608-783-9505** or toll-free at **1-888-459-3020** (*toll-free*). The Member Advocate works directly with you to help find an informal or formal solution to the complaint.
3. If the informal solutions are not satisfactory, you may submit a written complaint to — **Health Tradition, P.O. Box 188, La Crosse, WI 54602-0188**. The Health Tradition Grievance Committee will review the complaint, and you will receive a written response, normally within 30 days of receipt of the complaint.
4. You may request an appeal to be resolved on an expedited basis for an urgent care situation. We can help you decide if it is urgent. Please contact our Member Advocate at **608-783-9505** or toll-free at **1-888-459-3020** for assistance.
5. The decision of the grievance committee is the final step by Health Tradition Health Plan. If you do not agree with the decision of the grievance committee, you have the right to request and obtain an independent review

of denial of a claim, referral under certain conditions or experimental treatment. The right to independent review *does not apply* when Medicare denies you coverage for benefits that are not covered by Medicare. Please contact our Member Advocate at **608-783-9505** or toll-free at **1-888-459-3020** for assistance.

6. You may resolve a problem by taking the steps outlined above. You may also contact the Office of the Commissioner of Insurance, a state agency that enforces Wisconsin's insurance laws, and file a complaint. You may contact the Commissioner of Insurance/Complaints Department by calling 1-800-236-8517 or (608) 266-0103 and requesting a complaint form.

Please refer to your *Certificate of Coverage* for more information.

# Helpful Tips when Visiting Your Healthcare Provider

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*To get the most out of visits to your healthcare provider, be sure to accurately communicate your symptoms.*

## **Analyze Your Symptoms**

Before each healthcare appointment, refer to the questions below to help describe your symptoms:

- What is your main health concern?
- How long have you had these symptoms?
- How often do the symptoms occur?
- Do symptoms come and go, or are they persistent?
- What brings it on (activity, food, position, stress)?
- Is it associated with any other symptoms?
- Have other people in your family experienced similar problems?

Knowing the answers to these questions, as well as your personal and family medical history, makes diagnosing and treating your present problems easier and more efficient. If you are transferring from another healthcare plan or provider, please have your medical records transferred to your new healthcare provider.

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## Helpful Tips when Visiting Your Healthcare Provider, *continued*

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### During Your Visit

During your visit, remember to:

- **Answer questions accurately and completely.** Be specific and give examples when you can.
- **Listen carefully.** Repeat what you heard. Ask your healthcare provider to confirm or clarify the accuracy of the information.
- **Ask questions.** Whether your healthcare provider recommends tests, surgery, a special diet or medication, try to have all your questions answered during your appointment. Before you leave the visit, you should be able to describe your problem, explain your treatment and state if and when you need to return.
- **Follow instructions exactly.** If you are unable to follow your healthcare provider's instructions, explain why. Tell your healthcare provider of any adverse effects, symptoms or complications.
- **Consider your coverage.** If you have a question about whether a service or procedure is covered, you may call Customer Service during your visit, if possible.

# For More Information

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*We want you to understand Health Tradition Premier and how it works.*

**Summary of Benefits** This table outlines what you pay for services covered under the plan. Please keep this in a convenient place, and refer to it when you have general questions about plan benefits.

**Provider Directory** This directory lists the network healthcare providers, clinics, hospitals and allied service providers (for example, durable medical equipment) in your network.

**Member Handbook** The handbook (this booklet) explains how your plan works, how to access medical services and who to call with questions. Keep this booklet in a convenient place and refer to it when you have questions about how to use your plan.

**Certificate of Coverage** This legal document outlines the details of your plan. Please keep this document in a safe place, and refer to it when you have detailed plan and benefit questions.

**Who to Call** Our Customer Service Representatives are available to help you with any questions or concerns you may have about the plan. Our phone lines are open from 7 a.m. to 7 p.m., Monday through Friday. A 24-hour voice response unit also is available when you may not need to speak directly with a Customer Service Representative or for calls after hours.

**Web Site** The [www.healthtradition.com](http://www.healthtradition.com) Web site provides access to a variety of information about your health plan benefits. You may also access claim and eligibility information at [www.MMSIServices.com](http://www.MMSIServices.com).

# Member Bill of Rights

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*Members have the following rights under Wisconsin law.*

Along with your rights under the *Certificate of Coverage*, you also have these rights under law:

**To choose.** Members have the right to choose a personal healthcare provider from the Plan's network of healthcare providers. Health Tradition encourages you to establish a relationship with that network healthcare provider.

**To information.** Members have the right to information about the benefit plan relating to covered services and excluded healthcare benefits; available healthcare providers; preventive care; their illness and its care; the process to make known a complaint or request; and policies/procedures relevant to their care.

**To privacy and confidentiality.** Members have the right to privacy and confidentiality of all communications and records on covered services received.

**To participate in their care.** Members have the right to be active in decisions about their treatment. Members have the right to a candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost of benefit coverage. Members have the right to be informed about the risks and benefits of treatment and to refuse care.

**To present a complaint/grievance.** Members have the right to voice concerns about their care and to receive a prompt and fair review of any complaints.

**To be treated with respect and dignity.** Members have the right to be treated with respect and dignity regardless of race, age, gender, or creed.

# Member Responsibilities

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*Members have the following responsibilities under Wisconsin law.*

As a member of Health Tradition Premier, you have the following responsibilities under the Plan:

**To know their benefits and responsibilities.** Members have a responsibility to understand their health plan benefits, follow the required procedures, know how to use the Plan's provider network, and ask questions about things they don't understand.

**To provide accurate information.** Members have a responsibility to provide accurate and complete information about their health history and eligibility/enrollment. Members have a responsibility to show their membership card each time they receive services and to fulfill any financial obligations they may incur.

**To participate in their care.** Members have a responsibility to participate in their care by asking questions to understand their illness, following the recommended/agreed upon treatment plan, and making healthy lifestyle choices to try to maintain their health and prevent illness.

**To keep their appointments.** Members have a responsibility to keep their appointments or to give early notice if they must cancel.

**To show consideration and respect.** Members have a responsibility to show consideration and respect to healthcare providers and staff.

# Consumer Information

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**Cancellation** Your coverage may be cancelled by you or Health Tradition only under certain conditions. Your *Certificate of Coverage* describes all the reasons for the cancellation.

**Continuation** You may convert to an individual health maintenance organization contract or continue coverage under certain circumstances. These continuation and conversion rights are explained fully in the *Certificate of Coverage*.

**Exclusions and Limitations** Certain services or medical supplies are not covered. You should read the *Certificate of Coverage* for a detailed explanation of all exclusions and limitations.

**Full-time Student** Full-time students attending school outside the service area may receive the following covered services:

- Emergency care or urgent care without prior authorization. Prior authorization is required for subsequent follow-up care and durable medical equipment provided by an out-of-network healthcare provider.
- Coverage for healthcare services, supplies, or items is provided only if such healthcare services, supplies, or items could not reasonably be expected to be performed or obtained from an in-network healthcare provider.
- Limited mental health or chemical dependency outpatient treatment services as outlined in the mental health and chemical dependency services section.

**Newborn Coverage** If your health plan provides for dependent coverage, a newborn infant is covered from birth, but only for services provided under the terms of your *Certificate of Coverage*. Certain services are covered only upon referral or with prior authorization. It is your responsibility to enroll your newborn with the Plan. Health Tradition

will not automatically know of the infant's birth or that you would like coverage. If your health plan requires additional premium for each dependent, Health Tradition is entitled to all premiums due from the time of the infant's birth until the time you notify Health Tradition of the birth.

**Second Opinion** Coverage is provided for a second opinion on a covered service from an in-network healthcare provider. A member must have a Plan-approved referral to visit an out-of-network healthcare provider for a second opinion. Any tests, procedures, treatments or surgeries recommended by that out-of-network healthcare provider must be performed by an in-network healthcare provider unless a referral approved by the Plan is obtained for follow-up care from an out-of-network healthcare provider.

**Usual and Customary Charges** Usual and customary dollar amounts refer to the difference between what a provider or facility charges and what Health Tradition allows as payment for that service. Health Tradition allowances are based on a national standard specific to the zip code for your network healthcare provider. Participating network healthcare providers accept Health Tradition allowances as full payment, resulting in no differences being billed to you, although cost-sharing amounts will apply. Cost-sharing amounts include copayments, coinsurance, deductibles and hospital confinement fee amounts. Non-participating network healthcare providers (those not participating in the Health Tradition network) will bill the difference to you.

Members who have referrals to non-participating healthcare providers will be personally responsible for the usual and customary differences. A referral only approves access to the healthcare provider; it does not guarantee full payment of the charges.

# Glossary

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**Annual out-of-pocket limit** The maximum cost sharing amounts you will have to pay for covered services, excluding prescription drugs, received in a calendar year.

**Claim** A request for payment from the Plan.

**Cost-sharing amount** The dollar amount a member is responsible for paying when covered services are received from a healthcare provider. Cost-sharing amounts include coinsurance, copayments, deductibles and hospital confinement fee amounts.

**Covered services** Medically necessary medical treatment and other healthcare services for which benefits will be provided, unless limited or excluded by the *Certificate of Coverage*.

**Emergency care** Medical treatment required unexpectedly and immediately because of an accidental injury or emergency illness. An emergency shall exist when a member's symptoms are of sufficient severity to lead a prudent layperson to reasonably conclude that immediate medical attention is necessary. It does not include elective medical treatment for an illness or injury for which the need for care could reasonably have been foreseen.

**Exclusions** Charges, services or supplies not covered by the Plan.

**Healthcare provider** Institutional healthcare providers or individual healthcare providers (practitioners) providing healthcare services to members.

**Individual healthcare provider** The healthcare professional (for example, a physician, physician assistant or nurse healthcare provider) who provides primary care medical services and usually serves as your initial contact with the healthcare system. Primary care areas include family medicine, pediatrics, internal medicine, OB/GYN and Center for Women's Health.

**In-network providers** A specific group of healthcare providers that have an agreement with the Plan to provide services to the member.

**Inpatient services** Provided when you are admitted to the hospital for at least 24 hours. Inpatient services include room and board as well as nursing, diagnostic, therapeutic, medical or surgical services.

**Member** A subscriber or dependent who is participating under the benefit plan.

**Membership card** An identification card issued in the subscriber's name identifying the membership number of the subscriber.

**Out-of-network providers** Providers who do not have an agreement with the Plan to provide services to the member.

**Outpatient services** Healthcare services provided to you when you do not require a 24-hour stay in the hospital. Outpatient services may be provided in a healthcare provider's office, hospital, diagnostic center or surgical facility.

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**Prior authorization** The process of receiving written approval from the Plan for certain services or products in advance of the service or product being provided. Prior authorization does not guarantee payment of benefits.

**Referral** A written form from an in-network healthcare provider requesting authorization for a specific scope of services to be provided by an out-of-network healthcare provider. The Plan must approve referrals in writing to out-of-network healthcare providers before those services are received.

**Urgent Care** A condition requiring medically necessary care to treat an unforeseen illness or injury which is necessary to prevent serious deterioration of a member's health, and which cannot be reasonably delayed until the next available appointment with a member's individual healthcare provider.







# Health Tradition Health Plan

*A Mayo Health System Choice in Wisconsin*

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