

Member Handbook



Premier|*One*

Member Handbook: A Guide to Using Health Tradition Premier One Individual Plan.

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

Women's Health and Cancer Rights Act — Required Notice

Medical and surgical benefits to women who have undergone a mastectomy, a surgical procedure to remove the breast or breast tissue, were expanded under the federal Women's Health and Cancer Rights Act in 1998. The bill has a provision that requires health plans to provide coverage for certain mastectomy-related procedures. As an eligible plan member, you receive coverage for reconstruction of the

breast on which the mastectomy was performed, breast prosthesis (artificial substitute), surgery of the other breast to produce a symmetrical appearance and physical complications resulting from a mastectomy, including, but not limited to, lymphedemas. Please refer to the Certificate of Coverage for a description of mastectomy related benefits available under your health plan.

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

Health Tradition Health Plan offices are located in Onalaska, Wisconsin. Health Tradition is a managed care organization specifically designed to meet your health care needs and the health care needs of our region.

In This Handbook

Who to Contact When You Need Help	6
Health Care Provider Network	7
Choosing a Primary Health Care Provider	8
Your Membership Card	8
Referral and Specialty Care	9
Prior Authorization	9
<i>Ask Mayo Clinic 24-Hour Nurse Line</i>	10
Mayo Clinic Tobacco Quitline	10
Mayo Clinic EmbodyHealth Portal	11
Preventive Care	11
Urgent Care	12
Emergency Care	12
Hospitalization	13
Filing Benefit Claims	13
Coordination of Benefits	14
Complaints	14
For More Information	15
Member Bill of Rights	16
Member Responsibilities	16
Consumer Information	17
Glossary	18

Who to Contact When You Need Help

Health Tradition Premier One individual plan offers a range of health care resources when you need assistance.

When you need assistance, you have a variety of resources to choose from. Use the general guidelines below to help determine who to contact.

Your Health Care Provider

When you have any type of medical problem, contact your health care provider first. Based on your symptoms and condition, your health care provider will work with you to decide how to best treat your condition.

Ask Mayo Clinic

The nurse line is available 24 hours a day, 7 days a week as a strategic resource that will help you select the right level of care for illness or injuries, including self-care when appropriate. Call 1-877-817-0936 (toll-free).

Mayo Clinic Tobacco Quitline

You have access to Mayo Clinic Tobacco Quitline. Mayo Clinic physicians, nurses, researchers and professional counselors designed this innovative, telephonic tobacco cessation program to help you become tobacco-free. Call 1-888-642-5566 (toll-free) TDD: 1-866-257-2971.

Urgent Care Center

Urgent care centers are available to treat illnesses or injuries (for example, sprained ankle, minor cuts and burns) that are not life-threatening but do require medical attention before your health care provider may be available.

Members must notify the Plan of Urgent Care when out-of-network services are received within three business days. Members can call the Referral Coordinator at 1-608-781-2118 or 1-888-758-7848 (toll-free).

Emergency Room

Emergency rooms are available to treat conditions that require immediate care to preserve life, to prevent serious impairment to bodily function and organs, or to avoid placing your physical or mental health in serious jeopardy. These are available 24 hours a day. In the case of an emergency, go to the nearest hospital emergency room immediately or call 911 or emergency medical help.

Health Tradition Customer Service

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

Plan Materials

Information, such as this brochure, explains your plan and your individual responsibilities — please refer to your Certificate of Coverage for detailed information regarding your health plan coverage.

Health Care Provider Network

The Health Tradition provider network offers a wide range of network health care providers.

Health Tradition Premier One individual health plan is a comprehensive health care plan offering access to Franciscan Skemp Health Care, Luther Midelfort and other Mayo Health System providers, clinics and hospitals. Under Health Tradition, you can visit Mayo Clinic only when you receive prior approval from the Plan. The Health Tradition network includes health care providers in Wisconsin, Minnesota and Iowa.

A network is a specific group of health care providers under contract with Health Tradition. Although many health care providers are included in the network, please check the Health Tradition Provider Directory available at www.healthtradition.com to make sure your health care provider is listed. The Health Tradition health care 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 health care provider.

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

are covered and describes procedures you must follow to obtain coverage.

Note: Every effort is made to ensure the provider directories are accurate when issued. However, because facilities constantly change health care providers, we cannot guarantee that a particular health care provider listed in a directory will be participating at the time you seek care. In addition, some of the listed health care providers may occasionally close their practices to new patients.

Out-of-Network Care

Your plan does not provide out-of-network coverage unless it is a medical emergency. In most cases, you receive a higher level of benefits when you receive care from a health care provider within the network. If you select an out-of-network health care provider, you may be responsible for all charges.

If a situation arises and you need medical attention, please contact Customer Service at the number located on the back of your membership card. Prior authorization may be required and is your responsibility. Should you need emergency care or hospitalization for a life-threatening medical problem, go to the nearest emergency room. Please notify the plan within 48 hours or as soon as medically possible. In some situations you may need to pay upfront for services received and file a paper claim for reimbursement.

Choosing a Primary Health Care Provider

A health care provider gives you personalized, comprehensive care over time. He or she will get to know you, your medical history and your lifestyle. This health care provider is usually your first contact with the health care system. Drawing on all of the major disciplines, a personal health care provider works in the primary care setting and manages your total health needs. When choosing a personal health care provider:

- Take some time to carefully consider who will provide for your primary care needs — it is important that you feel comfortable with

your health care provider.

- Each family member can choose his or her own personal care provider.
- If you choose a new personal health care provider, you are encouraged to make an appointment and give the provider an opportunity to establish an understanding of your overall health.

Please refer to your Certificate of Coverage for detailed information about your plan benefits.

Your Membership Card

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

If you choose single or family coverage, you will receive two cards. Show your membership card when you receive any medical services. If you are enrolled in the prescription drug program, show the card to the pharmacy representative when filling prescriptions. Additional cards are available upon request or through **www.healthtradition.com**. When you receive your cards, please discard any previous health plan or pharmacy cards. Be sure to verify that your name and other information printed on the cards are correct. If any part is incorrect, please call the Customer Service number located on the back of your membership card.

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.

Referrals and Specialty Care

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 One, you must obtain a written referral and receive the Plan's authorization before you visit an out-of-network provider or specialist.

It is your responsibility for making sure the referral is obtained. All referrals to out-of-network health care providers and for certain services must be authorized by Health Tradition to be covered. Your in-network health care 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 some 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 or drugs or some durable medical equipment, require prior authorization. The Certificate of Coverage fully defines services requiring referrals or prior authorizations to obtain coverage. 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 a specialist refers you to another specialty care provider, you may make a direct appointment if the provider is an in-network specialist.

If you have questions about prior authorization or referrals, please contact the Health Tradition Referral Coordinator at 1-608-781-2118 or 1-888-758-7848 (toll-free). If you have questions about who is an out-of-network health care provider, call Customer Service at 1-877-832-1823 (toll-free).

Prior Authorization

Prior authorization is required from the plan for specific services before they are rendered. Listed below are some of the common services that require prior authorization from the plan. Please check your Certificate of Coverage for more information.

- Durable medical equipment, orthotics or prosthetics over \$750 or any rental to exceed four months
- Home health care
- Hospice care
- Mental health/chemical dependency
- Nonemergency hospital admissions — notify plan within 48 hours or as soon as medically possible

- Skilled care unit or acute rehabilitation
- Transplants

How to Obtain Prior Authorization

To obtain prior authorization for appropriate services, please contact the Health Tradition Referral Coordinator at 1-608-781-2118 or 1-888-758-7848 (toll-free). In order to receive the highest level of benefits, it is important that you make this phone call before you receive the medical service. Refer to your Certificate of Coverage for more information.

Note: Failure to obtain prior authorization or a referral when required may result in those services not being covered by the Plan.

Ask Mayo Clinic 24-hour Nurse Line

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

As a member of Health Tradition Premier One Individual Plan, you have direct access to *Ask Mayo Clinic*, a nurse line available 24 hours a day, 7 days a week. The nurses from *Ask Mayo Clinic* 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 health care references to answer your questions. *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 provide answers to plan benefit questions and is not a substitute for 911 or your medical emergency number. 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 health care provider, an urgent care center 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

Mayo Clinic Tobacco Quitline

Mayo Clinic Tobacco Quitline offers assessment and individualized counseling by phone in the comfort and privacy of your home. Professional counselors assess your readiness to change as well as motivate, encourage and help you move along the continuum of change to a new life without tobacco. While smoking is the most common form of tobacco use, Mayo Clinic Tobacco Quitline also offers an innovative

program for smokeless tobacco. If you use tobacco and would like to begin the journey to being tobacco-free, call today. Counselors are available between 7 a.m. and 7 p.m. Central time, Monday through Friday, and from 10 a.m. to 4 p.m. Central time, Saturdays, excluding holidays. For more information or to enroll, just call toll-free 1-888-642-5566 or TDD: 1-866-257-2971.

Mayo Clinic EmbodyHealth Portal

As part of your health plan benefits, you now have access to a state-of-the-art Web portal providing you with personal health management tools and wellness information that will help you and your family reduce health risks and maintain a healthy lifestyle. With this new tool you can:

- Look up claims status
- View and print your Explanation of Benefits (EOB)
- Learn healthy lifestyle behaviors

- Review your medication history
- And much more ...

To visit your Mayo Clinic EmbodyHealth portal, follow these steps:

1. Visit **www.healthtradition.com**.
2. Select the “Health and Wellness” tab.
3. Choose “Mayo Clinic EmbodyHealth” login located in the drop down menu.
4. Register or log in to the EmbodyHealth Web portal.

Preventive Care

Health Tradition Premier One individual plans provide 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 up to \$500 annually at in-network providers for:

- Preventive physical exams
- Lab and X-rays per current preventive guidelines
- Well-child care
- Well-woman gynecological exams, including Pap tests
- Mammograms
- Adult and child immunizations
- Hearing exams (one exam per calendar year)
- Vision exams (one exam per calendar year)

Some helpful definitions

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

Immunizations: Routine preventive immunizations for children and adults are covered. Immunizations for foreign travel are not covered.

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.

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.

Urgent Care

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 health care 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 health care 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, people 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 in-network urgent care clinics.

Emergency Care

In the case of an emergency, go to the nearest hospital emergency room immediately or call 911 or your medical emergency number.

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 for 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.

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

If you receive emergency care that is considered out-of-network and are hospitalized, please notify Health Tradition Utilization Management at 1-888-758-7848 (toll-free) within 48 hours or as soon as medically possible. If you cannot call, please have someone call for you.

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 in-network emergency care facilities.

Hospitalization

When you need hospital care, you may go to any Health Tradition network hospital. Your network health care provider will coordinate your hospital admission. If you are admitted to a hospital for an elective procedure, please contact Utilization Management at 1-888-758-7848 (toll-free) or 1-608-781-2118 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 1-888-758-7848 (toll-free) or 1-608-781-2118 within 48 hours or as soon as medically possible. If you are not able to call, please ask a family member or your health care provider to call for you. Failure to notify the Plan may result in claims being denied for

payment. See Emergency Care section for more information.

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.

Filing Benefit Claims

You do not need to file paper claims if you receive care within the provider network.

When you visit an in-network health care provider (as outlined in the Provider Directory), you do not need to file any medical claims — your health care provider will file them for you.

If you have a medical emergency that requires you to seek out-of-network emergency care, present your membership card upon arrival and, in most cases, they will handle the billing process. If there is a situation where you need to pay all or a portion of the charges for medical services and then file a claim to be reimbursed, follow these simple steps:

Step 1 — A claim should be filed on a universal billing form and must include the name of the plan; place of service; patient's full name, address and date of birth; date(s) of service; service

code(s); provider's name, credentials, address and tax ID number; diagnosis code; and amount of billed charges.

Step 2 — Write the ID number from the front of your membership card on the form.

Step 3 — Submit the original universal billing form and proof of payment to:

**Health Tradition c/o MMSI
4001 41st Street NW
Rochester, MN 55901-8901**

After the claim has been processed, payment for covered services will be mailed directly to you or your health care provider, as appropriate.

Note: Claims must be submitted within one year of the service being provided in order to be processed for payment.

Coordination of Benefits

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 One and another health plan cover you or your family, these plans will coordinate benefits and share the responsibility for paying your eligible health care costs. You may not, however, be reimbursed for more than the cost of any health care 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 One 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 One 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

Customer service representatives are available to answer your questions and address your complaints.

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

- 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.
- If you are unable to resolve the complaint through Customer Service, please contact our Member Advocate Department at 1-608-783-9505 or 1-888-459-3020 (toll-free). We will work directly with you to help find an informal or formal solution to the complaint.
- 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 Reconsideration Committee will review the complaint within 15 calendar days (if pre-service) or 30 calendar days (if post-service) of receipt of your letter. You will receive a written response, normally within 30 days of receipt of the written complaint.
- If you do not agree with the decision of the Reconsideration Committee, you have the option to make an additional appeal to our Grievance Committee to reconsider this decision within thirty (30) days. *Making an additional appeal to the Grievance Committee does not take away your right to have an independent review.*

Please refer to your Certificate of Coverage for more information.

For More Information

We want you to understand Health Tradition Premier One 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 A provider directory is available online at www.healthtradition.com and lists the network health care 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. Central time, 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. You may reach a Customer Service representative by calling 1-877-832-1823.

Web Site Health Tradition's Web site, www.healthtradition.com, provides access to a variety of information about your health plan benefits. You may also access claim and eligibility information at www.MMSIservices.com.

Member Bill of Rights

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 health care provider from the Plan's network of health care providers. Health Tradition encourages you to establish a relationship with that network health care provider.

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

Members have the following responsibilities under Wisconsin law.

Members of Health Tradition Premier One 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 health care providers and staff.

Consumer Information

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.

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
- Coverage for health care services, supplies, or items is provided only if such health care services, supplies, or items could not reasonably be expected to be performed or obtained from an in-network health care 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 health care provider. A member must have a Plan-approved referral to visit an out-of-network health care provider for a second opinion. Any tests, procedures, treatments or surgeries recommended by that out-of-network

health care provider must be performed by an in-network health care provider unless a referral approved by the Plan is obtained for follow-up care from an out-of-network health care 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 health care provider. Participating network health care 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. Nonparticipating network health care providers (those not participating in the Health Tradition network) will bill the difference to you.

Members who have referrals to nonparticipating health care providers will be personally responsible for the usual and customary charges. A referral only approves access to the health care provider; it does not guarantee full payment of the charges.

Glossary

Annual out-of-pocket maximum 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 health care provider. Cost-sharing amounts include coinsurance, copayments, deductibles and hospital-confinement fee amounts.

Covered services Medically necessary medical treatment and other health care 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.

Health care provider Institutional health care providers or individual health care providers (practitioners) providing health care services to members.

Individual health care provider The health care professional (for example, a physician, physician assistant or nurse health care provider) who provides primary care medical services and usually serves as your initial contact with the health care 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 health care providers that have an agreement with the Plan to provide services to the member.

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

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 health care provider requesting authorization for a specific scope of services to be provided by an out-of-network health care provider. The Plan must approve referrals in writing to out-of-network health care providers before those services are received.

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

Health Tradition Health Plan

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