HEALTH TRADITION

A Higher Level of Health

2019

OUTLINE OF MEDICARE SELECT COVERAGE

65Plus Platinum

Medicare Select Policy

The Wisconsin Insurance Commissioner has set standards for Medicare Select insurance. This policy meets these standards. It, along with Medicare, may not cover all of your medical costs. You should carefully review all policy limitations. For an explanation of these standards and other important information, see "Wisconsin Guide to Health Insurance for People With Medicare," given to you when you applied for this policy. Do not buy this policy if you did not get this guide.

Healthcare Security For Your Retirement

Health Tradition 65Plus Platinum is a Medicare Select Policy

Disclosures: Use this outline to compare benefits and premiums among policies.

Premium information: Health Tradition Health Plan can only increase your premium if we increase the premium for all policies like yours in this state. Your premium will also change on the first day of the month following your birthday which places you in a new age category.

Read your policy very carefully: This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

Right to return policy: If you find that you are not satisfied with your policy, you may return it to Health Tradition Health Plan, 45 Nob Hill Road, Madison, WI 53713. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments directly to you.

Policy replacement: If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Notice: This policy may not fully cover all of your medical costs.

Neither Health Tradition Health Plan nor its agents are connected with Medicare.

Plan Overview

Why do you need the coverage offered by Health Tradition 65Plus Platinum?

You may have discovered that Medicare does not cover everything. And you're right. Medicare does not pay for all your healthcare bills.

- For some services, you must pay a deductible and coinsurance before Medicare payments begin.
- In addition, Medicare limits or denies coverage for some preventive care, illnesses or lengthy hospitalizations.
- Health Tradition 65Plus Platinum pays for Medicare Part A and Medicare Part B deductibles and coinsurance that you will otherwise have to pay under the federal Medicare Program.

That is why Health Tradition Health Plan offers the Health Tradition 65Plus Platinum plan to help pay some of the healthcare expenses that Medicare does not pay. Health Tradition 65Plus Platinum supplements Medicare benefits to give you additional coverage for Medicare eligible expenses.

Health Tradition 65Plus Platinum also provides coverage for other healthcare services not covered by Medicare.

Please note that Health Tradition 65Plus Platinum members should receive their healthcare services from in-network healthcare providers to receive the supplemental benefits. Exceptions include emergency care, urgent care received outside the service area, limited benefits for a foreign travel emergency and services with a plan-approved referral or prior authorization.

Who is Eligible for Health Tradition 65Plus Platinum?

To be eligible for Health Tradition 65Plus Platinum you must:

- Live in the Health Tradition 65Plus Platinum service area* at least 245 days of every year and agree to receive all healthcare services from in-network healthcare providers except for out-of-area emergency care, urgent care, or authorized referral by Health Tradition Health Plan.
- Be eligible for and enrolled in both Medicare Part A hospital insurance and Medicare Part B medical insurance. Eligibility is determined by age (65 and over) or a certified disability (any age).

Medicare recipients of any age may enroll regardless of health status, receipt of healthcare or medical condition when an application for coverage is submitted during the open enrollment period, which is the 6-month period beginning with the first month in which you are first enrolled for benefits under Medicare Part B.

Health Tradition does not request, require or purchase genetic information prior to any person's enrollment in this policy in connection with such enrollment, or for use in underwriting.

** The Health Tradition Health Plan service area by county includes: Buffalo, Crawford, Grant, Jackson, Juneau, La Crosse, Monroe, Richland, Sauk, Trempealeau and Vernon counties.*

Key Features of Health Tradition 65Plus Platinum

- Annual physical exams
- Annual eye and hearing exams
- Immunizations
- Emergency and urgent care anywhere
- A total of 365 home healthcare visits per calendar year, including those covered by Medicare
- No health claim forms when in-network healthcare providers are used
- No physical exam required
- No waiting period for pre-existing conditions upon acceptance
- Guaranteed renewable for life if eligibility is maintained
- Competitive rates

Nurseline

A 24-hour nurseline is provided as part of your health benefits:

- A toll-free number you can call anytime, from anywhere in the country
- The reassurance of speaking to a friendly, experienced registered nurse
- Help deciding what to do when illness or injury occurs
- Reliable medical information, approved by Mayo Clinic experts

Quality Improvement Program

Health Tradition Health Plan has a quality assurance program that is under the direction of the Plan's Medical Director.

Evaluation of the quality of care delivered by in-network healthcare providers is performed by the Plan.

65Plus Platinum Provider Network

Health Tradition 65Plus Platinum will pay supplemental benefits only if covered services are obtained from in-network healthcare providers. Healthcare services received from out-of-network providers are not covered under Health Tradition 65Plus Platinum except for emergency care, urgent care received outside the service area, covered services with an approved referral or prior authorization from Health Tradition Health Plan, and limited coverage for foreign travel emergency.

A provider network is a group of healthcare providers contracted with Health Tradition 65Plus Platinum. For more information about the Health Tradition 65Plus Platinum provider network, refer to the 65Plus Platinum Provider Directory. This directory is also available online at www.healthtradition.com.

Medicare Select Part A – Hospital Services – Per Benefit Period*

		Medicare Part A	If you use an in-network healthcare provider	
	Per Benefit Period	Medicare Pays[1]	This Policy Pays[2]	You Pay[2]
Hospitalization Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but [$1,340]	[$1,340]	$0 for Medicare eligible expenses[3]
	61st to 90th day	All but [$335] per day	[$335] per day	$0 for Medicare eligible expenses[3]
	91st to 150th day (After 91st day using 60 lifetime reserve days)	All but [$670] per day	[$670] per day	$0 for Medicare eligible expenses[3]
	Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare eligible expenses[3]**	$0 for Medicare eligible expenses[3]
	Beyond the additional 365 days	$0	$0	100%
Skilled nursing care You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	$0	$0 for Medicare eligible expenses[3]
	21st through 100th day	All but [$167.50] per day	Up to [$167.50] per day	$0 for Medicare eligible expenses[3]
	101st day and after	$0	$0	100%
Inpatient psychiatric care In a participating psychiatric hospital		190 days per lifetime	175 days per lifetime	100% of expenses for care beyond 365 days per lifetime
Blood	First 3 pints	$0	First 3 pints	$0 for Medicare eligible expenses[3]
	Additional amounts	100%	$0	$0
Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive these services		All but very limited coinsurance for outpatient drugs and inpatient respite care	Limited coinsurance for outpatient drugs and inpatient respite care	$0

* A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. Please see notes in Medicare Parts A and B on page 6.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, Health Tradition Health Plan stands in the place of Medicare and will pay whatever amount Medicare would have paid as provided in the 65Plus Platinum Medicare Select Policy.

Medicare Part B Benefits

		Medicare Part B	If you use an in-network healthcare provider	
	Per Calendar Year	Medicare Pays[1]	This Policy Pays[2]	You Pay[2]
Medical expenses Eligible expenses for physician's services, inpatient and outpatient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment	Initial [$183] deductible - First [$183] of Medicare approved amounts*	$0	[$183] each calendar year	$0 for Medicare eligible expenses[3]
	After initial deductible - Remainder of Medicare approved amounts*	Generally, 80% of Medicare eligible charges[3]	Generally, 20% of Medicare eligible charges[3]	$0 for Medicare eligible expenses[3]
Preventive Care Covered by Medicare	Some preventive health services covered by Medicare	Generally 80% or more of Medicare approved charges	Remainder of Medicare eligible expenses[3]	$0 for Medicare eligible expenses[3]
Preventive Care Not Covered by Medicare Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare	After initial deductible	$0	• Physical exam • Eye exam • Hearing exam • Immunizations	$0
Blood	First 3 pints	$0	First 3 pints	$0 for Medicare eligible expenses[3]
	After initial deductible	80% of costs	20% of costs	$0 for Medicare eligible expenses[3]
Clinical laboratory services Tests for diagnostic services		100%	$0	$0 for Medicare eligible expenses[3]
Foreign Travel Emergency - Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.		$0	For each trip, after you pay a $250 deductible, we pay 80% of the billed charges for Medicare eligible expenses[3], up to a lifetime maximum benefit of $50,000	For each trip, you pay a $250 Deductible, then 20% and any amounts over the $50,000 lifetime maximum

* After the first [$183] of Medicare eligible expenses for covered services has been paid, your Part B Deductible will have been met for the calendar year. Please see notes for Medicare Parts A and B on the following page.

Medicare Part A and B Benefits, continued

	Medicare Parts A and B		If you use an in-network healthcare provider	
	Per Calendar Year	Medicare Pays[1]	This Policy Pays[2]	You Pay[2]
Home Healthcare Medicare approved services		100% of charges for visits considered medically necessary by Medicare	365 visits per year including those covered by Medicare	100% of expenses for visits beyond 365 visits per calendar year and for expenses that are not eligible

The Medicare dollar benefits shown above are effective [January 1, 2019]. They will change in future years as Medicare benefits are changed.

1. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the "Medicare & You" handbook for more details.
2. There are limitations on the choice of healthcare providers and the geographical area served. All healthcare services under Health Tradition 65Plus Platinum must be obtained from in-network healthcare providers except for emergency care, urgent care and authorized referrals.

   For services received by an out-of-network healthcare provider:

   - Benefits for emergency care or urgent care received outside the service area will be limited to the deductible and coinsurance up to the actual charge.
   - Authorized referrals to an out-of-network healthcare provider will be reimbursed the difference between the Medicare Part B eligible charges and the actual charge.
3. Medicare eligible means reasonable charges for items and services as determined by Medicare.

Summary of Benefits

Health Tradition 65Plus Platinum covers all Medicare eligible expenses and certain other healthcare services. Health Tradition 65Plus Platinum provides coverage for Medicare Part A and Part B deductibles, any coinsurance amount the member must pay under Medicare, and the difference between Medicare Part B eligible charges and the actual charges.

Health Tradition 65Plus Platinum supplements Medicare. It covers some hospital, skilled nursing facility, surgical and other outpatient services which are partially covered by Medicare. It will not cover all of your healthcare expenses.

Covered services are summarized below:

- Part A Deductible — 100% of Part A Deductible per benefit period
- Part B Deductible — 100% of Part B Deductible per calendar year
- Ambulance services
- Breast reconstruction of the affected tissue related to a mastectomy
- Chiropractic services by an in-network healthcare provider
- Colorectal Cancer Screening, cover colorectal cancer examinations and laboratory tests.
- Dental care to the extent covered by Medicare. Anesthesia and inpatient and outpatient hospital charges if medically necessary
- Diabetes treatment, including non-prescription equipment and supplies. Coverage is provided for test strips, lancets, blood glucose monitors and insulin infusion pumps
- Disposable medical supplies to the extent covered by Medicare.
- Durable medical equipment (rental and purchase) to the extent covered by Medicare, such as wheelchairs, walkers, and oxygen.
- Emergency services without prior authorization
- Foreign travel emergency coverage — after a $250 deductible, 80% of expenses associated with emergency medical care received outside the USA during the first 60 days of a trip with a lifetime maximum of $50,000
- Home healthcare — an aggregate of 365 visits per year, including those covered by Medicare
- Hospice care
- Kidney disease treatment
- Mental health/chemical dependency services, including inpatient and outpatient
- Office visits including diagnostic tests and x-rays
- Preventive services, including an annual physical exam, routine hearing exam and routine vision exam
- Prosthetic devices (excluding dental)
- Rehabilitation services, including physical, speech and occupational therapy
- Second opinion by an in-network healthcare provider

- Skilled nursing facility expenses to the extent covered by Medicare
- Skilled nursing facility expenses for 30 days when the confinement is not covered by Medicare, excluding custodial care
- Transplants
- Urgent care

Health Tradition 65Plus Platinum will not duplicate Medicare benefits.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the "Medicare & You" handbook for more details.

Grievance Procedure

If you have a complaint regarding your benefits or claim payment decisions, please contact Customer Service immediately.

We will attempt to resolve issues on an informal basis and will document your oral complaint.

In the event a complaint is not resolved on an informal basis, you may appeal the decision by filing a grievance. A grievance is any dissatisfaction with the Plan's provision of services or claim practices that is expressed in writing to the Plan by you or your authorized representative.

Write down your claim or benefit concern, including the reason you disagree with the Plan's payment or coverage decision. Mail your written grievance, along with copies of any materials that should be considered by us, to the following address:

Mailing address:

Health Tradition Health Plan
45 Nob Hill Road
Madison, WI 53713

Upon receipt of your written grievance, the Plan will acknowledge your grievance within 5 days. You will then be given 7 days notice of the date, time and place of where the grievance meeting will be held. A resolution letter will follow that meeting within 5 days. Complete review of your grievance will be no longer than 30 calendar days from receipt of grievance.

For more information about how to file a grievance, refer to your Medicare Select Policy which outlines the formal grievance procedure.

Alternative Therapies

- Acupuncture

Exclusions and Limitations

- Biofeedback unless the services are Medicare eligible expenses
- Holistic medicine
- Reflexology

Chiropractic Services

- Chiropractic services performed by an out-of-network healthcare provider

Dental Services

- Services for routine or preventive dental care, treatment, orthodontics, surgery, or services performed by dentists are limited to Medicare eligible expenses
- Services for, or related to, the fitting or adjustment of dental prostheses such as partial plates, bridges and dentures

Durable Medical Equipment, Disposable Supplies, and Prosthetics

- Bathroom assistive aids
- Coverage is provided for standard equipment only
- Common household first-aid items
- Certain compression gradient stockings except for certain diagnoses
- Duplicate or similar items
- Items that are of general use for non-therapeutic purposes (such as humidifiers, air conditioners, whirlpools, etc.), even if they are used for a medical condition
- Internal or external hearing aids or devices and related fitting or adjustment
- Home testing and monitoring supplies and devices, including blood pressure monitoring equipment, unless used in connection with the treatment of diabetes or home renal dialysis
- Modifications to a home or vehicle, including lifts
- Orthopedic shoes, non-custom shoe inserts, or other supportive devices for the feet unless the items are Medicare eligible expenses
- Physical fitness equipment or health club memberships, even if used for a medical condition
- Replacement or repair of durable medical equipment or prosthetics damaged or destroyed by member misuse, abuse, or carelessness; stolen; or lost
- Sharp infectious waste bio-hazard boxes
- Wigs

Eligibility, Plan, or Provider-Related Exclusions

- Charges incurred by the member as a result of failure to obtain referrals or prior authorization
- Equipment or supplies the plan determines are not within the intended scope of coverage or are otherwise ineligible
- Healthcare services provided before the member's coverage is effective
- Healthcare services provided after the member's coverage terminates, unless the member is hospitalized on the date of termination

Exclusions and Limitations, continued

Financial Exclusions

- Credit card interest when the member has paid a claim and is seeking reimbursement
- Expenses in excess of plan maximums or limitations
- Expenses for preparing medical reports, bills or claim forms, sales tax/mailing/shipping/special handling expenses, missed appointments, telephone calls or photocopying fees
- Expenses for which the member has no legal obligation to pay or which are free

General Exclusions

- Any services or items Medicare does not cover, unless this plan specifically provides for them
- Autopsies and related expenses
- Cosmetic surgery, services or cosmetic items
- Expenses for which the Member is compensated by Medicare
- Expenses for or related to travel, including mileage reimbursement, meals and non-ambulance, non-emergency transportation for care and any non-emergency transportation outside the United States
- Experimental/investigative healthcare services, or treatment used primarily for research
- Illness or injury resulting from committing or attempting a felony or involvement in illegal activity
- Massage therapies
- Most care outside the U.S. – coverage for foreign travel is limited to foreign travel emergency coverage only
- Non-authorized healthcare services received from out-of-network healthcare providers, except for emergency care, urgent care, and limited coverage for foreign travel emergency
- Personal comfort and convenience items
- Routine foot care for hygienic reasons or for paring/removal of corns, calluses or toenails
- Services provided by any Veteran's Administration Hospital/nursing home or clinic
- Services that are deemed unreasonable and unnecessary by Medicare
- Services that are not medically necessary
- Services that are primarily Custodial Care, Intermediate Care, or Respite Care (except for Hospice Respite Care). This includes homemaker, personal care workers, routine nursing home services, rest cures, and custodial or maintenance chiropractic treatment
- Smoking cessation programs, including inpatient treatment programs for tobacco use and nicotine replacement products. This includes nicotine gum (Nicorette), or any other drug containing nicotine if used as a smoking deterrent

Home Healthcare

- Administration of home infusion therapy the Member or another caregiver have been successfully trained to administer; or home infusion services that do not involve direct Member contact, such as delivery charges and record-keeping
- Care designed to assist an individual to meet the activities of daily living
- Home healthcare services provided by a member's immediate family or residents in the member's home
- Limited to 365 home healthcare visits per calendar year, including those paid for by Medicare

Hospitalization-Inpatient

- A continued hospital stay if a physician has documented that care could be provided in a less acute care setting
- Any admission for diagnostic tests that can be performed on an outpatient basis
- Extended hospital stays for reasons other than medical necessity

Mental Health and Chemical Dependency Services

- Mental health and chemical dependency services for the treatment of mental illnesses that will not substantially improve beyond the current level of functioning, or for conditions not subject to favorable modification or management according to generally accepted standard of psychiatric care, as determined by the plan
- Services and supplies rendered in connection with mental disorders not classified in the International Classification of Disease (ICD) of the U.S. Department of Health and Human Services

Plan is Not Liable

- Illness or injury caused directly or indirectly by war or an act of war
- Illness or injury covered by workers' compensation or other similar legislation
- Services or benefits that are paid or payable under Medicare or any other governmental program
- Services or hospitalization ordered by a court or other third party, unless medically necessary. This includes physical exams or evaluations given primarily at the request of, for the protection or convenience of, or to meet a requirement of third parties

Prescription Drugs

- Coverage is limited to Prescription Drugs covered by Medicare Part A or Medicare Part B that are Medicare-eligible expenses
- Outpatient Prescription Drugs covered by Medicare Part D
- Take-home drugs (medications or drugs dispensed by a hospital for use after discharge)

Exclusions and Limitations, continued

Preventive Health Services

- Educational classes or programs, or other services primarily educational in nature. This includes treatment for personal growth/ development or any nonmedical self-care and self-help training
- Employment-related immunizations, immunizations for foreign travel and immunizations covered under Medicare Part D, including but not limited to Shingles vaccines
- Physical exams for the sole purposes of research, licensure (including CDL and FAA flight physicals), employment, or insurance
- Preventive health services received from an out-of-network healthcare provider, including a Veteran's Hospital or clinic

Rehabilitation Services

- Phase III and Phase IV cardiac rehabilitation therapies
- Rehabilitation Services primarily educational in nature
- Vocational rehabilitation or recreational therapy

Skilled Nursing Facility Care

- Any surcharge or bed tax
- Bed hold charges
- Coverage is limited to what is covered by Medicare and the 30-day Wisconsin State Skilled Nursing mandate
- Non-Ambulance, non-Emergency transportation for care or social activities

Vision Care

- Replacement frames and lenses
- Surgery or implants solely for the correction of visual acuity or refractive errors
- The purchase, fitting, adjustment, or repair of:
  - Eyeglass frames and lenses (except following cataract surgery)
  - Contact lenses (except for aphakia, and congenital aphakia)
- Vision therapy or orthoptics (eye exercises)

Weight Control/Nutrition

- Services for the purpose of weight eduction, including weight reduction programs, food supplements, and weight checks

Common Questions About Medicare and Health Tradition 65Plus Platinum

Q What is Health Tradition 65Plus Platinum and will it replace my Medicare insurance?

A Health Tradition 65Plus Platinum is a Medicare Select Policy. You keep your Medicare Part A and B coverage when you join the plan.

Q Who is eligible for Health Tradition 65Plus Platinum?

A You are eligible if you are disabled or 65 or older, enrolled in Medicare Parts A and B and live within the Health Tradition 65Plus Platinum service area for most of the year.

Q How do I enroll in Health Tradition 65Plus Platinum and when will my coverage become effective?

A To apply, please complete the enclosed application. If you are applying within 6 months of your enrollment with Medicare Part A and B, you do not need to complete medical questions on the application. Please review the Instructions For Self-Enrollment in Health Tradition 65Plus Platinum, then mail the necessary forms and the first month's premium in the enclosed return envelope. If you need help completing the application, please contact Health Tradition at 1.877.832.1823 (toll-free).

Q How will I be billed for Health Tradition 65Plus Platinum?

A You will be billed a monthly premium. Or, you can set up a direct debit with Health Tradition.

Q Does the plan choose a provider for me?

A Health Tradition 65Plus Platinum does not choose a provider for you. The choice is entirely yours from the list of healthcare providers listed in the provider directory. You have a wide range of choices in Internal Medicine, Family Medicine, other medical specialties, chiropractors and vision care providers.

Q If I am currently seeing a provider who is not participating in Health Tradition 65Plus Platinum, will visits to this provider be covered?

A Generally speaking, no. When you join Health Tradition 65Plus Platinum, you should expect to receive your care from providers who are participating in the plan.

Q If I choose to enroll in Health Tradition 65Plus Platinum, will I still be covered by Basic Medicare?

Will I keep my regular Medicare card?

A Yes. When you choose Health Tradition 65Plus Platinum you have the security of the continuation of your Basic Medicare coverage. You will keep your regular Medicare card. If you choose to continue to see a non-participating provider, your basic Medicare coverage would still pay its portion of any Medicare-eligible charges. Keep in mind that Health Tradition Health Plan would not be responsible for any coinsurance or deductibles not yet met.

Q How are emergencies covered under Health Tradition 65Plus Platinum?

A If you need medical care because of an emergency condition in the service area or away from home, Health Tradition 65Plus Platinum will pay for covered services not paid by Medicare, up to the actual charge. When traveling outside the United States, Health Tradition 65Plus Platinum covers 80% of emergency medical expenses, up to $50,000 in your lifetime, after you pay a $250 deductible.

Q What should I do if I need emergency or urgent care?

A If you need emergency care, you should proceed immediately to the nearest medical facility. If you are out of the service area and must use a non-participating provider, have someone call Health Tradition Health Plan Customer Service within 48 hours or as soon as reasonably possible. Emergency care is covered anywhere.

If you need urgent care and are not within our service area, and cannot safely return to receive care from a participating provider in our service area, go to the nearest appropriate medical facility and notify Customer Service as soon as possible.

Follow-up care received after the urgent or emergency condition is stabilized must be received from a participating provider. If you choose to receive follow-up care out of the service area, your Basic Medicare coverage would still cover follow-up care for any Medicare eligible charges.

Q Does Health Tradition 65Plus Platinum cover prescription drugs?

A This Benefit Plan covers only Prescription Drugs covered by Medicare Part A and Medicare Part B that are Medicare-Eligible Expenses. Outpatient Prescription Drugs covered by Medicare Part D are not covered.

Q Do you cover diabetic supplies?

A Yes. Coverage is provided for the treatment of diabetes and diabetic self-management education programs, including non-prescription equipment and supplies. Coverage is provided for test strips, lancets, blood glucose monitors and insulin infusion pumps. Insulin and prescription medications covered by Medicare Part D are not covered.

Q Can I return the policy if I am unhappy with Health Tradition 65Plus Platinum?

A Yes. You will receive a copy of the policy once your application is approved. If you return the policy within 30 days, for any reason, we will refund your full payment and coverage will be discontinued. Any medical services incurred within this time period will be your responsibility.

Q Can Health Tradition 65Plus Platinum ever cancel my policy?

A No. Your Health Tradition 65Plus Platinum policy is guaranteed renewable for life, but is subject to continued eligibility requirements as defined in the policy.

To understand your Health Tradition 65Plus Platinum plan more clearly, it is important that you read your policy carefully. The policy will provide details of the rights and obligations of both you and Health Tradition 65Plus Platinum.

Guaranteed Renewable for Life

— Premium Subject to Change

We will renew this plan for as long as you pay the premium on time, remain in the Health Tradition Health Plan service area and maintain Medicare Part A and B coverage. Your coverage cannot be cancelled because you have used benefits. Health Tradition Health Plan can only raise your premium if we raise the premium for all plans like yours. Your premium will also change on the first day of the month after you attain the following ages: 70, 75, 80, and 85. Your premium will not increase on the basis of age after age 85. You can end your plan at any time by sending us written notice of termination.

The benefits of the Health Tradition 65Plus Platinum plan will automatically change to reflect changes in Medicare deductibles and coinsurance. When benefits change, your premium may change.

In addition to this outline of coverage, Health Tradition Health Plan will send an annual notice to you 30 days prior to the effective date of Medicare changes which will describe these changes and the changes in your Medicare Select coverage.

Filing Claims for:

Foreign Travel Claims
Out-of-Network Emergency Services

Written proof of claim must be submitted to Health Tradition 65Plus Platinum within 90 days of the date you received healthcare services. The following information must be received by Health Tradition 65Plus Platinum:

1. Itemized bill or insurance claim forms
2. Copy of the Medicare Summary Notice (MSN) you received from Medicare
3. Proof of payment if you are requesting reimbursement to be made directly to you.

If circumstances beyond your control make this time limit unreasonable, you must file as soon as possible; but it can't be later than fifteen (15) months after the date of service unless you are legally incapacitated.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult, "Medicare and You" for more information.

Quality Management

Ensuring quality healthcare and services for Health Tradition Health Plan members

The Health Tradition Quality Management Department evaluates and monitors key aspects of services and healthcare provided to Members. The Medical Director directs the Quality Management Department. Various committees consisting of Individual Healthcare Providers and Plan leadership guide, direct, and evaluate quality initiatives. Individual Healthcare Providers in the Plan's network are evaluated using nationally accepted criteria prior to joining the network and every two years thereafter.

An assessment of the Service Area and appointment access is conducted annually to ensure an adequate number of Healthcare Providers are available to members. Member input is collected, evaluated, and monitored through surveys and complaint tracking. Member quality of care concerns are resolved through peer review.

Health management studies and projects are completed to increase rates of preventive services and improve management of acute and chronic diseases. The Quality Management Department is responsible for directing the process of improvement efforts.

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