

PARTNERSHIP

HMO SNP

A Program of Care Wisconsin

2012 Summary of Benefits

For the following plans:

Dane County (Contract H5209, Plan 002)

Columbia, Dodge, Jefferson and Sauk Counties (Contract H7475, Plan 001)

Interpreter Services

Interpreter services are available free of charge. For help to translate or understand this, please call 1-800-963-0035 (TTY Call the Wisconsin Relay System at 711 or 1-800-947-3529).

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Yog xav tau kev pab txhais cov ntaub ntawv no kom koj totaub, hu rau 1-800-963-0035 (TTY Call the Wisconsin Relay System at 711 or 1-800-947-3529).

Please call Care Wisconsin Health Plan, Inc. for more information about this plan. Visit us at www.carewisconsinhealthplan.org or, call us: 1-800-963-0035. You can call 24 hours a day, 7 days a week.

If you are deaf or hard of hearing and using a TTY machine, dial the Wisconsin Relay System's toll-free TTY access number: 711, or if no answer: 1-800-947-3529 and a Wisconsin Relay Communication Assistant (CA) will answer your call. Provide the area code and phone number of your Team to the CA and they will connect you with someone who can help you. There is always a nurse practitioner on call to help you.

Current and Prospective members should call 1-800-963-0035 or the TTY number listed above for questions related to Partnership.

For more information about Medicare, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit www.medicare.gov on the web. You may also contact the Medigap Helpline at 1-800-242-1060.

For more information about Medicaid, call 1-800-362-3002. Or, visit www.dhs.wi.gov on the web.

If you have special needs, this document may be available in other formats.

Please refer to the "Special Features" section on page 30 and the "Statement About Your Medicaid Benefits" section on page 32 of this Summary of Benefits for more information about your Medicaid benefits.

**Introduction to the Summary of Benefits Report
for Partnership (HMO SNP)
January 1, 2012 – December 31, 2012
Dane County (Contract H5209, Plan 002)
Columbia, Dodge, Jefferson and Sauk Counties (Contract H7475, Plan 001)**

Thank you for your interest in Partnership (HMO SNP). Our plan is offered by CARE WISCONSIN HEALTH PLAN, INC., a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan (SNP). This plan is designed for people who meet specific enrollment criteria.

You may be eligible to join this plan if you receive assistance from the state and Medicare.

All cost sharing in this Summary of Benefits is based on your level of Medicaid eligibility.

Please call Partnership (HMO SNP) to find out if you are eligible to join. Our number is listed at the end of this introduction.

This Summary of Benefits tells you some features of our plan. It doesn't list every service we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Partnership (HMO SNP) and ask for the "Evidence of Coverage."

YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Partnership (HMO SNP). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program. If you are eligible for both Medicare and Medicaid (dual eligible) you may join or leave a plan at any time.

Please call Partnership (HMO SNP) at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare Partnership (HMO SNP) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

WHERE IS PARTNERSHIP (HMO SNP) AVAILABLE?

The service area for this plan includes: Dane County (Contract H5209, Plan 002) and Columbia, Dodge, Jefferson and Sauk Counties (Contract H7475, Plan 001) in Wisconsin. You must live in this area to join the plan.

WHO IS ELIGIBLE TO JOIN PARTNERSHIP (HMO SNP)?

You can join Partnership (HMO SNP) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area.

However, individuals with End-Stage Renal Disease generally are not eligible to enroll in Partnership (HMO SNP) unless they are members of our organization and have been since their dialysis began. You must also be enrolled in the Wisconsin Medicaid program to join this plan.

Please call the plan to see if you are eligible to join.

CAN I CHOOSE MY DOCTORS?

Partnership (HMO SNP) has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time. You can ask for a current provider directory. For an updated list, visit us at

www.carewisconsinhealthplan.org. Our customer service number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

If you choose to go to a doctor outside of our network, you must pay for these services yourself except in limited situations (for example, emergency care). Neither the plan nor the Original Medicare Plan will pay for these services.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

Partnership (HMO SNP) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at www.carewisconsinhealthplan.org. Our customer service number is listed at the end of this introduction.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

Partnership (HMO SNP) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Partnership (HMO SNP) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to

coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at www.carewisconsinhealthplan.org.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week; and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare & You.
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through

Friday. TTY/TDD users should call 1-800-325-0778; or

- Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas.

Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Partnership (HMO SNP), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You

may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of Partnership (HMO SNP), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our

decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate, but it is recommended that you take full advantage of this covered service if you are selected. Contact Partnership (HMO SNP) for more details.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Partnership (HMO SNP) for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.

- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have End-Stage Renal Disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and Infusion Drugs administered through DME.

web tools on www.medicare.gov and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

WHERE CAN I FIND INFORMATION ON PLAN RATINGS?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the

Please call Care Wisconsin Health Plan, Inc. for more information about Partnership (HMO SNP). Visit us at www.carewisconsinhealthplan.org or, call us. Customer Service hours: Monday, Tuesday, Wednesday, Thursday, Friday, 8:00 a.m. - 4:30 p.m., Central.

Current and Prospective members should call toll-free 1-800-963-0035 for questions related to the Medicare Advantage Program. (TTY/TDD 1-800-947-3529)

Current members should call locally (608) 240-0035 for questions related to the Medicare Advantage Program. (TTY/TDD 1-800-947-3529)

Prospective members should call locally (608) 245-3075 for questions related to the Medicare Advantage Program. (TTY/TDD 1-800-947-3529)

Current and Prospective members should call toll-free 1-800-963-0035 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 1-800-947-3529)

Current members should call locally (608) 240-0035 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 1-800-947-3529)

Prospective members should call locally (608) 245-3075 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 1-800-947-3529)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit www.medicare.gov on the web.

This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language. For additional information, call Customer Service at the phone number listed above.

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Summary of Benefits Report for Contracts H5209, Plan 002; H7475, Plan 001

Benefit Category	Original Medicare	Partnership (HMO SNP)
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IMPORTANT INFORMATION

1 - Premium and Other Important Information

In 2012 the monthly Part B Premium is \$0 and the annual Part B deductible amount is \$0.

If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.

General

* Depending on your level of Medicaid eligibility, you may not have any cost-sharing responsibility for original Medicare services.

** Please consult with your plan about cost sharing when receiving services from out-of-network providers.

\$0 monthly plan premium.*

In-Network

\$0 annual deductible.*

\$6,700 out-of-pocket limit for Medicare-covered services. However, in this plan you will have no cost sharing responsibility for Medicare-covered services, based on your level of Medicaid eligibility.

Because you are eligible for Medicaid, you may receive assistance paying your Medicare premium from Medicaid.

Some members may have to pay a monthly Medicaid cost share as determined by your county's Department of Human Services to remain eligible and enrolled in Partnership (HMO SNP).

Benefit Category	Original Medicare	Partnership (HMO SNP)
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2 - Doctor and Hospital Choice
 (For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)

You may go to any doctor, specialist or hospital that accepts Medicare.

In-Network
 You must go to network doctors, specialists, and hospitals.

No referral required for network doctors, specialists, and hospitals.

No referral is required for network doctors, specialists and hospitals for original Medicare, but prior authorization may be required for Partnership (HMO SNP). Contact your Team for details.

INPATIENT CARE

3 - Inpatient Hospital Care
 (includes Substance Abuse and Rehabilitation Services)

For each benefit period:
 Days 1 - 60: \$0 deductible
 Days 61 - 90: \$0 per day
 Days 91 - 150: \$0 per lifetime reserve day

Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.

Lifetime reserve days can only be used once.

A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

In-Network
 Plan covers 90 days each benefit period.

You will not be charged additional cost sharing for professional services.

\$0 annual deductible.*

\$0 copay.*

Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

Because you have Medicaid:

- There are no deductibles or copayments for covered stays at a network hospital.*
- You are covered for unlimited days each benefit period.*

- *You are required to use network hospitals, except in an emergency. You do NOT need a referral to receive services from a network hospital.*
- *Except in an emergency, your provider must obtain authorization from Partnership.*

4 - Inpatient Mental Health Care

For each benefit period:
 Days 1 - 60: \$0 deductible
 Days 61 - 90: \$0 per day
 Days 91 - 150: \$0 per lifetime reserve day

You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.

In-Network

\$0 copay.*

You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.

\$0 annual deductible.*

Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

Because you have Medicaid:

There are no deductibles or copayments for covered stays at a network hospital.

You are required to use network hospitals except in an emergency. You do NOT need a referral to receive services from a network hospital.

Except in an emergency, your provider must obtain authorization from Partnership.

**Benefit
Category**

**Original
Medicare**

Partnership (HMO SNP)

5 - Skilled Nursing Facility (SNF)
(in a Medicare-certified skilled
nursing facility)

In 2012 the amounts for each benefit period
after at least a 3-day covered hospital stay are:
Days 1 - 20: \$0 per day
Days 21 - 100: \$0 per day

100 days for each benefit period.

A “benefit period” starts the day you go into
a hospital or SNF. It ends when you go for
60 days in a row without hospital or skilled
nursing care. If you go into the hospital after
one benefit period has ended, a new benefit
period begins. There is no limit to the number
of benefit periods you can have.

General

Authorization rules may apply.

In-Network

Plan covers up to 100 days each benefit period.

3-day prior hospital stay is required.

\$0 annual deductible.*

\$0 copay for SNF services.*

You will not be charged additional cost sharing
for professional services.

Because you have Medicaid:

*There is no copayment for covered stays at a
network skilled nursing facility.*

*You are covered for an unlimited number of
days.*

*You are required to use network skilled nursing
facilities.*

No prior hospital stay is required.

*Prior authorization may be required. Contact
your Team for details.*

6 - Home Health Care

\$0 copay.

(includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)

General

Authorization rules may apply.

In-Network

\$0 copay for Medicare-covered home health visits*

Because you have Medicaid:

There is no copayment for covered home health visits.

Prior authorization may be required. Contact your Team for details.

7 - Hospice

You must get care from a Medicare-certified hospice.

General

You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.

Because you have Medicaid:

There are no copayments for hospice care.

You must receive care from a Medicare-certified hospice.

Prior authorization may be required. Contact your Team for details.

Benefit Category	Original Medicare	Partnership (HMO SNP)
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OUTPATIENT CARE

8 - Doctor Office Visits

0% coinsurance.

General

Authorization rules may apply.

In-Network

\$0 copay for each primary care doctor visit for Medicare-covered benefits.*

\$0 copay for the cost of each in-area, network urgent care Medicare-covered visit.*

\$0 copay for each specialist doctor visit for Medicare-covered benefits.*

Because you have Medicaid:

There are no deductibles or copayments for covered primary care doctor or specialist office visits.

9 - Chiropractic Services

Supplemental routine care not covered.

0% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.

General

Authorization rules may apply.

In-Network

\$0 copay for Medicare-covered chiropractic visits.*

Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.

Because you have Medicaid:

You are covered for manual manipulation of the spine to correct subluxation (a displacement of a joint or body part) provided by chiropractors or other qualified providers.

There are no deductibles or copayments for covered chiropractic services.

Prior authorization may be required. Contact your Team for details.

10 - Podiatry Services

Supplemental routine care not covered.

0% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.

General

Authorization rules may apply.

In-Network

\$0 copay for Medicare-covered podiatry benefits.*

Medicare-covered podiatry benefits are for medically-necessary foot care.

Because you have Medicaid:

There are no deductibles or copayments for covered podiatry services.

Prior authorization may be required. Contact your Team for details.

Benefit Category	Original Medicare	Partnership (HMO SNP)
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11 - Outpatient Mental Health Care

0% coinsurance for most outpatient mental health services.

0% coinsurance of the Medicare-approved amount for each service you get from a qualified professional as part of a Partial Hospitalization Program.

“Partial hospitalization program” is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.

General
Authorization rules may apply.

In-Network
\$0 copay for Medicare-covered Mental Health visits.*

\$0 copay for each Medicare-covered visit with a psychiatrist.*

\$0 copay for Medicare-covered partial hospitalization program services.*

Because you have Medicaid:
There are no deductibles or copayments for covered mental health care.

Prior authorization may be required. Contact your Team for details.

12 - Outpatient Substance Abuse Care

0% coinsurance.

General
Authorization rules may apply.

In-Network
\$0 copay for Medicare-covered visits.*

Because you have Medicaid:
There are no deductibles or copayments for covered substance abuse care.

Prior authorization may be required. Contact your Team for details.

13 - Outpatient Services/Surgery

0% coinsurance for the doctor's services.

0% coinsurance for ambulatory surgical center facility services.

General

Authorization rules may apply.

In-Network

\$0 copay for each Medicare-covered ambulatory surgical center visit.*

\$0 copay for each Medicare-covered outpatient hospital facility visit.*

Because you have Medicaid:

There are no deductibles or copayments for covered outpatient services/surgery.

Prior authorization may be required. Contact your Team for details.

14 - Ambulance Services

0% coinsurance.

(medically necessary ambulance services)

General

Authorization rules may apply.

In-Network

\$0 copay for Medicare-covered ambulance benefits.*

Because you have Medicaid:

There are no deductibles or copayments for covered ambulance services.

Prior authorization may be required. Contact your Team for details.

Benefit Category	Original Medicare	Partnership (HMO SNP)
<p>15 - Emergency Care</p> <p>(You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>0% coinsurance for the doctor's services.</p> <p>0% outpatient hospital facility emergency services.</p> <p>Not covered outside the U.S. except under limited circumstances.</p>	<p>General</p> <p>\$0 copay for Medicare-covered emergency room visits.*</p> <p>Not covered outside the U.S. except under limited circumstances. Contact the plan for more details.</p> <p>If you are admitted to the hospital within 3-day(s) for the same condition, you pay \$0 for the emergency room visit.</p> <p><i>Because you have Medicaid:</i> <i>There are no deductibles or copayments for covered emergency care.</i></p>
<p>16 - Urgently Needed Care</p> <p>(This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>0% coinsurance.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>General</p> <p>\$0 copay for Medicare-covered urgently-needed-care visits*</p> <p><i>Because you have Medicaid:</i> <i>There are no deductibles or copayments for covered urgently needed care.</i></p> <p><i>NOT covered outside the U.S. except under limited circumstances.</i></p>
<p>17 - Outpatient Rehabilitation Services</p> <p>(Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>0% coinsurance.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>There may be limits on physical therapy, occupational therapy, and speech and language</p>

pathology services If so, there may be exceptions to these limits.

\$0 copay for Medicare-covered Occupational Therapy visits.*

\$0 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.*

Because you have Medicaid:

There are no limits on physical therapy, occupational therapy and speech and language pathology services.

There are no deductibles or copayments for covered outpatient rehabilitation services.

Prior authorization may be required. Contact your Team for details.

OUTPATIENT MEDICAL SERVICES AND SUPPLIES

18 - Durable Medical Equipment 0% coinsurance.
(includes wheelchairs, oxygen, etc.)

General

Authorization rules may apply.

In-Network

\$0 copay for Medicare-covered items.*

Because you have Medicaid:

There are no deductibles or copayments for covered durable medical equipment.

Prior authorization may be required. Contact your Team for details.

Benefit Category	Original Medicare	Partnership (HMO SNP)
<p>19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)</p>	<p>0% coinsurance.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered items.*</p> <p><i>Because you have Medicaid: There are no deductibles or copayments for covered prosthetic devices.</i></p> <p><i>Prior authorization may be required. Contact your Team for details.</i></p>
<p>20 - Diabetes Programs and Supplies</p>	<p>0% coinsurance for diabetes self-management training.</p> <p>0% coinsurance for diabetes supplies.</p> <p>0% coinsurance for diabetic therapeutic shoes or inserts.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for diabetes self-management training.*</p> <p>\$0 copay for:</p> <ul style="list-style-type: none"> • Diabetes monitoring supplies* • Therapeutic shoes or inserts* <p><i>Because you have Medicaid: There are no deductibles or copayments for covered diabetes self-monitoring training and supplies or for medically necessary nutrition therapy.</i></p> <p><i>Prior authorization may be required. Contact your Team for details.</i></p>

21 - Diagnostic Tests, X-Rays, Lab Services,
and Radiology Services

0% coinsurance for diagnostic tests and x-rays.

\$0 copay for Medicare-covered lab services.

Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol.

0% coinsurance for the digital rectal exam and other related services.

Covered once a year for all men with Medicare over age 50.

General

Authorization rules may apply.

In-Network

\$0 copay for Medicare-covered:

- lab services*
- diagnostic procedures and tests*
- X-rays*
- diagnostic radiology services (not including X-rays)*
- therapeutic radiology services*

Because you have Medicaid:

There are no deductibles or copayments for covered diagnostic tests, x-rays and lab services.

Prior authorization may be required. Contact your Team for details.

Benefit Category	Original Medicare	Partnership (HMO SNP)
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PREVENTIVE SERVICES

22 - Cardiac and Pulmonary Rehabilitation Services

0% coinsurance for Cardiac Rehabilitation Services.

0% coinsurance for Pulmonary Rehabilitation Services.

0% coinsurance for Intensive Cardiac Rehabilitation Services.

This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.

General

Authorization rules may apply.

In-Network

\$0 copay for:

- Medicare-covered Cardiac Rehabilitation Services*
- Medicare-covered Intensive Cardiac Rehabilitation Services*
- Medicare-covered Pulmonary Rehabilitation Services*

Because you have Medicaid:

There are no deductibles or copayments for covered cardiac and pulmonary rehabilitation services.

Prior authorization may be required. Contact your Team for details.

23 - Preventive Services and Wellness/ Education Programs

No coinsurance, copayment or deductible for the following:

- Abdominal Aortic Aneurysm Screening
- Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.
- Cardiovascular Screening
- Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered

General

\$0 copay for all preventive services covered under Original Medicare at zero cost sharing:

- Abdominal Aortic Aneurysm screening
- Bone Mass Measurement
- Cardiovascular Screening
- Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam)
- Colorectal Cancer Screening
- Diabetes Screening

once a year for women with Medicare at high risk.

- Colorectal Cancer Screening
- Diabetes Screening
- Influenza Vaccine
- Hepatitis B Vaccine for people with Medicare who are at risk
- HIV Screening. \$0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.
- Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39.
- Medical Nutrition Therapy Services. Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.
- Personalized Prevention Plan Services (Annual Wellness Visits)
- Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in

- Influenza Vaccine
- Hepatitis B Vaccine
- HIV Screening
- Breast Cancer Screening (Mammogram)
- Medical Nutrition Therapy Services
- Personalized Prevention Plan Services (Annual Wellness Visits)
- Pneumococcal Vaccine
- Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only)
- Smoking Cessation (Counseling to stop smoking)
- Welcome to Medicare Physical Exam (Initial Preventive Physical Exam)

HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.

In-Network

This plan does not cover supplemental education/wellness programs.

Because you have Medicaid:

There are no deductibles or copayments for covered preventive services and wellness/education programs.

Prior authorization may be required. Contact your Team for details.

Benefit Category	Original Medicare	Partnership (HMO SNP)
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23 - Preventive Services and Wellness/
Education Programs Continued

your lifetime. Call your doctor for more information.

- Prostate Cancer Screening - Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50.
- Smoking Cessation (counseling to stop smoking). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.
- Welcome to Medicare Physical Exam (initial preventive physical exam). When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Physical Exam or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months.

24 - Kidney Disease and Conditions

0% coinsurance for renal dialysis.

0% coinsurance for kidney disease education services.

General
Authorization rules may apply.

In-Network
\$0 copay for renal dialysis.*

\$0 copay for kidney disease education services.*

Because you have Medicaid:

There are no deductibles or copayments for covered dialysis or kidney disease education services.

Prior authorization may be required. Contact your Team for details.

25 - Outpatient Prescription Drugs

Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.

Drugs covered under Medicare Part B General

\$0 annual deductible for Part B-covered drugs.*

\$0 copay for Part B covered chemotherapy drugs and other Part-B covered drugs.*

Drugs Covered under Medicare Part D General

This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.carewisconsinhealthplan.org on the web.

Different out-of-pocket costs may apply for people who

- have limited incomes,
- live in long term care facilities, or
- have access to Indian/Tribal/Urban (Indian Health Service) providers.

Your in-network prescription coverage may be limited to the plan's service area. This means that if you travel outside the service area, you may have to pay the full cost of your

**Benefit
Category**

**Original
Medicare**

Partnership (HMO SNP)

25 - Outpatient Prescription Drugs Continued

prescription. In certain emergencies, your drugs will be covered if you get them at an out-of-network pharmacy although you may have to pay additional charges. Contact the plan for details.

Total yearly drug costs are the total drug costs paid by you, the plan, and Medicare.

The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.

Some drugs have quantity limits.

Your provider must get prior authorization from Partnership (HMO SNP) for certain drugs.

You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's Web site, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.

If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

In-Network

You pay a \$0 annual deductible.

Initial Coverage

Depending on your income and institutional status, you pay the following:

For generic drugs (including brand drugs treated as generic), either:

- A \$0 copay; or
- A \$1.10 copay; or
- A \$2.60 copay.

For all other drugs, either:

- A \$0 copay; or
- A \$3.30 copay; or
- A \$6.50 copay.

Retail Pharmacy

You can get drugs the following way(s):

- one-month (30-day) supply
- three-month (90-day) supply

Long Term Care Pharmacy

You can get drugs the following way(s):

- one-month (31-day) supply

Catastrophic Coverage

You pay a \$0 copay.

Out-of-Network

Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You

**Benefit
Category**

**Original
Medicare**

Partnership (HMO SNP)

25 - Outpatient Prescription Drugs Continued

may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Partnership (HMO SNP).

You can get drugs the following way:

- 10-day supply

Out-of-Network Initial Coverage

Depending on your income and institutional status, you will be reimbursed by Partnership (HMO SNP) up to the plan's cost of the drug minus the following:

For generic drugs purchased out-of-network (including brand drugs treated as generic), either:

- A \$0 copay; or
- A \$1.10 copay; or
- A \$2.60 copay.

For all other drugs purchased out-of-network, either:

- A \$0 copay; or
- A \$3.30 copay; or
- A \$6.50 copay.

Out-of-Network Catastrophic Coverage

You will be reimbursed in full for drugs purchased out-of-network.

Because you have Medicaid and are enrolled in Partnership:

There are no deductibles or copayments for covered prescription drugs.

Prior authorization may be required. Contact your Team for details.

26 - Dental Services

Preventive dental services (such as cleaning) not covered.

General

Authorization rules may apply.

In-Network

\$0 copay for Medicare-covered dental benefits.*

In general, preventive dental benefits (such as cleaning) not covered.

Because you have Medicaid:

There are no deductibles or copayments for covered dental services, which includes preventive dental services.

Prior authorization may be required. Contact your Team for details.

27 - Hearing Services

Supplemental routine hearing exams and hearing aids not covered.

0% coinsurance for diagnostic hearing exams.

General

Authorization rules may apply.

In-Network

In general, supplemental routine hearing exams and hearing aids not covered.

\$0 copay for Medicare-covered diagnostic hearing exams.*

Benefit Category	Original Medicare	Partnership (HMO SNP)
27 - Hearing Services Continued		<p>Because you have Medicaid: There are no deductibles or copayments for covered hearing services.</p> <p>Prior authorization may be required. Contact your Team for details.</p>
28 - Vision Services	<p>0% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Supplemental routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p>General Authorization rules may apply.</p> <p>In-Network Non-Medicare supplemental eye exams and glasses not covered.</p> <p>\$0 copay for diagnosis and treatment for diseases and conditions of the eye.*</p> <p>\$0 copay for one pair of eyeglasses or contact lenses after cataract surgery.*</p> <p>Because you have Medicaid: There are no deductibles or copayments for covered vision services.</p> <p>Prior authorization may be required. Contact your Team for details.</p>
Over-the-Counter Items	Not covered.	<p>General The plan does not cover over-the-counter items.</p> <p>Because you have Medicaid: Certain over-the-counter items are covered.</p>

Prior authorization may be required. Contact your Team for details.

Transportation
(Routine)

Not covered.

In-Network

This plan does not cover supplemental routine transportation.

Because you have Medicaid:

Routine transportation is covered.

Prior authorization may be required. Contact your Team for details.

Acupuncture

Not covered.

In-Network

The plan does not cover acupuncture.

Because you have Medicaid:

Acupuncture may be covered. Authorization rules may apply.

Prior authorization may be required. Contact your Team for details.

Medicaid Covered Services

For a complete list of Medicaid services covered in this plan, please see the section “Statement About Your Medicaid Benefits” on pages 32-33 in this Summary of Benefits.

Special Features

If you have any questions about this plan's benefits and costs, please contact Partnership.

Partnership (HMO SNP), a Medicare Advantage Special Needs Plan, is a different kind of health plan. It gives you health care services in a personal way. We can work with you and your family to give the kind of care you need and want. We want you to stay independent and will encourage you to do as much for yourself as possible. We will help you to make informed health choices.

- Your health care is planned with you and your family or significant others by a special group of people working with you. An Interdisciplinary Team (Team) works with you to identify your goals (outcomes), and develops a Plan to support you with achieving these outcomes. The Team consists of:
 - You, the Partnership Member
 - Your family and significant others (at your option)
 - Your Primary Care Physician
 - Your Partnership Nurse Practitioner
 - Your Partnership Registered Nurse
 - Your Partnership Social Worker or Care Manager
 - Your Partnership Service Coordinator
 - Other people you choose to include on your Team
- Your Team is responsible for your assessment, care planning, service authorization and delivery, coordination, monitoring, and health education and prevention.
- Your Team members and network providers have the expertise to meet your outcomes.
- Your Team conducts an assessment in your home. This assessment identifies your needs, strengths and resources.
- Your Team will work with you to develop a member centered plan that clearly identifies your preferences, goals, specified treatments and strategies.
- Your Team coordinates your care by overseeing services delivered by other providers or by providing services to you directly.
- Your Team will meet with you regularly to review your care plan.
- Customer Service is available 24 hours a day, seven days a week.
- You and the Team develop your plan of care based on your outcomes, but Partnership has a responsibility to support your outcomes in the most cost-effective manner possible. To accomplish this, your Team uses a process called Resource Allocation Decision-Making (RAD). This process is approved by the State of Wisconsin to help guide decision-making regarding your plan of care. As stated above, you and others are part of the Team who take an active role in decision-making regarding the health and long-term care services you need to support your outcomes.

To be eligible for Partnership (HMO SNP) you must:

- Be at least 18 years old;
- Be a frail elder or an adult with physical or developmental disabilities;
- Reside in our service area which includes Columbia, Dane, Dodge, Jefferson and Sauk Counties;
- Be financially eligible for Wisconsin Medicaid;
- Be functionally eligible as determined via the Wisconsin Long-term Care Functional Screen prior to enrollment and annually thereafter; and
- Medicare eligible applicants to the Partnership program must be enrolled in all Parts of Medicare for which they are eligible. Once current enrollees become eligible for Medicare, they must enroll in the Partnership Medicare Advantage Special Needs Plan (SNP) and obtain all Medicare covered services from the Partnership Medicare Advantage SNP.

Please call, toll free, your county's Aging and Disability Resource Center (ADRC) or Partnership in Dane County, to find out if you are eligible to join and to enroll.

Columbia County ADRC	1-888-742-9233
Dane County Partnership	1-800-963-0035
Dodge County ADRC	1-800-924-6407
Jefferson County ADRC	1-866-740-2372
Sauk County ADRC	1-800-482-3710

Statement About Your Medicaid Benefits

If you have any questions about this plan's benefits and costs, please contact Partnership.

Partnership is a fully integrated Medicare and Medicaid health and long-term care program for the frail elderly and adults with physical or developmental disabilities. Members receive all Medicaid and Medicare benefits through the Partnership model of care which includes but is not limited to:

- combined Medicaid and Medicare eligibility determination;
- combined Medicaid and Medicare enrollment procedures;
- member participation in care planning;
- member and team cooperation in managing care;
- quality management; and
- responsiveness to grievances and appeals.

Listed below are the Wisconsin Medicaid benefits covered by Partnership. Because you are a member of this Partnership program, your Medicare deductible and coinsurance amounts are paid on your behalf.

When people are eligible for both Medicare and Medicaid, health care and prescription drugs are usually covered by Medicare while long-term care benefits and over-the-counter drugs are usually covered by Medicaid.

- Members are required to use network providers for all types of service, except emergency care.
- There are no deductibles or copayments for covered, authorized services.

- In 2012 Partnership members will not have to pay a copay for Part D prescription drugs. This is an important change that you will want to know about.
- Prior authorization is required for most types of service. Contact your Team for details.
- Services are NOT covered outside of the United States and its territories, except under limited circumstances.

All members of Partnership receive coverage for health care and drugs. These benefits include but are not limited to:

- Alcohol and other drug abuse (AODA) services
- Surgical services
- Anesthesiology
- Audiology
- Chiropractic
- Community support program
- Dental services
- Diagnostic testing services
- Dialysis services
- Drugs
- Durable medical equipment and medical supplies
- Family planning services
- Home health
- Hospice care services
- Hospital services
- Independent nurse practitioner services
- Mental health services

- Nursing home services
- Nursing services
- Occupational therapy
- Personal care services
- Physical therapy
- Physician services
- Podiatry services
- Private duty nursing services
- Speech and language pathology services
- Transportation
- Vision care services

All members of Partnership are also eligible to receive the following long-term care benefits which are covered by Medicaid:

- Adaptive aids
- Adult day care
- Care/case management
- Communication aids
- Counseling and therapeutic resources
- Financial management services
- Habilitation:
 - Daily living skills training
 - Day center service/treatment
 - Day services for children
 - Prevocational services
 - Supportive employment
 - Vocational futures planning
- Home delivered meals
- Home modifications
- Housing counseling
- Medical and non-medical transportation

- Member education and training
- Personal Emergency Response Systems
- Relocation services
- Residential care:
 - Adult family homes for 1-2 beds
 - Adult family homes for 3-4 beds
 - Children’s foster homes/treatment foster homes
 - Community-based residential facilities
 - Residential care apartment complexes
- Respite care
- Self Directed Supports (SDS)
- Specialized medical equipment and supplies
- Supportive home care

As a member of Partnership, you may be responsible for a monthly cost share. This amount is determined by your county and must be paid to keep your eligibility for Medicaid. Partnership will bill you for the cost share each month. (The federal government refers to this as the “post-eligibility treatment of income.”) If you reside in substitute care, you must also pay for room and board. Partnership will also bill you for room and board each month.

Providers may not bill you for covered benefits that were authorized by Partnership and received while you were enrolled in our plan. Providers may bill you for non-covered services that you have agreed to pay.

Please refer to the benefits comparison chart, beginning on page 7 of this Summary of Benefits, for a description of the Medicare benefits to which you are entitled as a member of Partnership.



Care Wisconsin's Partnership Program has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until December 31, 2014. NCQA's approval is based on a review of Care Wisconsin's Partnership Program Model of Care and is an indicator of compliance with CMS requirements. NCQA's approval is not an endorsement by CMS and/or NCQA of Care Wisconsin's Partnership Program or the quality of service provided by Care Wisconsin's Partnership Program. Care Wisconsin's Partnership Program will still need to be approved each year by CMS in order to operate. If you have questions regarding our approval by the NCQA, please contact us at 1-800-963-0035.

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