

PARTNERSHIP

A Program of Care Wisconsin

2010 Summary of Benefits

H5209-002_H7475-001_PSB08-7-09A CMS Approval: 9/29/2009

INTERPRETER SERVICES

For assistance in understanding this document in a language other than English,
at no cost, please call (608) 245-3075 or 1-800-963-0035.

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ຕ້ອງການຊ່ວຍເຫຼືອແປສິ່ງນີ້, ຈະແປໃຫ້ຟຣີ, ກະຮຸນາໂທ
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Introduction to the Summary of Benefits for Partnership

January 1, 2010 – December 31, 2010
Dane, Columbia, Dodge, Jefferson and Sauk Counties, Wisconsin
(CMS Contracts H5209-002 & H7475-001)

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

You may be eligible to join this plan if you have Medicaid. All cost sharing in this Summary of Benefits is based on your level of Medicaid eligibility. Please call your county's Aging and Disability Resource Center or Partnership if you are in Dane County to find out if you are eligible to join. Telephone numbers are listed at the end of this introduction.

This Summary of Benefits tells you some features of our plan. It does not list every service we cover or list every limitation or exclusion. To get a complete list of our benefits, please call your county's Aging and Disability Resource Center or Partnership if you are in Dane County, and ask for the "Evidence of Coverage/Member Handbook."

YOU HAVE CHOICES IN YOUR HEALTH CARE

Medicare beneficiaries and people who have Medicaid can choose from different health care options. For example, if you have Medicare, one option is the Original (fee-for-service) Medicare Plan, and if you have Medicaid, one option is the Wisconsin (fee-for-service) Medicaid Plan. Another option is a health plan like Partnership. You may have other options, too. You make the choice. No matter what you decide, if you have Medicare, you are still in the Medicare Program, and if you have Medicaid, you are still in the Wisconsin Medicaid Program.

Whether you are eligible for Medicaid or for both Medicare and Medicaid (dual eligible), you may join or leave our plan at any time.

For more information, please call your county's Aging and Disability Resource Center or Partnership if you are in Dane County. Telephone numbers are listed at the end of this introduction. You can also call 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 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. Please call your county's Aging and Disability Resource Center or Partnership if you are in Dane County for more information about your options.

Our members receive all of the benefits that the Original Medicare Plan offers, plus all the benefits of Wisconsin Medicaid and Wisconsin home and community-based waivers. We also offer more benefits, which may change from year to year.

WHERE IS PARTNERSHIP AVAILABLE?

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

WHO IS ELIGIBLE TO JOIN PARTNERSHIP?

You may be eligible to join Partnership if you are: eligible for Wisconsin Medicaid; age 18 or over; meet certain medical or disability requirements as determined by the State; and are a resident of the plan's service area. However, individuals with end-stage renal disease (ESRD) who are eligible for both Medicare and Medicaid are not eligible to enroll in Partnership. Individuals who are Medicaid-only or who were diagnosed with ESRD while enrolled in Partnership are eligible to remain enrolled.

To find out if you are eligible to join, please call your county's Aging and Disability Resource Center or Partnership if you are in Dane County. Telephone numbers are listed at the end of this introduction.

CAN I CHOOSE MY DOCTORS?

Partnership 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 up-to-date list or 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. Neither Partnership, the Original Medicare Plan or Wisconsin Medicaid will pay for these services, except with emergency, certain urgent care, and out-of-area dialysis services.

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

Partnership does cover Medicare Part B prescription drugs, Medicare Part D prescription drugs and Medicaid prescription drugs.

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

Partnership 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 current Pharmacy Network List or visit us at www.carewisconsinhealthplan.org. Our customer service number is listed at the end of this introduction.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Partnership uses a formulary. A formulary is a list of drugs covered by a 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. (Note: Medicaid-only members do not pay for their drugs.) 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 PRESCRIPTION DRUG PLAN COSTS?

Since you must have Wisconsin Medicaid to enroll in Partnership, you will qualify for extra help with your Medicare prescription drug plan costs, and your premium and costs at the pharmacy will be lower. Your monthly premium will be \$0. When you join Partnership, Medicare will tell us how much extra help you are getting with costs at the pharmacy. Then we will let you know the amount you will pay. If you are not getting this extra help you can see if you qualify by calling:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week;
- 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
- Wisconsin Medicaid at 1-800-362-3002. TTY users should call 1-800-362-3002.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans, including Partnership, agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare and Medicaid coverage in your area.

Payment for Covered Services

If you have both Medicare and Medicaid, you may have copays for your prescription drugs. Otherwise, you will not pay co-payments, coinsurance, or deductibles for covered services in Partnership. Except for Medicare Part D prescription drugs, our providers cannot bill, charge, collect or receive any form of payment from Partnership members for covered services.

All Services Except Part D Drugs

As a member of Partnership, you have the right to request a coverage 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.

Appeals

You have the right to request a coverage 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.

Grievances

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 our state, MetaStar (1-608-274-1940 or toll free at 1-800-362-2320).

Drug Coverage Determination

As a member of Partnership (HMO), 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.

Appeals

You have the right to request a coverage determination if you want us to cover a 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. (Note: Medicaid-only members do not have out-of-pocket costs.) 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.

Grievances

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 our state, MetaStar (1-608-274-1940 or toll free at 1-800-362-2320).

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we may 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 for more details.

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

If you have Medicaid and you do not have Medicare, your prescription drugs are covered under Medicaid. When you have Medicare 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 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 alpha 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 provided through Durable Medical Equipment.

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 Web tools on www.medicare.gov and select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to compare the plan ratings for Medicare plans in your area. You can also call us directly at (608) 245-3075 or 1-800-963-0035 to obtain a copy of the plan ratings for this plan. TTY users call WI Relay 711.

FOR MORE INFORMATION

Below are places you can get more information about Partnership, Medicaid, Family Care, and Medicare programs.

Prospective Members

Please call your county's Aging and Disability Resource Center or Partnership in Dane County. Hours of operation: Monday-Friday, 8 a.m. to 4:30 p.m., CT.

Columbia County

Aging and Disability Resource Center
(608) 742-9233 or 1-888-742-9233
TTY: (608) 742-9229

Dane County

Partnership Customer Service
(608) 245-3075 or 1-800-963-0035
TTY: WI Relay 711
www.carewisconsinhealthplan.org

Dodge County

Aging and Disability Resource Center
(920) 386-3580 or 1-800-924-6407
TTY: (920) 386-3883

Jefferson County

Aging and Disability Resource Center
(920) 674-8734 or 1-866-740-2372
TTY: (920) 674-5011

Sauk County

Aging and Disability Resource Center
(608) 355-3289 or 1-800-482-3710
TTY: (608) 355-3289

Current Members

Please call Partnership Customer Service at (608) 245-3075 or 1-800-963-0035. TTY users should call WI Relay 711. Hours of operation: Monday-Friday, 8 a.m. to 4:30 p.m., CT. Or visit www.carewisconsinhealthplan.org on the Web.

General Hotlines

Wisconsin Medicaid

For more information, please call 1-800-362-3002. TTY users should call 1-800-362-3002. You can call 24 hours a day, 7 days a week. Or visit www.dhs.wi.gov/medicaid on the Web.

Medigap

For more information, please call the Medigap Helpline at 1-800-242-1060.

Medicare

For more information, please 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.

Summary of Benefits (CMS Contracts H5209-002 & H7475-001)

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

Benefit Category	Original Medicare	Partnership Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Members who are eligible for Wisconsin Medicaid but not Medicare
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IMPORTANT INFORMATION

1 - Premium and Other Important Information

In 2010 the monthly Part B premium is \$0 and the yearly 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.

Most people will pay the standard monthly Part B premium. However, starting January 1, 2010, some people will pay a higher premium because of their yearly income. (For 2009, this amount was \$85,000 for singles, \$170,000 for married couples. This amount may change for 2010.) For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

General
\$0 monthly plan premium.

Some members may have to pay a monthly Medicaid cost share as determined by the County Department of Human Services to remain eligible for Wisconsin Medicaid.

General
There are no premiums, deductibles, or copayments for members who are eligible for Medicaid but not for Medicare.

Some members may have to pay a monthly Medicaid cost share as determined by the County Department of Human Services to remain eligible for Wisconsin Medicaid.

Out-of-Network
Unless otherwise noted, out-of-network services not covered.

*All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.

Benefit Category	Original Medicare	Partnership Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Members who are eligible for Wisconsin Medicaid but not Medicare
2 - Doctor and Hospital Choice (For more information, see #15 - Emergency Care and #16 - Urgently Needed Care.)	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.	In-Network You must go to network doctors, specialists and hospitals. No referral required for network doctors, specialists and hospitals.
INPATIENT CARE			
3 - Inpatient Hospital Care (includes substance abuse and rehabilitation services)	<p>For each benefit period: Days 1-60: \$0 deductible Days 61-90: \$0 per day Days 91-150: \$0 per lifetime reserve day</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>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 period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p>In-Network You will not be charged additional cost sharing for professional services. \$0 yearly deductible. \$0 copay. Plan covers unlimited days each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>In-Network There are no deductibles or copayments for covered stays at a network hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Plan covers unlimited days.</p>

4 - Inpatient Mental Health Care

Same deductible and copay as inpatient hospital care (see #3 - Inpatient Hospital Care).

190-day limit in a psychiatric hospital.

In-Network

\$0 yearly deductible.

\$0 copay.

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

In-Network

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

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

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

In 2010 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 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. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

General

Authorization rules may apply.

In-Network

\$0 yearly deductible.

\$0 copay for skilled nursing facility services.

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

Plan covers unlimited days each benefit period.

No prior hospital stay is required.

General

Authorization rules may apply.

In-Network

\$0 copay for covered stays at a skilled nursing facility.

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

Plan covers unlimited days each benefit period.

No prior hospital stay is required.

Benefit Category	Original Medicare	Partnership Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Members who are eligible for Wisconsin Medicaid but not Medicare
6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, rehabilitation services, etc.)	\$0 copay.	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for covered home health visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for covered home health visits.</p>
7 - Hospice	<p>You pay part of the cost for outpatient drugs.</p> <p>You must get care from a Medicare-certified hospice.</p>	<p>General You must get care from a Medicare-certified hospice.</p> <p>There are no copayments.</p>	<p>General Authorization rules may apply. Contact plan for details.</p> <p>There are no copayments for end-of-life care.</p>
OUTPATIENT CARE			
8 - Doctor Office Visits	0% coinsurance.	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for each primary care doctor visit for covered benefits.</p> <p>\$0 copay for the cost of each in-area, network urgent care covered visit.</p> <p>\$0 copay for each specialist doctor visit for covered benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for each primary care doctor visit for covered benefits.</p> <p>\$0 copay for the cost of each in-area, network urgent care covered visit.</p> <p>\$0 copay for each specialist doctor visit for covered benefits.</p>

9 - Chiropractic Services

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 covered chiropractic visits.

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.

General

Authorization rules may apply.

In-Network

\$0 copay for covered chiropractic visits.

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.

10 - Podiatry Services

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

General

Authorization rules may apply.

In-Network

\$0 copay for covered podiatry benefits.
Covered podiatry benefits are for medically-necessary foot care.

11 - Outpatient Mental Health Care

0% coinsurance for most outpatient mental health services.

General

Authorization rules may apply.

In-Network

\$0 copay for covered mental health visits.

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

General

Authorization rules may apply.

In-Network

\$0 copay for covered mental health visits.

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

Benefit Category	Original Medicare	Partnership Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Members who are eligible for Wisconsin Medicaid but not Medicare
12 - Outpatient Substance Abuse Care	0% coinsurance.	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for covered visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for covered visits.</p>
13 - Outpatient Services/Surgery	0% coinsurance for the doctor. 0% of outpatient facility charges.	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for each covered ambulatory surgical center visit. \$0 copay for each covered outpatient hospital facility visit.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for each covered ambulatory surgical center visit. \$0 copay for each covered outpatient hospital facility visit.</p>
14 - Ambulance Services (medically necessary ambulance services)	0% coinsurance.	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for covered ambulance benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for covered ambulance benefits.</p>
15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	0% coinsurance for the doctor. 0% of facility charge or 0% per emergency room visit. You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. NOT covered outside the U.S. except under limited circumstances.	<p>General \$0 copay for covered emergency room visits.</p> <p>Not covered outside the U.S. except under limited circumstances. Contact the plan for more details.</p>	<p>General \$0 copay for covered emergency room visits.</p> <p>Not covered outside the U.S. except under limited circumstances. Contact the plan for more details.</p>

16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	0% coinsurance. NOT covered outside the U.S. except under limited circumstances.	General \$0 copay for covered urgent-care visits. NOT covered outside the U.S. except under limited circumstances.	General \$0 copay for covered urgent-care visits. NOT covered outside the U.S. except under limited circumstances.
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17 - Outpatient Rehabilitation Services (includes occupational therapy, physical therapy, speech and language therapy)	0% coinsurance.	General Authorization rules may apply. In-Network \$0 copay for covered occupational therapy visits. \$0 copay for covered physical and/or speech/language therapy visits.	General Authorization rules may apply. In-Network \$0 copay for covered occupational therapy visits. \$0 copay for covered physical and/or speech/language therapy visits.
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OUTPATIENT MEDICAL SERVICES AND SUPPLIES

18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	0% coinsurance.	General Authorization rules may apply. In-Network \$0 copay for covered items.	General Authorization rules may apply. In-Network \$0 copay for covered items.
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19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	0% coinsurance.	General Authorization rules may apply. In-Network \$0 copay for covered items.	General Authorization rules may apply. In-Network \$0 copay for covered items.
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*All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.

Benefit Category	Original Medicare	Partnership Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Members who are eligible for Wisconsin Medicaid but not Medicare
<p>20 - Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p>	<p>0% coinsurance.</p> <p>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 or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for diabetes self-monitoring training.</p> <p>\$0 copay for nutrition therapy for diabetes.</p> <p>\$0 copay for diabetes supplies.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for diabetes self-monitoring training.</p> <p>\$0 copay for nutrition therapy for diabetes.</p> <p>\$0 copay for diabetes supplies.</p>
<p>21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</p>	<p>0% coinsurance for diagnostic tests and X-rays.</p> <p>\$0 copay for Medicare-covered lab services.</p> <p>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 routine screening tests, like checking your cholesterol.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for covered:</p> <ul style="list-style-type: none"> - lab services. - diagnostic procedures and tests. - X-rays. - diagnostic radiology services (not including X-rays). - therapeutic radiology services. 	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for covered:</p> <ul style="list-style-type: none"> - lab services. - diagnostic procedures and tests. - X-rays. - diagnostic radiology services (not including X-rays). - therapeutic radiology services.

PREVENTIVE SERVICES

22 - Bone Mass Measurement (for people with Medicare who are at risk)

0% coinsurance.

Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.

General

Authorization rules may apply.

In-Network

\$0 copay for covered bone mass measurement.

General

Authorization rules may apply.

In-Network

\$0 copay for covered bone mass measurement.

23 - Colorectal Screening Exams (for people with Medicare age 50 and older)

0% coinsurance.

Covered when you are high risk or when you are age 50 and older.

General

Authorization rules may apply.

In-Network

\$0 copay for covered colorectal screenings.

General

Authorization rules may apply.

In-Network

\$0 copay for covered colorectal screenings.

24 - Immunizations (flu vaccine, hepatitis B vaccine – for people with Medicare who are at risk, pneumonia vaccine)

\$0 copay for flu and pneumonia vaccines.

0% coinsurance for hepatitis B vaccine.

You may only need the pneumonia vaccine once in your lifetime. Call your doctor for more information.

General

Authorization rules may apply.

In-Network

\$0 copay for flu and pneumonia vaccines.

\$0 copay for hepatitis B vaccine.

No referral needed for flu and pneumonia vaccines.

General

Authorization rules may apply.

In-Network

\$0 copay for flu and pneumonia vaccines.

\$0 copay for hepatitis B vaccine.

No referral needed for flu and pneumonia vaccines.

*All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.

Benefit Category	Original Medicare	Partnership Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Members who are eligible for Wisconsin Medicaid but not Medicare
25 - Mammograms (Annual Screening) (for women with Medicare age 40 and older)	<p>0% coinsurance.</p> <p>No referral needed.</p> <p>Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.</p>	<p>In-Network</p> <p>\$0 copay for covered screening mammograms.</p>	<p>In-Network</p> <p>\$0 copay for covered screening mammograms.</p>
26 - Pap Smears and Pelvic Exams (for women with Medicare)	<p>\$0 copay for pap smears.</p> <p>Covered once every 2 years.</p> <p>Covered once a year for women with Medicare at high risk.</p> <p>0% coinsurance for pelvic exams.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for covered pap smears and pelvic exams.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for covered pap smears and pelvic exams.</p>
27 - Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	<p>0% coinsurance for the digital rectal exam.</p> <p>\$0 for the PSA test; 0% coinsurance for other related services.</p> <p>Covered once a year for all men with Medicare over age 50.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for covered prostate cancer screening.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for covered prostate cancer screening.</p>

28 - End-Stage Renal Disease

0% coinsurance for renal dialysis.

0% coinsurance for nutrition therapy for end-stage renal disease.

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 or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.

General

Authorization rules may apply.

In-Network

\$0 copay for in- and out-of-area renal dialysis.

\$0 copay for nutrition therapy for end-stage renal disease.

General

Authorization rules may apply.

In-Network

\$0 copay for renal dialysis.

\$0 copay for nutrition therapy for end-stage renal disease.

29 - 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 yearly deductible for 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:

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.

*All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.

Benefit Category	Original Medicare	Partnership Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Members who are eligible for Wisconsin Medicaid but not Medicare
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29 - Prescription Drugs
(continued)

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

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 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.

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 for certain drugs.

The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details.

Your in-network prescription coverage is 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 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.

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 for certain drugs.

The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details.

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

You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's Web site, formulary, and 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 yearly deductible.

In-Network

There are no deductibles or copayments for Medicaid-covered prescription drugs.

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 \$2.50 copay.

-For all other drugs, either:

- \$0 copay; or
- \$3.30 copay; or
- \$6.30 copay.

Benefit Category	Original Medicare	Partnership Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Members who are eligible for Wisconsin Medicaid but not Medicare
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29 - Prescription Drugs
(continued)

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

After your yearly out-of-pocket drug costs reach \$4,550, you pay a \$0 copay.

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

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 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.

You can get drugs the following way:
 -10-day supply

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

29 - Prescription Drugs
(continued)

Out-of-Network Initial Coverage

Depending on your income and institutional status, you will be reimbursed by Partnership up to the full 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 \$2.50 copay.

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

- \$0 copay; or
- \$3.30 copay; or
- \$6.30 copay.

Out-of-Network Catastrophic Coverage

After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed in full for drugs purchased out-of-network.

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

30 - Dental Services

Preventive dental services (such as cleaning) not covered.

General

Dental services covered. Authorization rules may apply. Contact plan for details.

In-Network

\$0 copay for covered dental benefits.

General

Dental services covered. Authorization rules may apply. Contact plan for details.

In-Network

\$0 copay for covered dental benefits.

*All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.

Benefit Category	Original Medicare	Partnership Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Members who are eligible for Wisconsin Medicaid but not Medicare
31 - Hearing Services	<p>Routine hearing exams and hearing aids not covered.</p> <p>0% coinsurance for diagnostic hearing exams.</p>	<p>General Hearing services covered. Authorization rules may apply. Contact plan for details.</p> <p>In-Network \$0 copay for covered hearing services.</p>	<p>General Hearing services covered. Authorization rules may apply. Contact plan for details.</p> <p>In-Network \$0 copay for covered hearing services.</p>
32 - Vision Services	<p>0% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>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 Vision services covered. Authorization rules may apply. Contact plan for details.</p> <p>In-Network \$0 copay for covered vision services.</p>	<p>General Vision services covered. Authorization rules may apply. Contact plan for details.</p> <p>In-Network \$0 copay for covered vision services.</p>
33 - Physical Exams	<p>0% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage.</p> <p>When you get Medicare Part B, you can get a one-time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.</p>	<p>General Physical exams and lab tests covered.</p> <p>In-Network \$0 copay for covered benefits.</p>	<p>General Physical exams and lab tests covered.</p> <p>In-Network \$0 copay for covered benefits.</p>

Other Health Related and Community Based Services (includes case management, supportive housing, personal care assistance and chore services, respite care, adult day care, home modifications, medical and nonmedical transportation, specialized medical supplies, home delivered meals and personal emergency response systems) Not covered.

General

Other health related and community based services covered. Authorization rules may apply. Contact plan for details.

You pay room and board charges for alternate housing.

In-Network

\$0 copayments for Medicaid-covered services and supplies.

General

Other health related and community based services covered. Authorization rules may apply. Contact plan for details.

You pay room and board charges for alternate housing.

In-Network

\$0 copayments for Medicaid-covered services and supplies.

PARTNERSHIP

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