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# Summary of Benefits

January 1, 2009 – December 31, 2009  
Chippewa, Dunn and Eau Claire Counties  
Wisconsin



## INTERPRETER SERVICES

Interpreter services are available free of charge.

For help to translate or understand this, please call  
1-800-842-1814 (TTY 1-715-838-2900).

Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono  
1-800-842-1814 (TTY 1-715-838-2900).

Если вам не всё понятно в этом документе, позвоните по телефону  
1-800-842-1814 (TTY 1-715-838-2900).

Yog xav tau kev pab txhais cov ntaub ntawv no kom koj totaub, hu rau  
1-800-842-1814 (TTY 1-715-838-2900).

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1-800-842-1814 (TTY 1-715-838-2900).

**Please call Community Health Partnership,  
A Program of Partnership Health Plan, Inc.  
for more information about this plan.**

Visit us at [www.communityhealthpartnership.com](http://www.communityhealthpartnership.com) or, call us:

### **Customer Service Hours:**

24 hours a day, 7 days a week

Current and Prospective members should call (800) 842-1814 for questions related to  
the Medicare Advantage and Medicare Part D Prescription Drug programs.  
TTY/TDD (715) 838-2900.

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

For more information about Wisconsin Medicaid, please call (800) 362-3002.  
TTY users should call (888) 701-1251.  
You can call 24 hours a day, 7 days a week.  
Or, visit [www.dhs.wisconsin.gov](http://www.dhs.wisconsin.gov) on the web.

For more information about Medigap, please call  
State of Wisconsin Board on Aging and Long Term Care (800) 242-1060.

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

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# 2009 SUMMARY OF BENEFITS

## Section 1 - Introduction

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Thank you for your interest in Community Health Partnership, A Program of Partnership Health Plan, Inc. (Community Health Partnership). Our plan is offered by Partnership Health Plan, Inc., a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan. This plan is designed for people who meet specific enrollment criteria. This includes anyone who receives Wisconsin Medicaid (Medical Assistance) and/or Medicare.

All cost sharing in this summary of benefits is based on your level of Medicaid eligibility. Please call Community Health Partnership to find out if you are eligible to join. Our number is listed at the beginning 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 Community Health Partnership 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 Wisconsin Medicaid, one option is the Wisconsin (fee-for-service) Medicaid Plan.

Another option is a Medicare health plan, like Community Health 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 Wisconsin Medicaid, you are still in the Wisconsin Medicaid Program.

Partnership is a voluntary program and you may join or leave a plan at any time. Please call Community Health Partnership at the telephone number listed at the beginning of this introduction, Medicare at 1-800-MEDICARE (1-800-633-4227), or Medicaid, at (800) 362-3002 for more information. Medicare TTY users should call (877) 486-2048 and Medicaid TTY users should call (888) 701-1251. You can call these numbers 24 hours a day, 7 days a week.

### **HOW CAN I COMPARE MY OPTIONS?**

You can compare Community Health 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.

Our members receive all of the benefits that the Original Medicare Plan offers, plus all of the benefits of Wisconsin Medicaid including long-term care and support services. We also offer more benefits, which may change from year to year.

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# 2009 SUMMARY OF BENEFITS

## Section 1 - Introduction

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### **WHERE IS COMMUNITY HEALTH PARTNERSHIP AVAILABLE?**

The service area for this plan includes: Chippewa, Dunn and Eau Claire Counties in Wisconsin. You must live in one of these areas to join the plan.

### **WHO IS ELIGIBLE TO JOIN COMMUNITY HEALTH PARTNERSHIP?**

You can join Community Health Partnership if you are an adult with a Physical or Developmental Disability or are over the age of 65, live in the service area, financially eligible for Wisconsin Medicaid, functionally eligible as determined by the State of Wisconsin Long-Term Care Functional Screen and if you are eligible for Medicare you must be enrolled in Medicare Part A, Part B, and Part D. Please call Community Health Partnership to see if you are eligible to join.

### **CAN I CHOOSE MY DOCTORS?**

Community Health 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 or for an up-to-date list or visit us at [www.communityhealthpartnership.com](http://www.communityhealthpartnership.com). Our customer service number is listed at the beginning 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 without first contacting your Team and getting prior authorization, you must pay for these services yourself. Neither Community Health Partnership, the Original Medicare Plan, nor Wisconsin Medicaid will pay for these services.

### **DOES MY PLAN COVER MEDICARE PART B, MEDICARE PART D, OR WISCONSIN MEDICAID DRUGS?**

Community Health Partnership covers Wisconsin Medicaid prescription drugs, Medicare Part B prescription drugs and Medicare Part D prescription drugs.

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

Community Health 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. If a pharmacy should leave our network, we will notify the members using that pharmacy and assist the members with changing to another network pharmacy. You can ask for a current Pharmacy Directory or visit us at [www.communityhealthpartnership.com](http://www.communityhealthpartnership.com). Our customer service number is listed at the beginning of this introduction.

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# 2009 SUMMARY OF BENEFITS

## Section 1 - Introduction

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### **WHAT IS A PRESCRIPTION DRUG FORMULARY?**

Community Health Partnership uses a formulary. A formulary is a list of drugs covered by our plan to meet our members' 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 members before the change is made. We will send a formulary to you and you can see our complete formulary on our website at [www.communityhealthpartnership.com](http://www.communityhealthpartnership.com).

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?**

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join Community Health Partnership, Medicare will tell us how much extra help you are getting. 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 users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

### **WHAT ARE MY PROTECTIONS IN THIS PLAN?**

Community Health Partnership is a Wisconsin Medicaid plan and a Medicare Advantage Plan. All Medicare Advantage Plans 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 90 days before your coverage will end. The letter will explain your options for Wisconsin Medicaid and Medicare coverage in your area.

As a member of Community Health Partnership, you have the right to request a prescription drug coverage determination, which may include 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 prescription 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.

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## 2009 SUMMARY OF BENEFITS

### Section 1 - Introduction

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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.

#### **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 Community Health Partnership 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:

- **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 DME.

Contact Community Health Partnership for more details.

# 2009 SUMMARY OF BENEFITS

## Section 2 – Benefits Comparison

*If you have any questions about the plan's benefit costs, please contact Community Health Partnership*

| Benefit Category                            | Original Medicare<br>AND<br>Community Health<br>Partnership Members<br>who are <u>not</u> eligible for<br>Wisconsin Medicaid | Community Health<br>Partnership Members<br>who are eligible<br>for <u>both</u> Medicare and<br>Wisconsin Medicaid   | Community Health<br>Partnership Members<br>who are eligible<br>for Wisconsin Medicaid<br>but <u>not</u> Medicare  |
|---|--|---|---|
| <b>IMPORTANT INFORMATION</b>                |  |   |   |
| 1 - Premium and Other Important Information | You pay the Medicare Part B premium of \$96.40 each month.<br>(1) (2)  | <p>There is a Medicare Part B premium of \$96.40 each month for your plan benefits. You may be eligible for Medicare Part B premium assistance depending on your income and asset level.</p> <p>There is an additional premium of \$29.00 each month for Medicare Part D prescription drug benefits. You are eligible for \$29.00 of Medicare Part D premium assistance.</p> <p>Unless otherwise noted, out-of-network services not covered.</p> <p>Some Members may have to pay a monthly Medicaid cost share as determined by the Chippewa, Dunn or Eau Claire County Department of Human Services to remain eligible for Wisconsin Medicaid and enrolled in Partnership.</p> | <p>There are no premiums, deductibles, or copayments for members who are eligible for Medicaid but not for Medicare.</p> <p>Unless otherwise noted, out-of-network services not covered.</p> <p>Some members may have to pay a monthly Medicaid cost share as determined by the Chippewa, Dunn or Eau Claire County Department of Human Services to remain eligible for Wisconsin Medicaid and enrolled in Partnership.</p> |

(1) Each year, you pay a total of one \$135 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

# 2009 SUMMARY OF BENEFITS

## Section 2 – Benefits Comparison

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|--|---|---|--|
| 2 - Doctor and Hospital Choice<br><i>(For more information, see Emergency - #15 and Urgently Needed Care - #16.)</i> | You may go to any doctor, specialist or hospital that accepts Medicare. (1)(2)  | You must go to network doctors, specialists, and hospitals.<br><br>You do <b>NOT</b> need a referral to go to network doctors, specialists, and hospitals.  | You must go to network doctors, specialists, and hospitals.<br><br>You do <b>NOT</b> need a referral to go to network doctors, specialists, and hospitals.   |
| <b>SUMMARY OF BENEFITS</b>   |   |   |  |
| <b>INPATIENT CARE</b>  |   |   |  |
| 3 - Inpatient Hospital Care<br><br><i>(includes Substance Abuse and Rehabilitation Services)</i>                     | You pay for each benefit period (3):<br><br>Days 1 - 60: an initial deductible of \$1,068<br><br>Days 61 - 90: \$267 each day<br><br>Days 91 - 150: \$534 each lifetime reserve day (4)<br><br>Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. (4) | There are no deductibles or copayments for covered stays at a network hospital.<br><br>You are covered for unlimited days each benefit period.<br><br>You are required to use network hospitals except in an emergency. You do NOT need a referral to receive services from a network hospital.<br><br>Except in an emergency, your provider must obtain authorization. | There are no deductibles or copayments for covered stays at a network hospital.<br><br>You are required to use network hospitals except in an emergency. You do NOT need a referral to receive services from a network hospital.<br><br>Except in an emergency, your provider must obtain authorization. |

(1) Each year, you pay a total of one \$135 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

(3) A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. 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.

(4) Lifetime reserve days can only be used once.

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### Section 2 – Benefits Comparison

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|---|--|--|--|
| 4 - Inpatient<br>Mental Health<br>Care  | You pay the same deductible and copayments as inpatient hospital care (above) except Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.   | There are no deductibles or copayments for covered stays at a network hospital.<br><br>You are required to use network hospitals except in an emergency. You do NOT need a referral to receive services from a network hospital.<br><br>Except in an emergency, your provider must obtain authorization from Community Health Partnership. | There are no deductibles or copayments for covered stays at a network hospital.<br><br>You are required to use network hospitals except in an emergency. You do NOT need a referral to receive services from a network hospital.<br><br>Except in an emergency, your provider must obtain authorization from Community Health Partnership. |
| 5 - Skilled Nursing<br>Facility<br><br><i>(in a Medicare-<br/>certified skilled<br/>nursing facility)</i> | You pay for each benefit period (3), following at least a 3-day covered hospital stay:<br><br>Days 1 - 20: \$0 for each day<br><br>Days 21 - 100: \$133.50 for each day<br><br>There is a limit of 100 days for each benefit period. (3) | There is no co-payment for covered stays at a network skilled nursing facility.<br><br>You are covered for an unlimited number of days.<br><br>You are required to use network skilled nursing facilities.<br><br>Prior authorization may be required. Contact plan for details.   | There is no co-payment for covered stays at a network skilled nursing facility.<br><br>You are required to use network skilled nursing facilities.<br><br>Prior authorization may be required. Contact plan for details.   |

*(3) A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. 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.*

## 2009 SUMMARY OF BENEFITS

### Section 2 – Benefits Comparison

*If you have any questions about the plan's benefit costs, please contact Community Health Partnership*

| Benefit Category  | Original Medicare<br>AND<br>Community Health<br>Partnership Members<br>who are <u>not</u> eligible for<br>Wisconsin Medicaid | Community Health<br>Partnership Members<br>who are eligible<br>for <u>both</u> Medicare and<br>Wisconsin Medicaid   | Community Health<br>Partnership Members<br>who are eligible<br>for Wisconsin Medicaid<br>but <u>not</u> Medicare  |
|---|--|---|---|
| 6 - Home Health Care<br><i>(includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</i> | There is no co-payment for all covered home health visits.   | There is no co-payment for covered home health visits.<br><br>Prior authorization may be required. Contact plan for details.  | There is no co-payment for covered home health visits.<br><br>Prior authorization may be required. Contact plan for details.  |
| 7 - Hospice   | You pay part of the cost for outpatient drugs.<br><br>You must receive care from a Medicare-certified hospice.               | You must receive care from a Medicare-certified hospice.<br><br>Prior authorization may be required. Contact plan for details.  | There are no copayments for end-of-life care.<br><br>Prior authorization may be required. Contact plan for details.   |
| <b>OUTPATIENT CARE</b>  |  |   |   |
| 8 - Doctor Office Visits  | You pay 20% of Medicare-approved amounts. (1)(2)   | There are no deductibles or copayments for covered primary care doctor or specialist office visits.<br><br>Prior authorization may be required. Contact plan for details. | There are no deductibles or copayments for covered primary care doctor or specialist office visits.<br><br>Prior authorization may be required. Contact plan for details. |

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# 2009 SUMMARY OF BENEFITS

## Section 2 – Benefits Comparison

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|------------------------------------|---|--|--|
| 9 - Chiropractic Services          | <p>You are covered for manual manipulation of the spine to correct subluxation, (a displacement or misalignment of a joint or body part) if provided by chiropractors or other qualified providers.</p> <p>You pay 100% for routine care.</p> | <p>There are no deductibles or copayments for covered chiropractic services.</p> <p>Prior authorization may be required. Contact plan for details.</p> | <p>There are no deductibles or copayments for covered chiropractic services.</p> <p>Prior authorization may be required. Contact plan for details.</p> |
| 10 - Podiatry Services             | <p>You pay 20% of Medicare-approved amounts. (1)(2)</p> <p>You are covered for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p> <p>You pay 100% for routine care.</p>                      | <p>There are no deductibles or copayments for covered podiatry services.</p> <p>Prior authorization may be required. Contact plan for details.</p>     | <p>There are no deductibles or copayments for covered podiatry services.</p> <p>Prior authorization may be required. Contact plan for details.</p>     |
| 11 - Outpatient Mental Health Care | <p>You pay 50% of Medicare-approved amounts for most outpatient mental health services. (1)(2)</p>  | <p>There are no deductibles or copayments for covered mental health care.</p> <p>Prior authorization may be required. Contact plan for details.</p>    | <p>There are no deductibles or copayments for covered mental health care.</p> <p>Prior authorization may be required. Contact plan for details.</p>    |

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|---|--|--|--|
| 12 - Outpatient<br>Substance Abuse<br>Care  | You pay 20% of<br>Medicare-approved<br>amounts. (1)(2)   | There are no deductibles<br>or copayments for<br>covered substance<br>abuse care.<br><br>Prior authorization may<br>be required. Contact<br>plan for details.        | There are no deductibles<br>or copayments for<br>covered substance<br>abuse care.<br><br>Prior authorization may<br>be required. Contact<br>plan for details.        |
| 13 - Outpatient<br>Services/Surgery   | You pay 20% of<br>Medicare-approved<br>amounts for the doctor.<br>(1)(2)<br><br>You pay 20% of<br>outpatient facility<br>charges. (1)(2) | There are no deductibles<br>or copayments for<br>covered outpatient<br>services/surgery.<br><br>Prior authorization may<br>be required. Contact<br>plan for details. | There are no deductibles<br>or copayments for<br>covered outpatient<br>services/surgery.<br><br>Prior authorization may<br>be required. Contact<br>plan for details. |
| 14 - Ambulance<br>Services<br><br><i>(medically<br/>necessary<br/>ambulance<br/>services)</i> | You pay 20% of<br>Medicare-approved<br>amounts. (1)(2)   | There are no deductibles<br>or copayments for<br>covered ambulance<br>services.<br><br>Prior authorization may<br>be required. Contact<br>plan for details.          | There are no deductibles<br>or copayments for<br>covered ambulance<br>services.<br><br>Prior authorization may<br>be required. Contact<br>plan for details.          |

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|--|---|---|---|
| <p>15 - Emergency Care</p> <p><i>(You may go to any emergency room if you reasonably believe you need emergency care.)</i></p>     | <p>You pay 20% of the facility charge or applicable copayment for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. (1)(2)</p> <p>You pay 20% of doctor charges (1)(2)</p> <p><i>(NOT covered outside the U.S. except under limited circumstances.)</i></p> | <p>There are no deductibles or copayments for covered emergency care.</p> <p><i>(NOT covered outside the U.S. except under limited circumstances.)</i></p>          | <p>There are no deductibles or copayments for covered emergency care.</p> <p><i>(NOT covered outside the U.S. except under limited circumstances.)</i></p>          |
| <p>16 - Urgently Needed Care</p> <p><i>(This is NOT emergency care, and in most cases, is out of the service area.)</i></p>        | <p>You pay 20% of Medicare-approved amounts or applicable copayment. (1)(2)</p> <p><i>(NOT covered outside the U.S. except under limited circumstances.)</i></p>  | <p>There are no deductibles or copayments for covered urgently needed care.</p> <p><i>(NOT covered outside the U.S. except under limited circumstances.)</i></p>    | <p>There are no deductibles or copayments for covered urgently needed care.</p> <p><i>(NOT covered outside the U.S. except under limited circumstances.)</i></p>    |
| <p>17 - Outpatient Rehabilitation Services</p> <p><i>(Occupational Therapy, Physical Therapy, Speech and Language Therapy)</i></p> | <p>You pay 20% of Medicare-approved amounts. (1)(2)</p>   | <p>There are no deductibles or copayments for covered outpatient rehabilitation services.</p> <p>Prior authorization may be required. Contact plan for details.</p> | <p>There are no deductibles or copayments for covered outpatient rehabilitation services.</p> <p>Prior authorization may be required. Contact plan for details.</p> |

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|--|---|--|--|
| <b>OUTPATIENT MEDICAL SERVICES AND SUPPLIES</b>  |   |  |  |
| 18 - Durable Medical Equipment<br><br><i>(includes wheelchairs, oxygen, etc.)</i>  | You pay 20% of Medicare-approved amounts. (1)(2)  | There are no deductibles or copayments for covered durable medical equipment.<br><br>Prior authorization may be required. Contact plan for details.                      | There are no deductibles or copayments for covered durable medical equipment.<br><br>Prior authorization may be required. Contact plan for details.                      |
| 19 - Prosthetic Devices<br><br><i>(includes braces, artificial limbs and eyes, etc.)</i>   | You pay 20% of Medicare-approved amounts. (1)(2)  | There are no deductibles or copayments for covered prosthetic devices.<br><br>Prior authorization may be required. Contact plan for details.                             | There are no deductibles or copayments for covered prosthetic devices.<br><br>Prior authorization may be required. Contact plan for details.                             |
| 20 - Diabetes Self-Monitoring Training, Nutrition Therapy and Supplies<br><br><i>(includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</i> | You pay 20% of Medicare-approved amounts. (1)(2)<br><br>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. | There are no deductibles or copayments for covered diabetes self-monitoring training and supplies.<br><br>Prior authorization may be required. Contact plan for details. | There are no deductibles or copayments for covered diabetes self-monitoring training and supplies.<br><br>Prior authorization may be required. Contact plan for details. |

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# 2009 SUMMARY OF BENEFITS

## Section 2 – Benefits Comparison

*If you have any questions about the plan's benefit costs, please contact Community Health Partnership*

| Benefit Category   | Original Medicare<br>AND<br>Community Health<br>Partnership Members<br>who are <u>not</u> eligible for<br>Wisconsin Medicaid  | Community Health<br>Partnership Members<br>who are eligible<br>for <u>both</u> Medicare and<br>Wisconsin Medicaid  | Community Health<br>Partnership Members<br>who are eligible<br>for Wisconsin Medicaid<br>but <u>not</u> Medicare   |
|--|---|--|--|
| 21 - Diagnostic Tests, X-Rays, and Lab Services                                    | <p>You pay 20% of Medicare-approved diagnostic tests and x-rays. (1)(2)</p> <p>There is no copayment for Medicare-approved lab services.</p>                            | <p>There are no deductibles or copayments for covered diagnostic tests, x-rays and lab services.</p> <p>Prior authorization may be required. Contact plan for details.</p> | <p>There are no deductibles or copayments for covered diagnostic tests, x-rays and lab services.</p> <p>Prior authorization may be required. Contact plan for details.</p> |
| <b>PREVENTIVE SERVICES</b>   |   |  |  |
| <p>22 - Bone Mass Measurement</p> <p><i>(for people who are at risk)</i></p>       | <p>You pay 20% of Medicare-approved amounts. (1)(2)</p> <p>Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</p> | <p>There are no deductibles or copayments for covered bone mass measurement.</p> <p>Prior authorization may be required. Contact plan for details.</p>                     | <p>There are no deductibles or copayments for covered bone mass measurement.</p> <p>Prior authorization may be required. Contact plan for details.</p>                     |
| <p>23 - Colorectal Screening Exams</p> <p><i>(for people age 50 and older)</i></p> | <p>You pay 20% of Medicare-approved amounts. (1)(2)</p> <p>Covered when you are high risk or when you are age 50 and older.</p>   | <p>There are no deductibles or copayments for covered colorectal screening exams.</p> <p>Prior authorization may be required. Contact plan for details.</p>                | <p>There are no deductibles or copayments for covered colorectal screening exams.</p> <p>Prior authorization may be required. Contact plan for details.</p>                |

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# 2009 SUMMARY OF BENEFITS

## Section 2 – Benefits Comparison

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|---|--|--|--|
| <p>24 –<br/>Immunizations</p> <p><i>(Flu vaccine,<br/>Hepatitis B<br/>vaccine- for<br/>people who are at<br/>risk, Pneumonia<br/>vaccine)</i></p> | <p>There is no copayment for the Pneumonia and Flu vaccines.</p> <p>You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine. (1)(2)</p> <p>You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.</p> | <p>There are no deductibles or copayments for the Flu, Pneumonia and Hepatitis B vaccines.</p> <p>No referral is necessary for the Flu, Pneumonia, and Hepatitis vaccines.</p> <p>Prior authorization may be required. Contact plan for details.</p> | <p>There are no deductibles or copayments for the Flu, Pneumonia and Hepatitis B vaccines.</p> <p>No referral is necessary for the Flu, Pneumonia, and Hepatitis vaccines.</p> <p>Prior authorization may be required. Contact plan for details.</p> |
| <p>25 -<br/>Mammograms<br/>(Annual<br/>Screening)</p> <p><i>(for women age<br/>40 and older)</i></p>  | <p>You pay 20% of Medicare-approved amounts. (2)</p> <p>No referral necessary for Medicare-covered screenings.</p> <p>Covered once a year for all women age 40 and older. One baseline mammogram covered for women between 35 and 39.</p>                                  | <p>There are no deductibles or copayments for covered mammograms.</p> <p>Prior authorization may be required. Contact plan for details.</p>  | <p>There are no deductibles or copayments for covered mammograms.</p> <p>Prior authorization may be required. Contact plan for details.</p>  |
| <p>26 - Pap Smears<br/>and Pelvic Exams</p> <p><i>(for women)</i></p>   | <p>There is no copayment for a Pap Smear once every 2 years, annually for beneficiaries at high risk. (2)</p> <p>You pay 20% of Medicare-approved amounts for Pelvic Exams.(2)</p>   | <p>There are no deductibles or copayments for covered pap smears and pelvic exams.</p> <p>Prior authorization may be required. Contact plan for details.</p>   | <p>There are no deductibles or copayments for covered pap smears and pelvic exams.</p> <p>Prior authorization may be required. Contact plan for details.</p>   |

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# 2009 SUMMARY OF BENEFITS

## Section 2 – Benefits Comparison

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|--|--|--|--|
| <p>27 - Prostate Cancer Screening Exams</p> <p><i>(for men age 50 and older)</i></p> | <p>There is no copayment for approved lab services.</p> <p>You pay 20% of Medicare-approved amounts for the exam and other related services. (1)(2)</p> <p>Covered once a year for all men over age 50.</p>  | <p>There are no deductibles or copayments for covered prostate cancer screening exams.</p> <p>Prior authorization may be required. Contact plan for details.</p> | <p>There are no deductibles or copayments for covered prostate cancer screening exams.</p> <p>Prior authorization may be required. Contact plan for details.</p> |
| <p>28 - ESRD</p>   | <p>You pay 20% of Medicare-approved dialysis. (1)(2)</p> <p>You pay 20% of Medicare-approved Nutrition Therapy for ESRD. (1)(2)</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>There are no deductibles or copayments for covered dialysis or nutrition therapy.</p> <p>Out-of-area dialysis services do not require authorization.</p>      | <p>There are no deductibles or copayments for covered dialysis or nutrition therapy.</p> <p>Out-of-area dialysis services do not require authorization.</p>      |

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# 2009 SUMMARY OF BENEFITS

## Section 2 – Benefits Comparison

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|---|--|--|--|
| <p>29 - Outpatient Prescription Drugs</p> <p>Drugs covered under Medicare Part B (Original Medicare)</p> <p>Drugs covered under Medicare Part D (Prescription Drug Benefit)</p> | <p>You pay 100% for most prescription drugs, unless you enroll in a Medicare Prescription Drug Plan.</p>                     | <p>There are no deductibles or copayments for Medicare Part B and Medicaid covered outpatient prescription drugs.</p> <p>This plan uses a formulary. A formulary is a list of drugs covered by your plan to meet members' needs. We may periodically add, remove, 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 members before the change is made. We will send a formulary to you and you can see our complete formulary on our Website at <a href="http://www.communityhealthpartnership.com">www.communityhealthpartnership.com</a>.</p> | <p>There are no deductibles or copayments for Medicaid covered outpatient prescription drugs.</p> <p>This plan uses a formulary. A formulary is a list of drugs covered by your plan to meet members' needs. We may periodically add, remove, 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 members before the change is made. We will send a formulary to you and you can see our complete formulary on our Website at <a href="http://www.communityhealthpartnership.com">www.communityhealthpartnership.com</a>.</p> |

# 2009 SUMMARY OF BENEFITS

## Section 2 – Benefits Comparison

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| Benefit Category           | Original Medicare<br>AND<br>Community Health<br>Partnership Members<br>who are <u>not</u> eligible for<br>Wisconsin Medicaid | Community Health<br>Partnership Members<br>who are eligible<br>for <u>both</u> Medicare and<br>Wisconsin Medicaid  | Community Health<br>Partnership Members<br>who are eligible<br>for Wisconsin Medicaid<br>but <u>not</u> Medicare |
|----------------------------|--|--|--|
| 29 - Continued Deductible  |  | There are no deductibles or coinsurance for Medicare Part D covered prescription drugs.  | There are no deductibles or coinsurance for Medicaid covered prescription drugs.                                 |
| Copayments                 |  | <p>You pay copayments of \$1.10 for generic prescription drugs and \$3.20 for brand name prescription drugs, or \$2.40 for generic prescription drugs and \$6.00 for brand name prescription drugs, depending on your income level.</p> <p>You do not pay copayments for prescription drugs during certain stays in a medical institution or nursing facility. Contact plan for details.</p> <p>People who have access to Indian/ Tribal/Urban (Indian Health Service) facilities may have different out-of-pocket drug costs. Contact plan for details.</p> | You have no copayments for Medicaid covered prescription drugs.  |
| In-Network Retail Pharmacy |  | You may receive prescription drugs for a one month (30 day) supply.  | You may receive prescription drugs for a one month (30 day) supply.  |

# 2009 SUMMARY OF BENEFITS

## Section 2 – Benefits Comparison

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|---|--|---|--|
| <p>29 - <i>Continued Catastrophic Coverage</i></p> <p>General Information</p> |  | <p>After your yearly out-of-pocket drug costs reach \$4,350, you will not pay copayments for the rest of the year.</p> <p>In some cases, the plan requires you to first try one drug to treat your medical condition before they will cover another drug for that condition.</p> <p>Certain prescription drugs will have maximum quantity limits.</p> <p>Certain over-the-counter drugs are part of the plan benefit.</p> <p>Your provider must get prior authorization from Community Health Partnership for certain prescription drugs.</p> | <p>In some cases, the plan requires you to first try one drug to treat your medical condition before they will cover another drug for that condition.</p> <p>Certain prescription drugs will have maximum quantity limits.</p> <p>Certain over-the-counter drugs are part of the plan benefit.</p> <p>Your provider must get prior authorization from Community Health Partnership for certain prescription drugs.</p> |

# 2009 SUMMARY OF BENEFITS

## Section 2 – Benefits Comparison

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|---|--|--|--|
| 29 - <i>Continued</i><br>General<br>Information |  | <p>Covered prescription drugs are available at out-of-network pharmacies in special circumstances including illness while traveling outside of the plan's service area where there is no network pharmacy. You may also incur an additional cost for drugs received at an out-of-network pharmacy.</p> <p>Please contact the plan for details.</p> | <p>Covered prescription drugs are available at out-of-network pharmacies in special circumstances including illness while traveling outside of the plan's service area where there is no network pharmacy. You may also incur an additional cost for drugs received at an out-of-network pharmacy.</p> <p>Please contact the plan for details.</p> |

# 2009 SUMMARY OF BENEFITS

## Section 2 – Benefits Comparison

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|--|---|--|--|
| <b>ADDITIONAL BENEFITS (WHAT ORIGINAL MEDICARE DOES NOT COVER)</b> |   |  |  |
| 30 - Dental Services   | In general, you pay 100% for dental services.   | There are no deductibles or copayments for covered dental services.<br><br>Prior authorization may be required. Contact plan for details.  | There are no deductibles or copayments for covered dental services.<br><br>Prior authorization may be required. Contact plan for details.  |
| 31 - Hearing Services  | You pay 100% for routine hearing exams and hearing aids.<br><br>You pay 20% of Medicare-approved amounts for diagnostic hearing exams. (1)(2)   | There are no deductibles or copayments for covered hearing services.<br><br>Prior authorization may be required. Contact plan for details. | There are no deductibles or copayments for covered hearing services.<br><br>Prior authorization may be required. Contact plan for details. |
| 32 - Vision Services   | You are covered for one pair of eyeglasses or contact lenses after each cataract surgery. (1)(2)<br><br>For people with Medicare who are at risk, you are covered for annual glaucoma screenings. (1)(2)<br><br>You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye. (1)(2)<br><br>You pay 100% for routine eye exams and glasses. | There are no deductibles or copayments for covered vision services.<br><br>Prior authorization may be required. Contact plan for details.  | There are no deductibles or copayments for covered vision services.<br><br>Prior authorization may be required. Contact plan for details.  |

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# 2009 SUMMARY OF BENEFITS

## Section 2 – Benefits Comparison

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|--------------------------------|--|--|--|
| 33 - Physical Exams            | <p>You pay 20% of the Medicare-approved amount for one exam within first 6 months of your new Medicare Part B coverage. (1)(2)</p> <p>When you get Medicare Part B, you can get a one time physical exam within the first 6 months of your new Part B coverage.</p> <p>This will not include laboratory tests.</p>                                       | There are no deductibles or copayments for covered physical exams.   | There are no deductibles or copayments for covered physical exams.   |
| 34 – Health/Wellness Education | <p>You pay 20% of the Medicare approved amount. (1) (2)</p> <p>You are covered for smoking cessation if ordered by your doctor. This includes 2 counseling attempts in a 12-month period if diagnosed with smoking-related illness or taking medicine that may be affected by tobacco. Each counseling attempt includes up to 4 face-to-face visits.</p> | <p>You pay nothing when you receive these covered services from network providers.</p> <p>Prior authorization may be required. Contact plan for details.</p> | <p>You pay nothing when you receive these covered services from network providers.</p> <p>Prior authorization may be required. Contact plan for details.</p> |

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# 2009 SUMMARY OF BENEFITS

## Section 2 – Benefits Comparison

*If you have any questions about the plan's benefit costs, please contact Community Health Partnership*

| Benefit Category   | Original Medicare AND Community Health Partnership Members who are <u>not</u> eligible for Wisconsin Medicaid | Community Health Partnership Members who are eligible for <u>both</u> Medicare and Wisconsin Medicaid  | Community Health Partnership Members who are eligible for Wisconsin Medicaid but <u>not</u> Medicare   |
|--|---|--|--|
| <p>35 – Other Health Related and Long-Term Care Services</p> <p><i>(case management, supportive housing, personal care assistance and chore services, respite care, adult day care, home modifications, medical and non-medical transportation, specialized medical supplies, home delivered meals, and personal emergency response systems)</i></p> | Not Covered   | <p>There are no copayments for Medicaid covered services and supplies, however, room and board in residential housing (including but not limited to an adult family home, a community-based residential facility and residential care apartment complexes) are not covered and, therefore, members are responsible for room and board charges.</p> <p>Prior authorization may be required. Contact plan for details.</p> | <p>There are no copayments for Medicaid covered services and supplies, however, room and board in residential housing (including but not limited to an adult family home, a community-based residential facility and residential care apartment complexes) are not covered and, therefore, members are responsible for room and board charges.</p> <p>Prior authorization may be required. Contact plan for details.</p> |

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## 2009 SUMMARY OF BENEFITS

### Section 3 – Benefits and Covered Services

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#### SPECIAL FEATURES

Community Health Partnership 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. We call them the Partnership Team. Your Partnership Team includes YOU and:
  - Your significant others;
  - Your primary care physician;
  - Your nurse practitioner;
  - Your registered nurse;
  - Your social services coordinator;
  - Your team assistant; and
  - Your other caregivers.
  
- 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 needs.
  
- Your Team conducts an assessment in your home. This assessment identifies your needs, strengths and resources.
  
- Your Team will work with you to develop an individualized service plan (ISP) 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.

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## 2009 SUMMARY OF BENEFITS

### Section 3 – Benefits and Covered Services

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#### ELIGIBILITY

To be eligible for Community Health Partnership you must be:

- An adult age 18 and over with a Physical or Developmental Disability or are over the age of 65;
- A resident of Community Health Partnership's service area, which is Chippewa, Dunn or Eau Claire County;
- Financially eligible for Wisconsin Medicaid;
- Functionally eligible as determined by the State of Wisconsin Long-Term Care Functional Screen; and
- If you are eligible for Medicare you must be enrolled in Medicare Part A, Part B, and Part D.

There are other eligibility requirements for this Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan, please refer to the Evidence of Coverage/Member Handbook for more details.

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Community Health Partnership, a Program of Partnership Health Plan is a program associated with Community Health Partnership, Inc.



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[www.communityhealthpartnership.com](http://www.communityhealthpartnership.com)