



Summary of Benefits of Community Care's Family Care Partnership Program (HMO)

January 1, 2010 - December 31, 2010

(Calumet, Kenosha, Milwaukee, Outagamie, Ozaukee,
Racine, Washington, Waukesha and Waupaca Counties)

Community Care Health Plan, Inc.
1555 South Layton Boulevard
Milwaukee, WI 53215



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SECTION 1 – INTRODUCTION

INTERPRETER SERVICES

Interpreter services are available free of charge.

- For help to translate or understand this, please call 1-866-992-6600 (TTY 1-866-288-9909).
- Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono 1-866-992-6600 (TTY 1-866-288-9909).
- Если вам не всё понятно в этом документе, позвоните по телефону 1-866-992-6600 (TTY 1-866-288-9909).
- Yog xav tau kev pab txhais cov ntaub ntawv no kom koj totaub, hu rau 1-866-992-6600 (TTY 1-866-288-9909).
- ເພື່ອຊ່ວຍໃນການແປ ຫລືເຂົ້າໃຈເນື້ອຫາໃນນີ້, ກະລຸນາໂທອະສັບຫາ 1-866-992-6600 (TTY 1-866-288-9909).

Please call Community Care for more information about this plan.
Visit us at www.CommunityCareInc.org or, call us:

1-866-992-6600

You can call 24 hours a day, 7 days a week

TTY users should call 1-866-288-9909 from 8:00 a.m. – 8:00 p.m. Central, 7 days a week. After these hours, if you are deaf or hard of hearing and using a TTY machine, then dial the Wisconsin Relay System's toll free TTY access number: 711, or if no answer: 1-800-947-3529. A Wisconsin Relay CA will answer your call. Provide the area code and phone number of your Team and they will connect you with someone who can help you. There is always a doctor on call to help you.

Current and Prospective members should call 1-866-992-6600 (TTY/TDD 1-866-288-9909) for questions related to the Medicare Advantage program or the Medicare Part D Prescription Drug program.

For more information about Medicare, call 1-800-MEDICARE (1-800-633-4227).
TTY users should call 1-800-486-2048.

You can call 24 hours a day, 7 days a week.
Or, visit www.medicare.gov on the web.

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You may also contract the Medigap Hot line at 1-800-1060.
For more information about Medicaid, call 1-608-266- 2522.
TTY users should call 1- 888-692-1402.
You can call 24 hours a day, 7 days a week.
Or, visit www.dhfs.state.wi.us on the web.

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

Thank you for your interest in Community Care's Family Care Partnership Program (HMO). Our plan is offered by Community Care Health Plan, Inc. (Community Care), a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan. Community Care is a Health plan with a Medicare contract. This plan is designed for people who meet specific enrollment criteria.

You may be eligible to join this plan if you are enrolled in Medicaid and have long-term care needs. All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.

Please call the Aging and Disability Resource Center (ADRC) in your county to find out if you are eligible to join. Please note that Milwaukee County has an Aging Resource Center (ARC) and a Disability Resource Center (DRC).

Calumet County ADRC	920-849-1451
Kenosha County ADRC	262-605-6646
Milwaukee County ARC	414-289-6874
Milwaukee County DRC	414-289-6660
Racine County ADRC	262-638-6800
Outagamie County ADRC	920-832-5178
Ozaukee County ADRC	262-284-8120
Washington County ADRC	262-335-4497
Waukesha County ADRC	262-548-7848
Waupaca County ADRC	715-258-6400

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 Care's Family Care Partnership Program (HMO) and ask for the "Evidence of Coverage (EOC)/ Member Handbook."

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SECTION 1 – INTRODUCTION

YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan, and if you have Wisconsin Medicaid, one option is the Wisconsin (fee-for-service) Medicaid Plan. Another option is a health plan, like Community Care's Family Care Partnership Program (HMO). 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.

You may join or leave Community Care's Family Care Partnership Program (HMO) at any time. Please call Community Care's Family Care Partnership Program (HMO) at the number listed in the beginning of this introduction or for more information about Medicare call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers 24 hours a day, 7 days a week

For more information about Medicaid, call 1-608-266- 2522, TTY users should call 1- 888-692-1402.

HOW CAN I COMPARE MY OPTIONS?

You can compare Community Care's Family Care Partnership Program (HMO) 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. All of our members are enrolled in Wisconsin Medicaid and some members are also eligible for and enrolled in Medicare.

Our members receive all of the benefits of Wisconsin Medicaid. Those members who also have Medicare receive all of the benefits offered by the Original Medicare Plan. Wisconsin Medicaid includes coverage of long-term care services. Our benefits may change from year to year.

WHERE IS COMMUNITY CARE'S FAMILY CARE PARTNERSHIP PROGRAM (HMO) AVAILABLE?

The service area for this plan includes: Calumet, Kenosha, Milwaukee, Outagamie, Ozaukee, Racine, Washington, Waukesha and Waupaca Counties in the State of Wisconsin. You must live in one of these places to join the plan.

WHO IS ELIGIBLE TO JOIN COMMUNITY CARE'S FAMILY CARE PARTNERSHIP PROGRAM (HMO)?

You can join Community Care's Family Care Partnership Program (HMO) if you live in the service area, are eligible for Wisconsin Medicaid, are at least eighteen (18) years old and are functionally eligible as determined by the State of Wisconsin Long-Term Care Functional Screen. In addition, if you are entitled to Medicare, you must be enrolled in all Parts of Medicare for which you are eligible. Please see Section 3 of this booklet for more detailed information.

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

SECTION 1 – INTRODUCTION

CAN I CHOOSE MY DOCTORS?

Community Care's Family Care Partnership Program (HMO) 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 visit us at www.CommunityCareInc.org. 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, you must pay for these services yourself. Neither Community Care's Family Care Partnership Program (HMO), the Original Medicare Plan, nor Wisconsin Medicaid will pay for these services.

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

Community Care's Family Care Partnership Program (HMO) covers Wisconsin Medicaid prescription drugs, and if you are entitled to Medicare, Part B and Medicare Part D prescription drugs.

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

Community Care's Family Care Partnership Program (HMO) 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.communitycareinc.org. Our customer service number is listed at the beginning of this introduction. We will notify the affected members if the pharmacy they are using is no longer part of the network.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Community Care's Family Care Partnership Program (HMO) 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 you are eligible for Medicaid only, you will not have to pay anything for your prescription drugs. 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.communitycareinc.org.

If you are currently taking a drug that is not on our formulary or is 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 to 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.

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HOW CAN I GET EXTRA HELP WITH PRESCRIPTION DRUG PLAN COSTS?

If you only have Medicaid and you do not have Medicare, then you have no premiums or other costs for your prescription drugs. If you have Medicare, when you join Community Care's Family Care Partnership Program (HMO), 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.

To get more information or apply for Medicare, you can call the Social Security Administration at 1-800-772-1313, TTY users should call 1-800-325-0778. You can also go to their website at <http://www.ssa.gov> or visit your local Social Security office.

To find out more about Medicaid and its programs, contact the Wisconsin Department of Health Services by calling 1-800-362-3002, TTY users should call 1-888-701-1251. You can also get information by visiting their website at www.dhs.wisconsin.gov/Medicaid.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

What if my Plan decides not to continue?

Community Care's Family Care Partnership Program (HMO) is a 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 your 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.

How can I ask the Plan to Cover an item or service and ask for a review if I do not agree with the Plan's decision?

- As a member of Community Care's Family Care Partnership Program (HMO), 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. 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.

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- You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision.
- Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for Wisconsin, MetaStar, Inc., 1-800-362-2320 (toll free).
- As a member of Community Care's Family Care Partnership Program (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.
- 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 for prescription drugs. 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. Medicaid only members have no out-of-pocket expenses.
- You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision.
- Finally, you have the right to file a grievance if you have any type of problem with us or one of our network providers or pharmacies that does not involve coverage for a benefit or a service.

Please refer to the Evidence of Coverage/ Member Handbook for a complete listing of your rights as a member of Community Care's Family Care Partnership Program (HMO).

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 Care's Family Care Partnership Program (HMO) for more details.

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

For members enrolled in Medicare some outpatient prescription drugs may be covered under Medicare Part B. There is no copay for the drugs covered under Medicare Part B. The cost of these drugs does not help you qualify for Medicare Part D catastrophic coverage. These may include, but are not limited to, the following types of drugs. Contact Community Care's Family Care Partnership Program (HMO) for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and Infusion Drugs provided through DME.

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 directly at 1-414-385-6600 or 1-866-992-6600 to obtain a copy of the plan ratings for this plan. TTY uses call 1-866-288-9909.

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FOR ASSISTANCE OR MORE INFORMATION

Please call Community Care for more information about Community Care's Family Care Partnership Program (HMO). Visit us at www.communitycareinc.org or, call us at 1-(866)-992-6600, TTY users should call 1-(866)-288-9909.

Customer Service Hours:

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m.
Central Standard Time.

Current and Prospective members should call toll-free (866)-992-6600 for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug Program. TTY users should call 1- (866)-288-9909.

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

For more information about Medicaid, please contact the Wisconsin Department of Health Services by calling 1-800-362-3002, TTY users should call 1-888-701-1251. You can also get information by visiting their website at www.dhs.wisconsin.gov/Medicaid.

For more information about whether you are eligible to join Community Care's Family Care Partnership Program (HMO), please call the Aging and Disability Resource Center (ADRC) in your county. Please note that Milwaukee County has an Aging Resource Center (ARC) and a Disability Resource Center (DRC).

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SECTION 2 – SUMMARY OF BENEFITS *If you have any questions about this plan’s benefits and costs, please contact Community Care.*

Benefit Category	Original Medicare	Partnership Program Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Program Members who are eligible for Wisconsin Medicaid but not Medicare
1 - Premium and Other Important Information	In 2009 the monthly Part B premium is \$96.40 and the yearly Part B deductible is \$135.00. These amounts may change in 2010.	<p>In 2009 the monthly Part B premium is \$96.40. This amount may change in 2010. Because you are eligible for Medicaid, you may receive assistance in paying this premium.</p> <p>Some members may have to pay a monthly Medicaid cost share as determined by your county’s Department of Human Services to remain eligible and enrolled in Community Care’s Family Care Partnership Program (HMO).</p>	<p>There are no premiums, deductibles, or co-payments for members who are eligible for Medicaid but not for Medicare.</p> <p>Some members may have to pay a monthly Medicaid cost share as determined by your county’s Department of Human Services to remain eligible and enrolled in Community Care’s Family Care Partnership Program. (HMO).</p>
2 – Doctor and Hospital Choice	You may go to any doctor, specialist or hospital that accepts Medicare	<p>You must go to network doctors, specialists and hospitals.</p> <p>Authorization rules may apply. Prior authorization may be required. Contact plan for details.</p>	<p>You must go to network doctors, specialists and hospitals.</p> <p>Authorization rules may apply. Prior authorization may be required. Contact plan for details.</p>

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SUMMARY OF BENEFITS			
INPATIENT CARE			
3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	In 2009 the amount you pay for each benefit period (3): Days 1 - 60: an initial deductible of \$1,068 Days 61 - 90: \$267 each day Days 91 - 150: \$534 each lifetime reserve day (4) These amounts may change in 2010. Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.	There are no deductibles or co-payments for covered stays at a network hospital. You are covered for unlimited days each benefit period. You are required to use network hospitals, except in an emergency. You do NOT need a referral to receive services from a network hospital. Except in an emergency, your provider must obtain authorization from Community Care.	There are no deductibles or co-payments for covered stays at a network hospital. You are covered for unlimited days each benefit period. You are required to use network hospitals, except in an emergency. You do NOT need a referral to receive services from a network hospital. Except in an emergency, your provider must obtain authorization from Community Care.

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Benefit Category	Original Medicare	Partnership Program Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Program Members who are eligible for Wisconsin Medicaid but not Medicare
4- Inpatient Mental Health 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.	<p>There are no deductibles or co-payments for covered stays at a network hospital.</p> <p>You are required to use network hospitals except in an emergency. You do NOT need a referral to receive services from a network hospital.</p> <p>Except in an emergency, your provider must obtain authorization from Community Care.</p>	<p>There are no deductibles or co-payments for covered stays at a network hospital.</p> <p>You are required to use network hospitals except in an emergency. You do NOT need a referral to receive services from a network hospital.</p> <p>Except in an emergency, your provider must obtain authorization from Community Care.</p>
5 - Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	<p>In 2009 the amounts for each benefit period after (3), at least a 3-day covered hospital stay are:</p> <p>Days 1 - 20: \$0 for each day</p> <p>Days 21 - 100: \$133.50 for each day</p> <p>This amount may change in 2010.</p> <p>There is a limit of</p>	<p>There is no co-payment for covered stays at a network skilled nursing facility.</p> <p>You are covered for an unlimited number of days.</p> <p>You are required to use network skilled nursing facilities.</p> <p>No prior hospital stay is required.</p> <p>Authorization rules may apply. Prior authorization may be required. Contact plan for details.</p>	<p>There is no co-payment for covered stays at a network skilled nursing facility.</p> <p>You are covered for an unlimited number of days</p> <p>You are required to use network skilled nursing facilities.</p> <p>No prior hospital stay is required.</p> <p>Authorization rules may apply. Prior authorization may be required. Contact plan for details.</p>

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Benefit Category	Original Medicare	Partnership Program Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Program Members who are eligible for Wisconsin Medicaid but not Medicare
	100 days for each benefit period. (3)		
6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	There is no copayment for all covered home health visits.	There is no co-payment for covered home health visits. Authorization rules may apply. Prior authorization may be required. Contact plan for details.	There is no co-payment for covered home health visits. Authorization rules may apply. Prior authorization may be required. Contact plan for details.
7 - Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must receive care from a Medicare-certified hospice.	There are no co-payments for hospice care. You must receive care from a Medicare-certified hospice. Authorization rules may apply. Prior authorization may be required. Contact plan for details.	There are no co-payments for end-of-life care. Authorization rules may apply. Prior authorization may be required. Contact plan for details.
OUTPATIENT CARE			
8 - Doctor Office Visits	You pay 20% of Medicare-approved amounts. (1)(2)	There are no deductibles or co-payments for covered primary care doctor or specialist office visits.	There are no deductibles or co-payments for covered primary care doctor or specialist office visits.

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Benefit Category	Original Medicare	Partnership Program Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Program Members who are eligible for Wisconsin Medicaid but not Medicare
9 - Chiropractic Services	<p>You are covered for manual manipulation of the spine to correct subluxation (a displacement of a joint or body part) provided by chiropractors or other qualified providers.</p> <p>You pay 100% for routine care.</p> <p>You pay 20% of Medicare-approved amounts. (1)(2)</p>	<p>You are covered for manual manipulation of the spine to correct subluxation (a displacement of a joint or body part) provided by chiropractors or other qualified providers.</p> <p>There are no deductibles or co-payments for covered chiropractic services.</p> <p>Authorization rules may apply. Prior authorization may be required. Contact plan for details.</p>	<p>You are covered for manual manipulation of the spine to correct subluxation (a displacement of a joint or body part) provided by chiropractors or other qualified providers.</p> <p>There are no deductibles or co-payments for covered chiropractic services.</p> <p>Authorization rules may apply. 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 co-payments for covered podiatry services.</p> <p>Authorization rules may apply. Prior authorization may be required. Contact plan for details.</p>	<p>There are no deductibles or co-payments for covered podiatry services.</p> <p>Authorization rules may apply. Prior authorization may be required. Contact plan for details.</p>

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Benefit Category	Original Medicare	Partnership Program Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Program Members who are eligible for Wisconsin Medicaid but not Medicare
11 - Outpatient Mental Health Care	You pay 50% of Medicare-approved amounts with the exception of certain situations and services for which you pay 20% of approved charges. (1)(2)	There are no deductibles or co-payments for covered mental health care. Authorization rules may apply. Prior authorization may be required. Contact plan for details.	There are no deductibles or co-payments for covered mental health care. Authorization rules may apply. Prior authorization may be required. Contact plan for details.
12 - Outpatient Substance Abuse Care	You pay 20% of Medicare-approved amounts. (1)(2)	There are no deductibles or co-payments for covered substance abuse care. Authorization rules may apply. Prior authorization may be required. Contact plan for details.	There are no deductibles or co-payments for covered substance abuse care. Authorization rules may apply. Prior authorization may be required. Contact plan for details.
13 - Outpatient Services/Surgery	You pay 20% of Medicare-approved amounts for the doctor. (1)(2) You pay 20% of outpatient facility charges. (1)(2)	There are no deductibles or co-payments for covered outpatient services/surgery. Authorization rules may apply. Prior authorization may be required. Contact plan for details.	There are no deductibles or co-payments for covered outpatient services/surgery. Authorization rules may apply. Prior authorization may be required. Contact plan for details.
14 - Ambulance Services (medically necessary ambulance services)	You pay 20% of Medicare-approved amounts or applicable fee schedule charge. (1)(2)	There are no deductibles or co-payments for covered ambulance services. Authorization rules may apply. Prior authorization may be required. Contact plan for details.	There are no deductibles or co-payments for covered ambulance services. Authorization rules may apply. Prior authorization may be required. Contact plan for details.

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Benefit Category	Original Medicare	Partnership Program Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Program Members who are eligible for Wisconsin Medicaid but not Medicare
<p>15 - Emergency Care</p> <p>(You may go to any emergency room if you reasonably believe you need emergency care.)</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>NOT covered outside the U.S. except under limited circumstances.</p>	<p>There are no deductibles or co-payments for covered emergency care.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>There are no deductibles or co-payments for covered emergency care.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>
<p>16 - Urgently Needed Care</p> <p>(This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>You pay 20% of Medicare-approved amounts or applicable Copayment. (1)(2)</p> <p>NOT covered outside the U.S. except under circumstances.</p>	<p>There are no deductibles or co-payments for covered urgently needed care.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>There are no deductibles or co-payments for covered urgently needed care.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>

Summary of Benefits for Community Care's Family Care Partnership Program (HMO)
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SECTION 2 – SUMMARY OF BENEFITS *If you have any questions about this plan's benefits and costs, please contact Community Care.*

Benefit Category	Original Medicare	Partnership Program Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Program Members who are eligible for Wisconsin Medicaid but not Medicare
17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	You pay 20% of Medicare-approved amounts. (1)(2)	There are no deductibles or co-payments for covered outpatient rehabilitation services. Authorization rules may apply. Prior authorization may be required. Contact plan for details.	There are no deductibles or co-payments for covered outpatient rehabilitation services. Authorization rules may apply. Prior authorization may be required. Contact plan for details.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES			
18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)	There are no deductibles or co-payments for covered durable medical equipment. Authorization rules may apply. Prior authorization may be required. Contact plan for details.	There are no deductibles or co-payments for covered durable medical equipment. Authorization rules may apply. Prior authorization may be required. Contact plan for details.
19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)	There are no deductibles or co-payments for covered prosthetic devices. Authorization rules may apply. Prior authorization may be required. Contact plan for details.	There are no deductibles or co-payments for covered prosthetic devices. Authorization rules may apply. Prior authorization may be required. Contact plan for details.

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Benefit Category	Original Medicare	Partnership Program Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Program Members who are eligible for Wisconsin Medicaid but not Medicare
20 - Diabetes Self-Monitoring Training, Nutrition Therapy and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	You pay 20% of Medicare-approved amounts. (1)(2)	There are no deductibles or co-payments for covered diabetes self-monitoring training and supplies or for medically necessary nutrition therapy. Authorization rules may apply. Prior authorization may be required. Contact plan for details.	There are no deductibles or co-payments for covered diabetes self-monitoring training and supplies or for medically necessary nutrition therapy. Authorization rules may apply. Prior authorization may be required. Contact plan for details.
21 - Diagnostic Tests, X-Rays, and Lab Services	You pay 20% of Medicare-approved amounts, except for approved lab services. (1)(2) There is no copayment for Medicare-approved lab services.	There are no deductibles or co-payments for covered diagnostic tests, x-rays and lab services. Authorization rules may apply. Prior authorization may be required. Contact plan for details.	There are no deductibles or co-payments for covered diagnostic tests, x-rays and lab services. Authorization rules may apply. Prior authorization may be required. Contact plan for details.

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SECTION 2 – SUMMARY OF BENEFITS *If you have any questions about this plan's benefits and costs, please contact Community Care.*

Benefit Category	Original Medicare	Partnership Program Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Program Members who are eligible for Wisconsin Medicaid but not Medicare
PREVENTIVE SERVICES			
22 - Bone Mass Measurement (for people who are at risk)	You pay 20% of Medicare-approved amounts. (1)(2) Covered once every 24 months, more often if medically necessary, if you meet certain conditions.	There are no deductibles or co-payments for covered bone mass measurement. Authorization rules may apply. Prior authorization may be required. Contact plan for details.	There are no deductibles or co-payments for covered bone mass measurement. Authorization rules may apply. Prior authorization may be required. Contact plan for details.
23 - Colorectal Screening Exams (for people age 50 and older)	You pay 20% of Medicare-approved amounts. (1)(2)	There are no deductibles or co-payments for covered colorectal screening exams. Authorization rules may apply. Prior authorization may be required. Contact plan for details.	There are no deductibles or co-payments for covered colorectal screening exams. Authorization rules may apply. Prior authorization may be required. Contact plan for details.
24 – Immunizations (Flu vaccine, Hepatitis B vaccine- for people who are at risk, Pneumonia vaccine)	There is no copayment for the Pneumonia and Flu vaccines. You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine. (1)(2) You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.	There are no deductibles or co-payments for the Flu, Pneumonia and Hepatitis B vaccines. No referral is necessary for the Flu, Pneumonia, and Hepatitis vaccines. Authorization rules may apply. Prior authorization may be required. Contact plan for details.	There are no deductibles or co-payments for the Flu, Pneumonia and Hepatitis B vaccines. No referral is necessary for the Flu, Pneumonia, and Hepatitis vaccines. Authorization rules may apply. Prior authorization may be required. Contact plan for details.

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SECTION 2 – SUMMARY OF BENEFITS *If you have any questions about this plan’s benefits and costs, please contact Community Care.*

Benefit Category	Original Medicare	Partnership Program Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Program Members who are eligible for Wisconsin Medicaid but not Medicare
<p>25 - Mammograms (Annual Screening)</p> <p>(Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between the ages of 35 and 39.)</p>	<p>You pay 20% of Medicare-approved amounts. (2)</p> <p>No referral necessary for Medicare-covered screenings.</p>	<p>There are no deductibles or co-payments for covered mammograms. Authorization rules may apply. Prior authorization may be required. Contact plan for details.</p>	<p>There are no deductibles or co-payments for covered mammograms. Authorization rules may apply. Prior authorization may be required. Contact plan for details.</p>
<p>26 - Pap Smears and Pelvic Exams</p> <p>(for women)</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 co-payments for covered pap smears and pelvic exams. Authorization rules may apply. Prior authorization may be required. Contact plan for details.</p>	<p>There are no deductibles or co-payments for covered pap smears and pelvic exams. Authorization rules may apply. Prior authorization may be required. Contact plan for details.</p>

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Benefit Category	Original Medicare	Partnership Program Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Program Members who are eligible for Wisconsin Medicaid but not Medicare
27 - Prostate Cancer Screening Exams (for men age 50 and older)	There is no copayment for approved lab services and a copayment of 20% of Medicare-approved amounts for other related services. (1)(2)	There are no deductibles or co-payments for covered prostate cancer screening exams. Authorization rules may apply. Prior authorization may be required. Contact plan for details.	There are no deductibles or co-payments for covered prostate cancer screening exams. Authorization rules may apply. Prior authorization may be required. Contact plan for details.
28- End Stage Renal Disease (ESRD)	You pay 20% of Medicare-approved amounts. (1)(2)	There are no deductibles or co-payments for covered dialysis services. Authorization rules may apply. Prior authorization may be required. Contact plan for details.	There are no deductibles or co-payments for covered dialysis services. Authorization rules may apply. Prior authorization may be required. Contact plan for details.
29 - Prescription Drugs	You pay 100% for most prescription drugs, unless you enroll in the Medicare Part D Prescription Drug program. Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug		

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Benefit Category	Original Medicare	Partnership Program Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Program Members who are eligible for Wisconsin Medicaid but not Medicare
	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 (Original Medicare)		There are no deductibles or co-payments for Medicare Part B or Medicaid covered outpatient prescription drugs.	There are no deductibles or co-payments for Medicaid covered outpatient prescription drugs.
Drugs covered under Medicare Part D (Prescription Drug Benefit)		This plan 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 your ability to fill your prescriptions, we will notify you before the change is made. We will send a formulary to you, and you can see our complete formulary on our Website at www.communitycareinc.org	This plan 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 your ability to fill your prescriptions, we will notify you before the change is made. We will send a formulary to you, and you can see our complete formulary on our Website at www.communitycareinc.org

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Benefit Category	Original Medicare	Partnership Program Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Program Members who are eligible for Wisconsin Medicaid but not Medicare
Deductibles and Coinsurance		There are no deductibles or coinsurance for Medicare Part D covered drugs.	There are no deductibles or coinsurance for Medicaid covered prescription drugs.
Co-payments		You pay co-payments of \$1.10 for generic prescription drugs and \$3.30 for brand name prescription drugs, or \$2.50 for generic prescription drugs and \$6.30 for brand name prescription drugs, depending on your income level. You do not pay co-payments for prescription drugs during certain stays in a medical institution or nursing facility. Contact plan for details.	You have no co-payments for Medicaid covered prescription drugs.
In-Network Retail Pharmacy		You may receive drugs for a one month (30 day) supply.	You may receive drugs for a one month (30 day) supply.
Catastrophic Coverage		After your yearly out-of-pocket drug costs reach \$4,550, you will not pay co-payments for the rest of the year.	
General Information		In some cases, Community Care's Family Care Partnership Program (HMO) requires you to first try one drug to treat your medical condition before they will cover another drug for that condition.	In some cases, Community Care's Partnership Program (HMO) requires you to first try one drug to treat your medical condition before they will cover another drug for that condition.

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SECTION 2 – SUMMARY OF BENEFITS *If you have any questions about this plan’s benefits and costs, please contact Community Care.*

Benefit Category	Original Medicare	Partnership Program Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Program Members who are eligible for Wisconsin Medicaid but not Medicare
		<p>Certain prescription drugs will have maximum quantity limits.</p> <p>Your provider must get prior authorization from Community Care’s Family Care Partnership (HMO) for certain prescription drugs.</p> <p>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>Certain prescription drugs will have maximum quantity limits.</p> <p>Your provider must get prior authorization from Community Care’s Family Care Partnership Program (HMO) for certain prescription drugs.</p> <p>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>

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Benefit Category	Original Medicare	Partnership Program Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Program Members who are eligible for Wisconsin Medicaid but not Medicare
OTHER SERVICES			
ADDITIONAL BENEFITS (WHAT ORIGINAL MEDICARE DOES NOT COVER)			
30 - Dental Services	In general, you pay 100% for dental services.	There are no deductibles or co-payments for covered dental services. Authorization rules may apply. Prior authorization may be required. Contact plan for details.	There are no deductibles or co-payments for covered dental services. Authorization rules may apply. Prior authorization may be required. Contact plan for details.
31 - Hearing Services	You pay 100% for routine hearing exams and hearing aids. You pay 20% of Medicare-approved amounts for diagnostic hearing exams. (1)(2)	There are no deductibles or co-payments for covered hearing services. Authorization rules may apply. Prior authorization may be required. Contact plan for details.	There are no deductibles or co-payments for covered hearing services. Authorization rules may apply. 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) For people with Medicare who are at risk, you are covered for annual glaucoma screenings. (1)(2)	There are no deductibles or co-payments for covered vision services.	There are no deductibles or co-payments for covered vision services.

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Benefit Category	Original Medicare	Partnership Program Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Program Members who are eligible for Wisconsin Medicaid but not Medicare
	<p>You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye. (1)(2)</p> <p>You pay 100% for routine eye exams and glasses.</p>		
33 - Physical Exams	<p>When you get Medicare Part B, you may receive a one time physical exam within the first twelve months of your new Part B coverage.</p> <p>This will not include laboratory tests. Please contact your plan for further details.</p> <p>You pay 20% of the Medicare-approved amount.(1)(2)</p>	There are no deductibles or co-payments for covered physical exams.	There are no deductibles or co-payments for covered physical exams.

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Benefit Category	Original Medicare	Partnership Program Members who are eligible for both Medicare and Wisconsin Medicaid	Partnership Program Members who are eligible for Wisconsin Medicaid but not Medicare
34 – Other Health Related and long term care services (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)	Not Covered	There are no co-payments for covered services and supplies. Room and board in supportive housing, including but not limited to, a community based residential facility, an adult family home and assisted living facility, are not covered. Therefore, members are responsible for room and board charges. Authorization rules may apply. Prior authorization may be required. Contact plan for details.	There are no co-payments for covered services and supplies. Room and board in supportive housing, including but not limited to a community based residential facility, an adult family home and assisted living facility, are not covered. Therefore, members are responsible for room and board charges Authorization rules may apply. Prior authorization may be required. Contact plan for details.

These footnotes only apply to Original Medicare.

- (1) *In 2009, you pay a total of one \$135 deductible. This amount may change for 2010.*
- (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 3 – BENEFITS AND COVERED SERVICES *If you have any questions about this plan's benefits and costs, please contact Community Care.*

SPECIAL FEATURES

Community Care's Family Care Partnership Program (HMO) 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 worker; and
 - Others you want to include
- Your team is responsible for your assessment, care planning, service authorization and delivery, coordination, monitoring, and health education and prevention.
- Your team members and network providers have the expertise to meet your outcomes.
- Your team conducts an assessment in your home. This assessment identifies your needs, strengths and resources.
- Your team will work with you to develop an individualized service plan that clearly identifies your preferences, goals, specified treatments and strategies.
- Your team coordinates your care by overseeing services delivered by other providers or by providing services to you directly.
- Your team will meet with you regularly to review your care plan.
- Customer service is available 24 hours a day, seven days a week.

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SECTION 4 – STATEMENT ABOUT YOUR MEDICAID BENEFITS *If you have any questions about this plan's benefits and costs, please contact Community Care.*

To be Eligible for Community Care's Family Care Partnership Program (HMO) you must:

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

County of Residence	Effective Date
Calumet	April 1, 2010*
Kenosha	January 1, 2010
Milwaukee	January 1, 2010
Outagamie	April 1, 2010*
Ozaukee	January 1, 2010
Racine	January 1, 2010
Washington	January 1, 2010
Waukesha	January 1, 2010
Waupaca	July 1, 2010*

*Projected effective date which is subject to change. If you have any questions, please contact Customer Service. Contact information is located in Section 1 of this booklet.

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You may also contact the Aging and Disability Resource Center (ADRC) in your county to find out if you are eligible to join. Please note that Milwaukee County has an Aging Resource Center (ARC) and a Disability Resource Center (DRC).

Calumet County ADRC	920-849-1451
Kenosha County ADRC	262-605-6646
Milwaukee County ARC	414-289-6874
Milwaukee County DRC	414-289-6660
Racine County ADRC	262-638-6800
Outagamie County ADRC	920-832-5178
Ozaukee County ADRC	262-284-8120
Washington County ADRC	262-335-4497
Waukesha County ADRC	262-548-7848
Waupaca County ADRC	715-258-6400

Section 2 of this Summary of Benefits provides a detailed description of all of the benefits to which you are entitled as a member of Community Care's Family Care Partnership Program (HMO). Partnership is a fully integrated Medicare and Medicaid health and long-term care program for frail elderly and adults with disabilities. Members receive all Medicaid and if applicable, Medicare benefits through the Partnership model of care which includes but is not limited to:

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

For people who are eligible for both Medicare and Medicaid, health care and drugs are usually covered by Medicare while long-term care benefits are usually covered by Medicaid. However, if you are only eligible for Medicaid, all of your benefits are covered by Medicaid.

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All members of Community Care's Family Care Partnership Program (HMO) are eligible to receive the following long-term care benefits:

- a. Adaptive aids
- b. Adult day care
- c. Care/case management
- d. Communication aids
- e. Counseling and therapeutic resources
- f. Financial management services
- g. Habilitation:
 - o Daily living skills training
 - o Day center service/treatment
 - o Day services for children
 - o Prevocational services
 - o Supportive employment
 - o Vocational futures planning
- h. Home delivered meals
- i. Home modifications
- j. Housing counseling
- k. Medical and non-medical transportation
- l. Member education and training
- m. Personal Emergency Response Systems
- n. Relocation services
- o. Residential Care
 - o Adult family homes for 1-2 beds
 - o Adult family homes for 3-4 beds
 - o Children's foster homes/treatment foster homes
 - o Community-based residential facilities
 - o Residential care apartment complexes
- p. Respite care
- q. Self directed Supports (SDS)
- r. Specialized medical equipment and supplies
- s. Supportive home care

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All members of Community Care's Family Care Partnership Program (HMO) also receive coverage for health care and drugs. These benefits include but are not limited to:

1. AODA services
2. Surgical services
3. Anesthesiology
4. Audiology
5. Chiropractic
6. Community support program
7. Dental services
8. Diagnostic testing services
9. Dialysis services
10. Drugs
11. Durable medical equipment and medical supplies
12. Family planning services
13. Home health
14. Hospice care services
15. Hospital services
16. Independent nurse practitioner services
17. Mental health services
18. Nursing home services.
19. Nursing services
20. Occupational therapy
21. Personal care services
22. Physical therapy
23. Physician services
24. Podiatry services
25. Private duty nursing services
26. Speech and language pathology services
27. Transportation
28. Vision care services

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SECTION 4 – STATEMENT ABOUT YOUR MEDICAID BENEFITS *If you have any questions about this plan's benefits and costs, please contact Community Care.*

As a member of Community Care's Partnership plan (HMO) you may be responsible for a monthly cost share. This amount is determined by your county and must be paid to keep your eligibility for Medicaid. Community Care will bill you for the cost share each month.

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

Please refer to Section 2 for a complete description of all of the benefits to which you are entitled as a member of Community Care's Family Care Partnership Program (HMO).



communitycareinc.org
866-992-6600

About Community Care

Community Care is a private, non-profit organization that integrates health, home and community services to provide the wider range of help that frail adults or adults with disabilities need. Serving the residents of Wisconsin since 1977, our services allow people to continue living in their own home and communities.