

Charter Plans Summary of Benefits



PUGET SOUND
HEALTH PARTNERS

Puget Sound Health Partners

Medicare Advantage Plan

Partners Charter Plan - H9302-004

Partners Charter Plus Rx Plan - H9302-003

Section I

Introduction to the Summary of Benefits for Partners Charter and Partners Charter Plus Rx

January 1, 2009 - December 31, 2009

Thank you for your interest in Partners Charter and Partners Charter Plus Rx. Our plan is offered by PUGET SOUND HEALTH PARTNERS, INC., a Medicare Advantage Health Maintenance Organization (HMO). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Partners Charter Partners and Charter Plus Rx and ask for the "Evidence of Coverage".

YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Partners Charter and Partners Charter Plus Rx. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call Partners Charter and Partners Charter Plus Rx at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare Partners Charter and Partners Charter Plus Rx and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

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

WHERE IS PARTNERS CHARTER AND PARTNERS CHARTER PLUS RX AVAILABLE?

The service area for this plan includes: King, Pierce, Thurston, and Snohomish Counties, WA. You must live in one of these areas to join the plan.

WHO IS ELIGIBLE TO JOIN PARTNERS CHARTER AND PARTNERS CHARTER PLUS RX AVAILABLE?

You can join Partners Partners Charter and Charter Plus Rx if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are generally not eligible to enroll in Partners Charter Plus Rx unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

Partners Charter and Partners Charter Plus Rx 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.OurPSHP.com. Our customer service number is listed at the end of this introduction.

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

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither Partners Charter and Partners Charter Plus Rx nor the Original Medicare Plan will pay for these services.

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

Partners Charter Plan does cover Medicare Part B prescription drugs. Partners Charter Plan does NOT cover Medicare Part D prescription drugs. Partners Charter Plus Rx does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

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

Partners Charter and Partners Charter Plus Rx has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at www.OurPSHP.com. Our customer service number is listed at the end of this introduction.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Partners Charter Plus Rx uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our website at www.OurPSHP.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 Partners Charter Plus Rx, 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?

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 Medicare coverage in your area.

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

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 Partners Charter Plus Rx for more details.

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

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Partners Charter and Partners Charter Plus Rx for more details.

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

Please call Puget Sound Health Partners for more information about Partners Charter and Partners Charter Plus Rx. Visit us at www.OurPSHP.com or, call us:

Customer Service Hours:

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

Current and Prospective members should call toll-free 1-866-789-7747 for questions related to the Medicare Advantage Program. (TTY/TDD 1-866-264-4141).

Current and Prospective members should call locally (253) 779-8830 for questions related to the Medicare Advantage Program. (TTY/TDD (253)-284-3900).

Current and Prospective members should call toll-free 1-866-789-7747 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 1-866-264-4141)

Current and Prospective members should call locally (253) 779-8830 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (253) 284-3900)

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.

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

Section II

Summary of Benefits for Partners Charter Plan and Partners Charter Plus Rx Plan

BENEFIT CATEGORY

ORIGINAL MEDICARE

IMPORTANT INFORMATION

1. Premium and Other Important Information

In 2008 the monthly Part B Premium was \$96.40 and will change for 2009 and the yearly Part B deductible amount was \$135 and will change for 2009.

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

2. Doctor and Hospital Choice (For more information, see Emergency – #15 and Urgently Needed Care – #16)

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

January 1, 2009 - December 31, 2009

PARTNERS CHARTER

PARTNERS CHARTER PLUS RX

General

\$0 monthly plan premium in addition to your monthly Medicare Part B premium.

In-Network

\$2750 in-network out-of-pocket limit.
Contact the plan for services that apply.

All plan services covered under the out-of-pocket limit.

General

\$41 monthly plan premium in addition to your monthly Medicare Part B premium.

In-Network

\$2750 in-network out-of-pocket limit.
Contact the plan for services that apply.

All plan services covered under the out-of-pocket limit.

In-Network

You must go to network doctors, specialists, and hospitals.

Referral required for network hospitals and specialists (for certain benefits).

You may have to pay a separate copay for certain doctor office visits.

In-Network

You must go to network doctors, specialists, and hospitals.

Referral required for network hospitals and specialists (for certain benefits).

You may have to pay a separate copay for certain doctor office visits.

Section II: Summary of Benefits

BENEFIT CATEGORY	ORIGINAL MEDICARE
INPATIENT CARE 3. Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	<p>In 2008 the amounts for each benefit period were:</p> <p>Days 1 - 60: \$1024 deductible Days 61 - 90: \$256 per day Days 91 - 150: \$512 per lifetime reserve day</p> <p>These amounts will change for 2009.</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once.</p> <p>A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new 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.</p>
4. Inpatient Mental Health Care	<p>Same deductible and copay as inpatient hospital care (see “Inpatient Hospital Care” above).</p> <p>190 day lifetime limit in a Psychiatric Hospital.</p>

PARTNERS CHARTER

PARTNERS CHARTER PLUS RX

In-Network

For Medicare-covered hospital stays:

Days 1 - 10: \$250 copay per day

Days 11 - 90: \$0 copay per day

For additional hospital days:

Days 91-100: \$250 copay per day

Days 101 and beyond: \$0 copay per day

No limit to the number of days covered by the plan each benefit period.

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

In-Network

For Medicare-covered hospital stays:

Days 1 - 10: \$250 copay per day

Days 11 - 90: \$0 copay per day

For additional hospital days:

Days 91-100: \$250 copay per day

Days 101 and beyond: \$0 copay per day

No limit to the number of days covered by the plan each benefit period.

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

In-Network

For hospital stays:

Days 1 - 10: \$250 copay per day

Days 11 - 90: \$0 copay per day

Plan covers 60 lifetime reserve days.

Cost per lifetime reserve day:

Days 1 - 10: \$250 copay per day

Days 11 - 60: \$0 copay per day

You get up to 190 days in a Psychiatric Hospital in a lifetime.

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

In-Network

For hospital stays:

Days 1 - 10: \$250 copay per day

Days 11 - 90: \$0 copay per day

Plan covers 60 lifetime reserve days.

Cost per lifetime reserve day:

Days 1 - 10: \$250 copay per day

Days 11 - 60: \$0 copay per day

You get up to 190 days in a Psychiatric Hospital in a lifetime.

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

Section II: Summary of Benefits

BENEFIT CATEGORY	ORIGINAL MEDICARE
<p>5. Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)</p>	<p>In 2008 the amounts for each benefit period after at least a 3-day covered hospital stay were: Days 1 - 20: \$0 per day Days 21 - 100: \$128 per day</p> <p>These amounts will change for 2009.</p> <p>100 days for each benefit period.</p> <p>A “benefit period” starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>
<p>6. Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>\$0 copay.</p>
<p>7. Hospice</p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must get care from a Medicare-certified hospice.</p>

PARTNERS CHARTER

General

Authorization rules may apply.

In-Network

For SNF stays:

Days 1 - 100: \$150 copay per day

Plan covers up to 100 days each benefit period

No prior hospital stay is required.

PARTNERS CHARTER PLUS RX

General

Authorization rules may apply.

In-Network

For SNF stays:

Days 1 - 100: \$150 copay per day

Plan covers up to 100 days each benefit period

No prior hospital stay is required.

General

Authorization rules may apply.

In-Network

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

General

Authorization rules may apply.

In-Network

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

General

You must get care from a Medicare-certified hospice.

General

You must get care from a Medicare-certified hospice.

Section II: Summary of Benefits

BENEFIT CATEGORY	ORIGINAL MEDICARE
OUTPATIENT CARE	
8. Doctor Office Visits	20% coinsurance
9. Chiropractic Services	Routine care not covered. 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.
10. Podiatry Services	Routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.

PARTNERS CHARTER

PARTNERS CHARTER PLUS RX

General

See "Physical Exams," for more information.

In-Network

\$10 copay for each primary care doctor visit for Medicare-covered benefits.

\$10 to \$30 copay for each in-area, network urgent care Medicare-covered visit.

\$30 copay for each specialist visit for Medicare-covered benefits.

General

See "Physical Exams," for more information.

In-Network

\$10 copay for each primary care doctor visit for Medicare-covered benefits.

\$10 to \$30 copay for each in-area, network urgent care Medicare-covered visit.

\$30 copay for each specialist visit for Medicare-covered benefits.

General

Authorization rules may apply.

In-Network

\$25 copay for Medicare-covered visits.

\$25 copay for up to 20 routine visit(s) every year

Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.

General

Authorization rules may apply.

In-Network

\$25 copay for Medicare-covered visits.

\$25 copay for up to 20 routine visit(s) every year

Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.

In-Network

\$10 to \$30 copay for each Medicare-covered visit.

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

In-Network

\$10 to \$30 copay for each Medicare-covered visit.

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

Section II: Summary of Benefits

BENEFIT CATEGORY	ORIGINAL MEDICARE
11. Outpatient Mental Health Care	50% coinsurance for most outpatient mental health services.
12. Outpatient Substance Abuse Care	20% coinsurance
13. Outpatient Services/Surgery	20% coinsurance for the doctor 20% of outpatient facility charges
14. Ambulance Services (medically necessary ambulance services)	20% coinsurance

PARTNERS CHARTER

General

Authorization rules may apply.

In-Network

\$30 copay for each Medicare-covered individual or group visit.

PARTNERS CHARTER PLUS RX

General

Authorization rules may apply.

In-Network

\$30 copay for each Medicare-covered individual or group visit.

General

Authorization rules may apply.

In-Network

\$30 copay for Medicare-covered individual or group visits.

General

Authorization rules may apply.

In-Network

\$30 copay for Medicare-covered individual or group visits.

General

Authorization rules may apply.

In-Network

\$200 copay for each Medicare-covered ambulatory surgical center visit.

\$30 to \$200 copay for each Medicare-covered outpatient hospital facility visit.

General

Authorization rules may apply.

In-Network

\$200 copay for each Medicare-covered ambulatory surgical center visit.

\$30 to \$200 copay for each Medicare-covered outpatient hospital facility visit.

General

Authorization rules may apply.

In-Network

\$150 copay for Medicare-covered ambulance benefits.

If you are admitted to the hospital, you pay \$0 for Medicare-covered ambulance benefits.

General

Authorization rules may apply.

In-Network

\$150 copay for Medicare-covered ambulance benefits.

If you are admitted to the hospital, you pay \$0 for Medicare-covered ambulance benefits.

Section II: Summary of Benefits

BENEFIT CATEGORY	ORIGINAL MEDICARE
<p>15. Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>20% coinsurance for the doctor</p> <p>20% of facility charge, or a set copay per emergency room visit</p> <p>You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>
<p>16. Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>20% coinsurance, or a set copay</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>
<p>17. Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>20% coinsurance</p>

PARTNERS CHARTER

In-Network

\$50 copay for Medicare-covered emergency room visits.

Out-of-Network

Worldwide coverage.

In and Out-of-Network

If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit.

General

\$30 copay for Medicare-covered urgently needed care visits.

If you are admitted to the hospital within 24-hour(s) for the same condition, \$0 for the urgent-care visit.

General

Authorization rules may apply.

In-Network

\$0 to \$30 copay for Medicare-covered Occupational Therapy visits.

\$0 to \$30 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.

PARTNERS CHARTER PLUS RX

In-Network

\$50 copay for Medicare-covered emergency room visits.

Out-of-Network

Worldwide coverage.

In and Out-of-Network

If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit.

General

\$30 copay for Medicare-covered urgently needed care visits.

If you are admitted to the hospital within 24-hour(s) for the same condition, \$0 for the urgent-care visit.

General

Authorization rules may apply.

In-Network

\$0 to \$30 copay for Medicare-covered Occupational Therapy visits.

\$0 to \$30 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.

Section II: Summary of Benefits

BENEFIT CATEGORY	ORIGINAL MEDICARE
OUTPATIENT MEDICAL SERVICES AND SUPPLIES	
18. Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance
19. Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance
20. Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	20% coinsurance 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.

PARTNERS CHARTER

PARTNERS CHARTER PLUS RX

General

Authorization rules may apply.

In-Network

20% of the cost for Medicare-covered items.

General

Authorization rules may apply.

In-Network

20% of the cost for Medicare-covered items.

General

Authorization rules may apply.

In-Network

20% of the cost for Medicare-covered items.

General

Authorization rules may apply.

In-Network

20% of the cost for Medicare-covered items.

In-Network

\$0 copay for Diabetes self-monitoring training.

\$10 copay for Nutrition Therapy for Diabetes.

\$0 copay for Diabetes supplies.

In-Network

\$0 copay for Diabetes self-monitoring training.

\$10 copay for Nutrition Therapy for Diabetes.

\$0 copay for Diabetes supplies.

Section II: Summary of Benefits

BENEFIT CATEGORY	ORIGINAL MEDICARE
21. Diagnostic Tests, X-Rays, and Lab Services	20% coinsurance for diagnostic tests and x-rays. \$0 copay for Medicare-covered lab services. Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.

PREVENTIVE SERVICES

22. Bone Mass Measurement (for people with Medicare who are at risk)	20% coinsurance Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.
23. Colorectal Screening Exams (for people with Medicare age 50 and older)	20% coinsurance Covered when you are high risk or when you are age 50 and older.

PARTNERS CHARTER

General

Authorization rules may apply.

In-Network

\$0 copay for Medicare-covered:

- lab services
- diagnostic procedures and tests

\$0 copay for Medicare-covered X-rays.

\$0 to \$100 copay for Medicare-covered diagnostic radiology services.

\$0 copay for Medicare-covered therapeutic radiology services.

PARTNERS CHARTER PLUS RX

General

Authorization rules may apply.

In-Network

\$0 copay for Medicare-covered:

- lab services
- diagnostic procedures and tests

\$0 copay for Medicare-covered X-rays.

\$0 to \$100 copay for Medicare-covered diagnostic radiology services.

\$0 copay for Medicare-covered therapeutic radiology services.

In-Network

\$0 copay for Medicare-covered bone mass measurement.

In-Network

\$0 copay for Medicare-covered bone mass measurement.

In-Network

\$0 copay for Medicare-covered colorectal screenings.

In-Network

\$0 copay for Medicare-covered colorectal screenings.

Section II: Summary of Benefits

BENEFIT CATEGORY	ORIGINAL MEDICARE
<p>24. Immunizations (Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine)</p>	<p>\$0 copay for Flu and Pneumonia vaccines</p> <p>20% coinsurance for Hepatitis B vaccine</p> <p>You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.</p>
<p>25. Mammograms (Annual Screening) (for women with Medicare age 40 and older)</p>	<p>20% coinsurance</p> <p>No referral needed.</p> <p>Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.</p>
<p>26. Pap Smears and Pelvic Exams (for women with Medicare)</p>	<p>\$0 copay for Pap smears.</p> <p>Covered once every 2 years. Covered once a year for women with Medicare at high risk.</p> <p>20% coinsurance for Pelvic Exams</p>
<p>27. Prostate Cancer Screening Exams (for men with Medicare age 50 and older)</p>	<p>20% coinsurance for the digital rectal exam.</p> <p>\$0 for the PSA test; 20% coinsurance for other related services.</p> <p>Covered once a year for all men with Medicare over age 50.</p>

PARTNERS CHARTER

In-Network

\$0 copay for Flu and Pneumonia vaccines.

\$0 copay for Hepatitis B vaccine.

No referral needed for Flu and Pneumonia vaccines.

PARTNERS CHARTER PLUS RX

In-Network

\$0 copay for Flu and Pneumonia vaccines.

\$0 copay for Hepatitis B vaccine.

No referral needed for Flu and Pneumonia vaccines.

In-Network

\$0 copay for Medicare-covered screening mammograms and up to 1 additional screening mammogram(s) every year.

In-Network

\$0 copay for Medicare-covered screening mammograms and up to 1 additional screening mammogram(s) every year.

In-Network

\$0 copay for Medicare-covered pap smears and pelvic exams and up to 1 additional pap smear(s) and pelvic exam(s) every year.

In-Network

\$0 copay for Medicare-covered pap smears and pelvic exams and up to 1 additional pap smear(s) and pelvic exam(s) every year.

In-Network

\$0 copay for Medicare-covered prostate cancer screening.

In-Network

\$0 copay for Medicare-covered prostate cancer screening.

Section II: Summary of Benefits

BENEFIT CATEGORY	ORIGINAL MEDICARE
28. ESRD	<p>20% coinsurance for renal dialysis</p> <p>20% coinsurance for Nutrition Therapy for End-Stage Renal Disease Authorization rules may apply.</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>

PARTNERS CHARTER

General

Authorization rules may apply.

In-Network

\$30 copay for renal dialysis

\$10 copay for Nutrition Therapy End-Stage Renal Disease.

PARTNERS CHARTER PLUS RX

General

Authorization rules may apply.

In-Network

\$30 copay for renal dialysis

\$10 copay for Nutrition Therapy End-Stage Renal Disease.

Section II: Summary of Benefits

BENEFIT CATEGORY	ORIGINAL MEDICARE
29. Prescription Drugs	<p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>

PARTNERS CHARTER

Drugs covered under Medicare Part B

General

10% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs).

10% of the cost for Part B-covered chemotherapy drugs.

Drugs Covered under Medicare Part D

General

This plan does not offer prescription drug coverage.

Most drugs not covered

PARTNERS CHARTER PLUS RX

Drugs covered under Medicare Part B

General

10% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs).

10% of the cost for Part B-covered chemotherapy drugs.

Drugs covered under Medicare Part D

General

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

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

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

The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).

Total yearly drug costs are the total drug costs paid by both you and the plan. Some drugs have quantity limits. Your provider must get prior authorization from Partners Charter Rx for certain drugs.

The plan will pay for certain over-the-counter drugs as part of its utilization management

Section II: Summary of Benefits

BENEFIT CATEGORY	ORIGINAL MEDICARE
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29. Prescription Drugs (continued)

program. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details.

You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plans website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on [Medicare.gov](https://www.medicare.gov).

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

In-Network

\$295 deductible on all drugs except generics until you reach the deductible. You pay \$5 copay for generic drugs. Some covered drugs don't count toward your out-of-pocket drug costs.

Initial Coverage

After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$3,200:

Retail Pharmacy

Tier I

- \$5 copay for a one-month (30-day) supply of drugs in this tier
- \$10 copay for a three-month (90-day) supply of drugs in this tier

Tier II

- \$25 copay for a one-month (30-day) supply of drugs in this tier
- \$50 copay for a three-month (90-day) supply of drugs in this tier

Section II: Summary of Benefits

BENEFIT CATEGORY	ORIGINAL MEDICARE
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29. Prescription Drugs (continued)

- \$100 copay for a three-month (90-day) supply of drugs in this tier

Tier IV

- 10% coinsurance for a one-month (30-day) supply of drugs in this tier

- 10% coinsurance for a three-month (90-day) supply of drugs in this tier

Long Term Care Pharmacy

Tier I

- \$5 copay for a one-month (31-day) supply of drugs in this tier

Tier II

- \$25 copay for a one-month (31-day) supply of drugs in this tier

Tier III

- \$50 copay for a one-month (31-day) supply of drugs in this tier

Tier IV

- 10% coinsurance for a one-month (31-day) supply of drugs in this tier

Mail Order

Tier I

- \$5 copay for a one-month (30-day) supply of drugs in this tier

- \$10 copay for a three-month (90-day) supply of drugs in this tier

Tier II

- \$25 copay for a one-month (30-day) supply of drugs in this tier

- \$50 copay for a three-month (90-day) supply of drugs in this tier

Tier III

- \$50 copay for a one-month (30-day) supply of drugs in this tier

- \$100 copay for a three-month (90-day) supply of drugs in this tier

Tier IV

- 10% coinsurance for a one-month (30-day) tier

Section II: Summary of Benefits

BENEFIT CATEGORY	ORIGINAL MEDICARE
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29. Prescription Drugs (continued)

Section II: Summary of Benefits

PARTNERS CHARTER

PARTNERS CHARTER PLUS RX

Coverage Gap

After your total yearly drug cost reach \$3,200, you pay 100% until your yearly out-of-pocket drug cost reach \$4350.

Catastrophic Coverage

After your yearly out-of-pocket drug costs reach \$ 4,350, you pay the greater of:

- A \$ 2.40 copay for generic (including brand drugs treated as generic) and a \$ 6.00 copay for all other drugs, or
- 5% coinsurance.

Out-of-Network

Plan drugs may be covered in special circumstances, for instance, illness while traveling outside outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Partners Charter Plus Rx.

Out-of-Network Initial Coverage

After you pay your yearly deductible, you will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$3,200:

Section II: Summary of Benefits

BENEFIT CATEGORY	ORIGINAL MEDICARE
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29. Prescription Drugs (continued)

Out-of-Network Pharmacy

Tier I

- \$5 copay for a (10-day) supply of drugs in this tier

Tier II

- \$25 copay for a (10-day) supply of drugs in this tier

Tier III

- \$50 copay for a (10-day) supply of drugs in this tier

Tier IV

- 10% coinsurance for a (10-day) supply of drugs in this tier

Out-of-Network Coverage Gap

After your total yearly drug costs reach \$3,200, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,350. You will not be reimbursed by Partners Charter Plus Rx for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Partners Charter Plus Rx so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.

Out-of-Network Catastrophic Coverage

After your yearly out-of-pocket drug costs reach \$ 4,350, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:

- A \$ 2.40 copay for generic (including brand drugs treated as generic) and a \$ 6.00 copay for all other drugs, or
- 5% coinsurance.

Section II: Summary of Benefits

BENEFIT CATEGORY	ORIGINAL MEDICARE
30. Dental Services	Preventive dental services (such as cleaning) not covered.
31. Hearing Services	Routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.
32. Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.

PARTNERS CHARTER

In-Network

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

However, this plan covers preventive dental for an extra cost (see "Optional Benefits")

\$30 copay for Medicare-covered dental benefits.

In-Network

Hearing aids not covered.

- \$0 to \$30 copay for diagnostic hearing exams.
- \$0 to \$30 copay for up to 1 routine hearing test(s) every year.

In-Network

\$0 copay for
- one pair of eyeglasses or contact lenses after each cataract surgery.

\$30 copay for exams to diagnose and treat diseases and conditions of the eye.

\$30 copay for up to 1 routine eye exam(s) every year.

PARTNERS CHARTER PLUS RX

In-Network

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

However, this plan covers preventive dental for an extra cost (see "Optional Benefits")

\$30 copay for Medicare-covered dental benefits.

In-Network

Hearing aids not covered.

- \$0 to \$30 copay for diagnostic hearing exams.
- \$0 to \$30 copay for up to 1 routine hearing test(s) every year.

In-Network

\$0 copay for
- one pair of eyeglasses or contact lenses after each cataract surgery.

\$30 copay for exams to diagnose and treat diseases and conditions of the eye.

\$30 copay for up to 1 routine eye exam(s) every year.

Section II: Summary of Benefits

BENEFIT CATEGORY	ORIGINAL MEDICARE
33. Physical Exams	<p>20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage</p> <p>When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.</p>
Health/Wellness Education	<p>Smoking Cessation: Covered if ordered by your doctor Includes two counseling attempts within 12-mth period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.</p>
Transportation (Routine)	Not Covered.
Acupuncture	Not covered.

PARTNERS CHARTER

In-Network

\$10 copay for routine exams.

Limited to 1 exam(s) every year.

\$10 copay for Medicare-covered benefits.

PARTNERS CHARTER PLUS RX

In-Network

\$10 copay for routine exams.

Limited to 1 exam(s) every year.

\$10 copay for Medicare-covered benefits.

In-Network

This plan does not cover health/wellness education benefits.

In-Network

This plan does not cover health/wellness education benefits.

General

Authorization rules may apply.

General

Authorization rules may apply.

In-Network

\$0 copay for up to 20 one-way trip(s) to plan-approved location every year.

In-Network

\$0 copay for up to 20 one-way trip(s) to plan-approved location every year.

General

Authorization rules may apply.

General

Authorization rules may apply.

In-Network

\$25 copay per visit up to 20 visit(s) every year.

In-Network

\$25 copay per visit up to 20 visit(s) every year.

Section II: Summary of Benefits

BENEFIT CATEGORY	ORIGINAL MEDICARE
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OPTIONAL BENEFITS

Optional Supplemental Package #1

Premium and Other Important Information

Dental Services

Package: 1 - SmartSmile**Dental Plan:**

\$17.50 monthly premium, in addition to your \$0 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits:

- Dental Services

Package: 1 - SmartSmile**Dental Plan:**

\$17.50 monthly premium, in addition to your \$41 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits:

- Dental Services

General

Plan offers additional comprehensive dental benefits.

General

Plan offers additional comprehensive dental benefits.

In-Network

- \$12 to \$20 copay for up to 2 cleaning(s) every year
- \$5 copay for fluoride treatments
- \$2 copay for oral exams
- \$0 to \$25 copay for up to 1 dental x-ray visit(s) every three years

In-Network

- \$12 to \$20 copay for up to 2 cleaning(s) every year
- \$5 copay for fluoride treatments
- \$2 copay for oral exams
- \$0 to \$25 copay for up to 1 dental x-ray visit(s) every three years

Section II: Summary of Benefits

BENEFIT CATEGORY	ORIGINAL MEDICARE
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Optional Supplemental Package #2

Premium and Other Important Information

Dental Services

PARTNERS CHARTER

PARTNERS CHARTER PLUS RX

Package: 2 - Super SmartSmile Dental Plan:

\$21.95 monthly premium, in addition to your \$0 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits:

- Dental Services

Package: 2 - Super SmartSmile Dental Plan:

\$21.95 monthly premium, in addition to your \$41 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits:

- Dental Services

General

Plan offers additional comprehensive dental benefits.

General

Plan offers additional comprehensive dental benefits.

In-Network

- \$12 to \$20 copay for up to 2 cleaning(s) every year
- \$5 copay for fluoride treatments
- \$2 copay for oral exams
- \$0 to \$25 copay for up to 1 dental x-ray visit(s) every three years

In-Network

- \$12 to \$20 copay for up to 2 cleaning(s) every year
 - \$5 copay for fluoride treatments
 - \$2 copay for oral exams
 - \$0 to \$25 copay for up to 1 dental x-ray visit(s) every three years
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