

Summary of Benefits

Ascent (HMO)
Alpine (HMO)



PUGET SOUND
HEALTH PARTNERS



Section I - Introduction 2011 Summary of Benefits

Alpine (HMO) and Ascent (HMO)

January 1, 2011 - December 31, 2011

Counties: King, Lewis, Pierce, Snohomish, Thurston

Thank you for your interest in Alpine (HMO) and Ascent (HMO). Our plans are offered by Puget Sound Health Partners INC., a Medicare Advantage Health Maintenance Organization (HMO). This Summary of Benefits tells you some features of our plans. 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 Alpine (HMO) and Ascent (HMO) and ask for the "Evidence of Coverage".

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

How can I compare my options?

You can compare Alpine (HMO), Ascent (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 plans cover 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 Alpine (HMO) and Ascent (HMO) available?

The service area for these plans include: King, Lewis, Pierce, Snohomish, and Thurston Counties, WA. You must live in one of these areas to join one of our plans.

Who is Alpine (HMO) and Ascent (HMO)?

You can join Alpine (HMO) and Ascent (HMO) 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 Alpine (HMO) and Ascent (HMO) unless they are members of our organization and have been since their dialysis began.

Can I choose my Doctors?

Alpine (HMO) and Ascent (HMO) have 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 except in limited situations (for example, emergency care). Neither the plan nor the Original Medicare Plan will pay for these services.

Does my plan cover Medicare Part B or Part D Drugs?

Alpine (HMO) and Ascent (HMO) cover Medicare Part B prescription drugs. Alpine (HMO) and Ascent (HMO) do NOT cover Medicare Part D prescription drugs.

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 plan decides 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 Alpine (HMO) and Ascent (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 an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a

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

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 Alpine (HMO) and Ascent (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.

Where can I find information on plan ratings?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for these plans. Our customer service number is listed below.

This document may be available in a different format or language. For additional information, call customer service at the phone number listed below.

Please call Puget Sound Health Partners for more information about: Alpine (HMO) and Ascent (HMO).

Visit us at www.OurPSHP.com or, call us:

Member Service Hours:
8am – 8pm, 7 days a week

You may receive a messaging service on weekends and holidays from March 2 through November 14. Please leave a message and your call will be returned the next business day.

Current & Prospective Members

Call toll-free **1-866-789-7747** for questions related to the Medicare Advantage Program and questions related to Medicare Part D Prescription. (TTY/TDD 1-866-264-4141).

Call locally **253-779-8830** for questions related to the Medicare Advantage Program and questions related to Medicare Part D Prescription. (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.

Section II - 2011 Summary of Benefits

BENEFIT CATEGORY	ORIGINAL MEDICARE
IMPORTANT INFORMATION	
<p>1. Premium & Other Important Information</p>	<p>In 2010 the monthly Part B Premium was \$96.40 and may change for 2011 and the yearly Part B deductible amount was \$155 and may change for 2011.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income. (Over \$85,000 for singles, \$170,000 for married couples.) For more information about Part B premiums based on income, call Medicare @ 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>
<p>2. Doctor & Hospital Choice</p> <p>(For more information, see Emergency – #15 & Urgently Needed Care – #16)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>

IMPORTANT INFORMATION

**ASCENT
(HMO)**

**ALPINE
(HMO)**

General

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

This plan covers all Medicare-covered preventive services with zero cost sharing.

In-Network

\$3,400 out-of-pocket limit.

All plan services included.

Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income. (Over \$85,000 for singles, \$170,000 for married couples.) For more information about Part B premiums based on income, call Medicare @ 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

General

\$39 monthly plan premium in addition to your monthly Medicare Part B premium.

This plan covers all Medicare-covered preventive services with zero cost sharing.

In-Network

\$2,250 out-of-pocket limit.

All plan services included.

Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income. (Over \$85,000 for singles, \$170,000 for married couples.) For more information about Part B premiums based on income, call Medicare @ 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

In-Network

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

Referral required for network specialists (for certain benefits).

In-Network

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

Referral required for network specialists (for certain benefits).

BENEFIT CATEGORY**ORIGINAL MEDICARE****INPATIENT CARE****3. Inpatient Hospital Care**

(includes Substance Abuse and Rehabilitation Services)

In 2010 the amounts for each benefit period were:
 Days 1 - 60: \$1100 deductible
 Days 61 - 90: \$275 per day
 Days 91 - 150: \$550 per lifetime reserve day

These amounts will change for 2011.

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

Lifetime reserve days can only be used once.

A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period.

There is no limit to the number of benefit periods you can have.

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In-Network

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

For Medicare-covered hospital stays:

Days 1 - 8: \$275 copay per day
Days 9 - 90: \$0 copay per day
\$0 copay for additional hospital days

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

In-Network

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

For Medicare-covered hospital stays:

Days 1 - 5: \$200 copay per day
Days 6 - 90: \$0 copay per day
\$0 copay for additional hospital days

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

BENEFIT CATEGORY**ORIGINAL MEDICARE****4. Inpatient Mental Health Care**

Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above).

190 day lifetime limit in a Psychiatric Hospital.

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In-Network

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

For Medicare-covered hospital stays:

Days 1 - 7: \$300 copay per day
Days 8 -90: \$0 copay per day

Plan covers 60 lifetime reserve days.

Cost per lifetime reserve day:

Days 1 - 7: \$300 copay per day
Days 8 -60: \$0 copay per day

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

In-Network

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

For Medicare-covered hospital stays:

Days 1 - 5: \$200 copay per day
Days 6 - 90: \$0 copay per day

Plan covers 60 lifetime reserve days.

Cost per lifetime reserve day:

Days 1 - 5: \$200 copay per day
Days 6 - 60: \$0 copay per day

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

BENEFIT CATEGORY	ORIGINAL MEDICARE
<p>5. Skilled Nursing Facility (SNF)</p> <p>(in a Medicare-certified skilled nursing facility)</p>	<p>In 2010 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: \$137.50 per day</p> <p>These amounts will change for 2011.</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.</p> <p>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</p> <p>(includes medically necessary intermittent skilled nursing care, home health aide services, & 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>

ASCENT (HMO)	ALPINE (HMO)
<p>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p> <p>For SNF stays:</p> <p>Days 1 - 30: \$100 copay per day Days 31-100: \$0 copay per day</p>	<p>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p> <p>For SNF stays:</p> <p>Days 1 - 10: \$0 copay per day Days 11 - 33: \$100 copay per day Days 34 - 100: \$0 copay per day</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits.</p>
<p>General You must get care from a Medicare-certified hospice.</p>	<p>General You must get care from a Medicare-certified hospice.</p>

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.

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<p>In-Network \$10 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$40 copay for each in-area, network urgent care Medicare-covered visit.</p> <p>\$40 copay for each specialist visit for Medicare-covered benefits.</p>	<p>In-Network \$10 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$30 copay for each in-area, network urgent care Medicare-covered visit.</p> <p>\$30 copay for each specialist visit for Medicare-covered benefits.</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$15 copay for each Medicare-covered visit.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$15 copay for each Medicare-covered visit.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE
<p>10. Podiatry Services</p>	<p>Routine care not covered.</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>
<p>11. Outpatient Mental Health Care</p>	<p>45% coinsurance for most outpatient mental health services.</p>
<p>12. Outpatient Substance Abuse Care</p>	<p>20% coinsurance.</p>
<p>13. Outpatient Services/Surgery</p>	<p>20% coinsurance for the doctor.</p> <p>Specified copayment for outpatient hospital facility charges. Copay cannot exceed Part A inpatient hospital deductible.</p> <p>20% coinsurance for ambulatory surgical center facility charges.</p>

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<p>In-Network \$10 to \$40 copay for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>	<p>In-Network \$10 to \$30 copay for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$40 copay for each Medicare-covered individual or group therapy visit.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for each Medicare-covered individual or group therapy visit.</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$40 copay for Medicare-covered individual or group visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for Medicare-covered individual or group visits.</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$250 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$40 to \$250 copay for each Medicare-covered outpatient hospital facility visit.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$150 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$30 to \$150 copay for each Medicare-covered outpatient hospital facility visit.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE
<p>14. Ambulance Services</p> <p>(medically necessary ambulance services)</p>	<p>20% coinsurance.</p>
<p>15. Emergency Care</p> <p>(You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>20% coinsurance for the doctor.</p> <p>Specified copayment for outpatient hospital emergency room (ER) facility charge.</p> <p>ER copay cannot exceed Part A inpatient deductible.</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>

**ASCENT
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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.

General

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

Worldwide coverage.

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

General

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

Worldwide coverage.

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

BENEFIT CATEGORY	ORIGINAL MEDICARE
<p>16. Urgently Needed Care</p> <p>(This is NOT emergency care, & 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</p> <p>(Occupational Therapy, Physical Therapy, Speech & Language Therapy, Respiratory Therapy Services, Social/Psychological Service, and more)</p>	<p>20% coinsurance.</p>
<p>OUTPATIENT MEDICAL SERVICES AND SUPPLIES</p>	
<p>18. Durable Medical Equipment</p> <p>(includes wheelchairs, oxygen, etc.)</p>	<p>20% coinsurance.</p>

<p style="text-align: center;">ASCENT (HMO)</p>	<p style="text-align: center;">ALPINE (HMO)</p>
<p>General \$40 copay for Medicare-covered urgently needed care visits.</p> <p>If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the urgently-needed care visit.</p>	<p>General \$30 copay for Medicare-covered urgently needed care visits.</p> <p>If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the urgently-needed care visit.</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$0 to \$40 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$0 to \$40 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.</p> <p>\$0 to \$40 copay for Medicare-covered Cardiac Rehab services.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 to \$30 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$0 to \$30 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.</p> <p>\$0 to \$30 copay for Medicare-covered Cardiac Rehab services.</p>
<p>General Authorization rules may apply.</p> <p>In-Network 25% of the cost for Medicare-covered items.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE
<p>19. Prosthetic Devices</p> <p>(includes braces, artificial limbs & eyes, etc.)</p>	<p>20% coinsurance.</p>
<p>20. Diabetes Self-Monitoring Training, Nutrition Therapy, & Supplies</p> <p>(includes coverage for glucose monitors, test strips, lancets, screening tests, self-management training, retinal exam/glaucoma test, and foot exam/therapeutic soft shoes)</p>	<p>20% coinsurance.</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>
<p>21. Diagnostic Tests, X-Rays, Lab Services, & Radiology Services</p>	<p>20% coinsurance for diagnostic tests and x-rays.</p> <p>\$0 copay for Medicare-covered lab services.</p> <p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p>

ASCENT (HMO)	ALPINE (HMO)
<p>General Authorization rules may apply.</p> <p>In-Network 25% of the cost for Medicare-covered items.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p>
<p>In-Network \$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p> <p>Separate Office Visit cost sharing of \$0 to \$40 may apply.</p>	<p>In-Network \$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p> <p>Separate Office Visit cost sharing of \$0 to \$30 may apply.</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered lab services.</p> <p>\$0 copay for Medicare-covered diagnostic procedures and tests.</p> <p>\$0 copay for Medicare-covered X-rays.</p> <p>\$0 to \$200 copay for Medicare-covered diagnostic radiology services (not including x-rays).</p> <p>\$40 copay for Medicare-covered therapeutic radiology services.</p> <p>Separate Office Visit cost sharing of \$0 to \$40 may apply for Outpatient Diagnostic Procedures, Tests and Lab Services.</p> <p>Separate Office Visit cost sharing of \$0 to \$40 may apply for Outpatient Diagnostic and Therapeutic Radiological Services.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered lab services.</p> <p>\$0 copay for Medicare-covered diagnostic procedures and tests.</p> <p>\$0 copay for Medicare-covered X-rays.</p> <p>\$0 to \$130 copay for Medicare-covered diagnostic radiology services (not including x-rays).</p> <p>\$30 copay for Medicare-covered therapeutic radiology services.</p> <p>Separate Office Visit cost sharing of \$0 to \$30 may apply for Outpatient Diagnostic Procedures, Tests and Lab Services.</p> <p>Separate Office Visit cost sharing of \$0 to \$30 may apply for Outpatient Diagnostic and Therapeutic Radiological Services.</p>

BENEFIT CATEGORY

ORIGINAL MEDICARE

PREVENTIVE SERVICES

22. Bone Mass Measurement

(for people with Medicare who are at risk)

No coinsurance, copayment or deductible.

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 & older)

No coinsurance, copayment or deductible for screening colonoscopy or screening flexible sigmoidoscopy.

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

24. Immunizations

(Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine)

\$0 copay for Flu, Pneumonia and Hepatitis B vaccines.

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

25. Mammograms (Annual Screening)

(for women with Medicare age 40 & older)

No coinsurance, copayment or deductible.

No referral needed.

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.

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<p>In-Network \$0 copay for Medicare-covered bone mass measurement.</p> <p>Separate Office Visit cost sharing of \$0 to \$40 may apply.</p>	<p>In-Network \$0 copay for Medicare-covered bone mass measurement.</p> <p>Separate Office Visit cost sharing of \$0 to \$30 may apply.</p>
<p>In-Network \$0 copay for Medicare-covered colorectal screenings.</p> <p>Separate Office Visit cost sharing of \$0 to \$40 may apply.</p>	<p>In-Network \$0 copay for Medicare-covered colorectal screenings.</p> <p>Separate Office Visit cost sharing of \$0 to \$30 may apply.</p>
<p>In-Network \$0 copay for Flu and Pneumonia vaccines.</p> <p>\$0 copay for Hepatitis B vaccine.</p> <p>No referral needed for Flu and pneumonia vaccines.</p>	<p>In-Network \$0 copay for Flu and Pneumonia vaccines.</p> <p>\$0 copay for Hepatitis B vaccine.</p> <p>No referral needed for Flu and pneumonia vaccines.</p>
<p>In-Network \$0 copay for additional screening mammograms.</p>	<p>In-Network \$0 copay for additional screening mammograms.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE
<p>26. Pap Smears & Pelvic Exams (for women with Medicare)</p>	<p>No coinsurance, copayment or deductible for Pap smears.</p> <p>No referral needed.</p> <p>No coinsurance, copayment or deductible for Pelvic and clinical breast exams.</p> <p>Covered once every 2 years. Covered once a year for women with Medicare at high risk.</p>
<p>27. Prostate Cancer Screening Exams (for men with Medicare age 50 & 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>
<p>28. End-Stage Renal Disease (ESRD)</p>	<p>20% coinsurance for renal dialysis.</p> <p>20% coinsurance for Nutrition Therapy for End-Stage Renal Disease.</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>

ASCENT (HMO)	ALPINE (HMO)
<p>In-Network \$0 copay for Medicare-covered pap smears and pelvic exams.</p> <p>- up to 1 additional pap smear and pelvic exam every year.</p> <p>Separate Office Visit cost sharing of \$0 to \$40 may apply.</p>	<p>In-Network \$0 copay for Medicare-covered pap smears and pelvic exams.</p> <p>- up to 1 additional pap smear and pelvic exam every year.</p> <p>Separate Office Visit cost sharing of \$0 to \$30 may apply.</p>
<p>In-Network \$0 copay for Medicare-covered prostate cancer screening.</p> <p>Separate Office Visit cost sharing of \$0 to \$40 may apply.</p>	<p>In-Network \$0 copay for Medicare-covered prostate cancer screening.</p> <p>Separate Office Visit cost sharing of \$0 to \$30 may apply.</p>
<p>General Authorization rules may apply.</p> <p>In-Network 23% of the cost for renal dialysis.</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for renal dialysis.</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE
<p>29. Prescription Drugs</p>	<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>
<p>30. Dental Services</p>	<p>Preventive dental services (such as cleaning) not covered.</p>
<p>31. Hearing Services</p>	<p>Routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams.</p>

ASCENT (HMO)	ALPINE (HMO)
<p>Drugs covered under Medicare Part B</p> <p>General Most drugs not covered.</p> <p>20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>Drugs Covered under Medicare Part D</p> <p>General This plan does not offer perscription drug coverage.</p>	<p>Drugs covered under Medicare Part B</p> <p>General Most drugs not covered.</p> <p>20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>Drugs Covered under Medicare Part D</p> <p>General This plan does not offer perscription drug coverage.</p>
<p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits.")</p> <p>\$40 copay for Medicare-covered dental benefits.</p>	<p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits.")</p> <p>\$30 copay for Medicare-covered dental benefits.</p>
<p>In-Network - \$0 to \$40 copay for Medicare-covered diagnostic hearing exams.</p> <p>- \$0 to \$40 copay for up to 1 routine hearing test every year.</p> <p>Hearing aids not covered.</p>	<p>In-Network - \$0 to \$30 copay for Medicare-covered diagnostic hearing exams.</p> <p>- \$0 to \$30 copay for up to 1 routine hearing test every year.</p> <p>Hearing aids not covered.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE
<p>32. Vision Services</p>	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>
<p>33. Welcome to Medicare; and Annual Wellness Visit</p>	<p>When you join Medicare Part B, then you are eligible as follows:</p> <p>During the first 12 months of your new Medicare Part B coverage, you can get either a Welcome to Medicare exam or an Annual Wellness visit.</p> <p>After your first 12 months, you can get one Annual Wellness visit every 12 months.</p> <p>There is no coinsurance, copayment or deductible for either the Welcome to Medicare exam or the Annual Wellness visit.</p> <p>The Welcome to Medicare exam does not include lab tests.</p>

ASCENT (HMO)	ALPINE (HMO)
<p>In-Network</p> <ul style="list-style-type: none"> - \$0 copay for one pair of eyeglasses or contact lenses after cataract surgery. - \$0 to \$40 copay for exams to diagnose and treat diseases and conditions of the eye. - \$0 copay for up to 1 routine eye exam every year. - \$15 copay for up to 1 pair of glasses every year. - \$15 copay for up to 1 pair of contacts every year. - \$15 copay for up to 1 pair of lenses every year. - \$15 copay for up to 1 frame every year. <p>\$120 plan coverage limit for eye wear every year.</p>	<p>In-Network</p> <ul style="list-style-type: none"> - \$0 copay for one pair of eyeglasses or contact lenses after cataract surgery. - \$0 to \$30 copay for exams to diagnose and treat diseases and conditions of the eye. - \$0 copay for up to 1 routine eye exam every year. - \$15 copay for up to 1 pair of glasses every year. - \$15 copay for up to 1 pair of contacts every year. - \$15 copay for up to 1 pair of lenses every year. - \$15 copay for up to 1 frame every year. <p>\$120 plan coverage limit for eye wear every year.</p>
<p>In-Network</p> <p>\$0 copay for the required Medicare-covered initial preventive physical exam and annual wellness visits.</p>	<p>In-Network</p> <p>\$0 copay for the required Medicare-covered initial preventive physical exam and annual wellness visits.</p>

BENEFIT CATEGORY	ORIGINAL MEDICARE
<p>34. Health/Wellness Education</p>	<p>Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month 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> <p>\$0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit.</p> <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months of up to three times during a pregnancy.</p>
<p>Transportation (Routine)</p>	<p>Not covered.</p>
<p>Acupuncture</p>	<p>Not covered.</p>

ASCENT (HMO)	ALPINE (HMO)
<p>In-Network The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletters. - Health Club Membership/Fitness Classes. - Other Wellness Benefits. <p>\$0 copay for each Medicare-covered smoking cessation counseling session.</p> <p>\$0 copay for each Medicare-covered HIV screening.</p> <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.</p>	<p>In-Network The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletters. - Health Club Membership/Fitness Classes. - Other Wellness Benefits. <p>\$0 copay for each Medicare-covered smoking cessation counseling session.</p> <p>\$0 copay for each Medicare-covered HIV screening.</p> <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.</p>
<p>In-Network This plan does not cover routine transportation.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for up to 20 one-way trips to plan-approved location every year.</p>
<p>In-Network This plan does not cover Acupuncture.</p>	<p>In-Network This plan does not cover Acupuncture.</p>

BENEFIT CATEGORY

ORIGINAL MEDICARE

OPTIONAL BENEFITS

Optional Supplemental Package #1

Premium & Other Important Information

Dental Services

OPTIONAL BENEFIT

**ASCENT
(HMO)**

**ALPINE
(HMO)**

<p>General Package: 1 - Partners Dental Plan: \$56 monthly premium, in addition to your \$0 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: - Preventive Dental</p> <p>Comprehensive Dental \$1,500 plan coverage limit every year for these benefits.</p>	<p>General Package: 1 - Partners Dental Plan: \$56 monthly premium, in addition to your \$39 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: - Preventive Dental</p> <p>Comprehensive Dental \$1,500 plan coverage limit every year for these benefits.</p>
<p>General Plan offers additional comprehensive dental benefits.</p> <p>In-Network - 0% to 20% of the cost for up to 2 cleanings every year.</p> <p>- 0% to 20% of the cost for up to 2 fluoride treatments every year.</p> <p>- 0% to 20% of the cost for up to 2 oral exams every year.</p> <p>- 0% to 20% of the cost for up to 1 dental x-ray every year.</p> <p>\$1,500 plan coverage limit for dental benefits every year.</p>	<p>General Plan offers additional comprehensive dental benefits.</p> <p>In-Network - 0% to 20% of the cost for up to 2 cleanings every year.</p> <p>- 0% to 20% of the cost for up to 2 fluoride treatments every year.</p> <p>- 0% to 20% of the cost for up to 2 oral exams every year.</p> <p>- 0% to 20% of the cost for up to 1 dental x-ray every year.</p> <p>\$1,500 plan coverage limit for dental benefits every year.</p>

BENEFIT CATEGORY

ORIGINAL MEDICARE

Optional Supplemental Package #2

Premium & Other Important Information

Chiropractic Services

OPTIONAL BENEFIT

**ASCENT
(HMO)**

**ALPINE
(HMO)**

General

Package: 2 - Partners Alternative Care Plan:

\$5 monthly premium, in addition to your \$0 monthly plan premium and the monthly

Medicare Part B premium, for the following optional benefits:

- Chiropractic Services.
- Acupuncture.

In-Network

\$15 copay for up to 20 routine visit(s) every year.

General

Package: 2 - Partners Alternative Care Plan:

\$5 monthly premium, in addition to your \$39 monthly plan premium and the monthly

Medicare Part B premium, for the following optional benefits:

- Chiropractic Services.
- Acupuncture.

In-Network

\$15 copay for up to 20 routine visit(s) every year.

In-Network

\$15 copay for up to 20 routine visits every year.

In-Network

\$15 copay for up to 20 routine visits every year.

Puget Sound Health Partners Important Phone Numbers

PSHP Member Services

1-866-789-PSHP (7747)
8am-8pm, 7 days a week

You may receive a messaging service on weekends and holidays from March 2 through November 14. Please leave a message and your call will be returned the next business day.

TTY / TDD users call
1-866-264-4141

PSHP Mailing Address

PO Box 4537
Federal Way, WA 98063

PSHP Website

www.OurPSHP.com

Medicare

1-800-MEDICARE (633-4227)
24 hrs a day, 7 days a week

TTY/TTD users call
1-877-486-2048

Social Security Office

1-800-772-1213
7am-7pm, Monday-Friday

TTY/TTD users call
1-800-325-0778

Other Important Phone Numbers:



PUGET SOUND
HEALTH PARTNERS

Puget Sound Health Partners is a Medicare approved HMO.