

<b>PBP 2006 Data Entry</b>	<b>Plan Response</b>	<b>SB Sentence</b>
Automatically generated sentence	N/A	People who have low incomes, who live in long term care facilities, or who have access to Indian/Tribal/Urban (Indian Health Service) facilities may have different out-of-pocket drug costs. Contact plan for details.

**Defined Standard Benefit SB Sentences**

<b>PBP 2006 Data Entry</b>	<b>Plan Response</b>	<b>SB Sentence</b>
Enter Deductible: \$250 fixed amount	N/A	You pay a \$250 yearly deductible.
Enter Coinsurance: 25% fixed amount	N/A	After you have paid your yearly deductible and before your total drug costs reach \$2,250, you pay 25% of your drug costs.
Enter Initial Coverage Limit Amount: \$2250 fixed amount	N/A	
Enter Annual Out-of-Pocket Cost Threshold: \$3600 fixed amount	N/A	After your total drug costs reach \$2,250, you pay 100% of your drug costs until your out-of-pocket drug costs reach \$3,600.
Medicare Defined Cost Shares Applicable Beyond the Annual Out-of-Pocket Cost Threshold Charged on a Drug-by-Drug Basis as: The greater of \$2 for generic or a preferred drug that is a multiple source drug and \$5 for all other drugs, or 5% coinsurance.	N/A	After your out-of-pocket drug costs reach \$3,600, you pay the greater of: - \$2 for generic or a preferred drug that is a multiple source drug and \$5 for all other drugs, or - 5% coinsurance.

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<p>Select location where drugs can be acquired: <i>(Select one or more)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> In-Network Preferred Pharmacy</li> <li><input type="checkbox"/> In-Network Non-Preferred Pharmacy</li> <li><input type="checkbox"/> Out-of-Network Pharmacy</li> <li><input type="checkbox"/> Mail Order</li> </ul>	<p>In-Network Preferred Pharmacy  <i>AND/OR</i>                  In-Network Non-Preferred Pharmacy  <i>AND/OR</i>                  Out-of-Network Pharmacy  <i>AND/OR</i>                  Mail Order</p>	
<p>Indicate prescription supply level(s) for In-Network Preferred Pharmacy drugs: <i>(Select one or more)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> One month supply</li> <li><input type="checkbox"/> Three month supply</li> <li><input type="checkbox"/> Other</li> </ul>	<p>One month supply  <i>AND/OR</i>                  Three month supply  <i>AND/OR</i>                  Other</p>	<p>You may receive drugs from an In-Network Preferred Pharmacy for a one-month supply, three month supply, and <i>x</i> days/months supply.</p>
<p>Select Days or Months for Other supply for In-Network Preferred Pharmacy drugs: <i>(Select one)</i></p> <ul style="list-style-type: none"> <li><input type="radio"/> Days</li> <li><input type="radio"/> Months</li> </ul>	<p>Days <i>OR</i> Months</p>	
<p>Enter number of Days or Months for In-Network Preferred Pharmacy drugs:                  _____</p>	<p>Number</p>	
<p>Indicate prescription supply level(s) for In-Network Non-Preferred Pharmacy drugs: <i>(Select one or more)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> One month supply</li> <li><input type="checkbox"/> Three month supply</li> <li><input type="checkbox"/> Other</li> </ul>	<p>One month supply  <i>AND/OR</i>                  Three month supply  <i>AND/OR</i>                  Other</p>	<p>You may receive drugs from an In-Network Non-Preferred Pharmacy for a one-month supply, three month supply, and <i>x</i> days/months supply.</p>

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<p>Select Days or Months for Other supply for In-Network Non-Preferred Pharmacy drugs: <i>(Select one)</i></p> <ul style="list-style-type: none"> <li><input type="radio"/> Days</li> <li><input type="radio"/> Months</li> </ul>	<p>Days <i>OR</i> Months</p>	
<p>Enter number of Days or Months for In-Network Non-Preferred Pharmacy drugs:</p> <p>_____</p>	<p>Number</p>	
<p>Indicate prescription supply level(s) for Out-of-Network Pharmacy drugs: <i>(Select one or more)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> One month supply</li> <li><input type="checkbox"/> Three month supply</li> <li><input type="checkbox"/> Other</li> </ul>	<p>One month supply <i>AND/OR</i> Three month supply <i>AND/OR</i> Other</p>	<p>You may receive drugs from an Out-of-Network Pharmacy for a one-month supply, three month supply, and <i>x</i> days/months supply.</p>
<p>Select Days or Months for Other supply for Out-of-Network Pharmacy drugs: <i>(Select one)</i></p> <ul style="list-style-type: none"> <li><input type="radio"/> Days</li> <li><input type="radio"/> Months</li> </ul>	<p>Days <i>OR</i> Months</p>	
<p>Enter number of Days or Months for Out-of-Network Pharmacy drugs:</p> <p>_____</p>	<p>Number</p>	
<p>Indicate prescription supply level(s) for Mail Order Pharmacy drugs: <i>(Select one or more)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> One month supply</li> <li><input type="checkbox"/> Three month supply</li> <li><input type="checkbox"/> Other</li> </ul>	<p>One month supply <i>AND/OR</i> Three month supply <i>AND/OR</i> Other</p>	<p>You may receive drugs from a Mail Order Pharmacy for a one-month supply, three month supply, and <i>x</i> days/months supply.</p>
<p>Select Days or Months for Other supply for Mail Order Pharmacy drugs: <i>(Select one)</i></p> <ul style="list-style-type: none"> <li><input type="radio"/> Days</li> <li><input type="radio"/> Months</li> </ul>	<p>Days <i>OR</i> Months</p>	

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Enter number of Days or Months for Mail Order Pharmacy drugs: _____	Number	
Are there quantity limits on certain prescription drugs? (Select one) <input type="radio"/> Yes <input type="radio"/> No	Yes	Certain prescription drugs will have maximum quantity limits. Contact plan for details.
	No	No sentence.
Is Prior Authorization required for certain prescription drugs? (Select one) <input type="radio"/> Yes <input type="radio"/> No	Yes	Your provider must get prior authorization from <Plan Name> for certain prescription drugs. Contact plan for details.
	No	No sentence.

**Actuarial Equivalent Standard Benefit SB Sentences**

PBP 2006 Data Entry	Plan Response	SB Sentence
Enter Deductible:\$250 fixed amount	N/A	You pay a \$250 yearly deductible.
How do you apply your cost sharing before the ICL is reached? ( <i>Select one</i> ) <ul style="list-style-type: none"> <li>○ No Cost Sharing</li> <li>○ 25% Coinsurance amount</li> <li>○ One or more groups of cost sharing</li> </ul>	- No Cost sharing	After you have paid your yearly deductible and before your total drug costs reach \$2,250, there is no copayment for prescription drugs.
	- 25% Coinsurance amount	After you have paid your yearly deductible and before your total drug costs reach \$2,250, you pay 25% of your yearly drug costs.
	- One or more groups of cost sharing	After you have paid your yearly deductible and before your total drug costs reach \$2,250, you pay the following for prescription drugs:
Select number of cost share groups: 1-10	1-10	

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<p>Select label for Group (1-10): <i>(Select one)</i></p> <ul style="list-style-type: none"><li><input type="radio"/> Formulary Generic</li><li><input type="radio"/> Formulary Preferred Brand</li><li><input type="radio"/> Formulary Brand</li><li><input type="radio"/> Non-formulary Generic</li><li><input type="radio"/> Non-formulary Brand</li><li><input type="radio"/> Generic</li><li><input type="radio"/> Preferred Brand</li><li><input type="radio"/> Brand</li><li><input type="radio"/> Tier 1</li><li><input type="radio"/> Tier 2</li><li><input type="radio"/> Tier 3</li><li><input type="radio"/> Tier 4</li><li><input type="radio"/> Tier 5</li><li><input type="radio"/> Tier 6</li><li><input type="radio"/> Tier 7</li><li><input type="radio"/> Tier 8</li><li><input type="radio"/> Tier 9</li><li><input type="radio"/> Tier 10</li></ul>	<p>Label</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
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<p><i>If label is “Tier” then</i> Enter Tier label for Group</p> <hr/>	<p>Label</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p><i>If label is “Tier” then</i> Select drug types covered for Group (1-10): <i>(Select one or more)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Generic</li> <li><input type="checkbox"/> Preferred Brand</li> <li><input type="checkbox"/> Brand</li> </ul>	<p>Generic <i>AND/OR</i> Preferred Brand <i>AND/OR</i> Brand</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Select location where drugs can be acquired for Group (1-10): <i>(Select one or more)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> In-Network Preferred Pharmacy</li> <li><input type="checkbox"/> In-Network Non-Preferred Pharmacy</li> <li><input type="checkbox"/> Out-of-Network Pharmacy</li> <li><input type="checkbox"/> Mail Order</li> </ul>	<p>In-Network Preferred Pharmacy <i>AND/OR</i> In-Network Non-Preferred Pharmacy <i>AND/OR</i> Out-of-Network Pharmacy <i>AND/OR</i> Mail Order</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Indicate prescription supply level(s) for In-Network Preferred Pharmacy drugs: <i>(Select one or more)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> One month supply</li> <li><input type="checkbox"/> Three month supply</li> <li><input type="checkbox"/> Other</li> </ul>	<p>One month supply <i>AND/OR</i> Three month supply <i>AND/OR</i> Other</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Select Days or Months for Other supply for In-Network Preferred Pharmacy drugs: <i>(Select one)</i></p> <ul style="list-style-type: none"> <li><input type="radio"/> Days</li> <li><input type="radio"/> Months</li> </ul>	<p>Days <i>OR</i> Months</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Enter number of Days or Months for In-Network Preferred Pharmacy drugs:</p> <hr/>	<p>Number</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>

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<p>Indicate prescription supply level(s) for In-Network Non-Preferred Pharmacy drugs: <i>(Select one or more)</i></p> <p><input type="checkbox"/> One month supply</p> <p><input type="checkbox"/> Three month supply</p> <p><input type="checkbox"/> Other</p>	<p>One month supply <i>AND/OR</i> Three month supply <i>AND/OR</i> Other</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Select Days or Months for Other supply for In-Network Non-Preferred Pharmacy drugs: <i>(Select one)</i></p> <p><input type="radio"/> Days</p> <p><input type="radio"/> Months</p>	<p>Days <i>OR</i> Months</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Enter number of Days or Months for In-Network Non-Preferred Pharmacy drugs:</p> <p>_____</p>	<p>Number</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Indicate prescription supply level(s) for Out-of-Network Pharmacy drugs: <i>(Select one or more)</i></p> <p><input type="checkbox"/> One month supply</p> <p><input type="checkbox"/> Three month supply</p> <p><input type="checkbox"/> Other</p>	<p>One month supply <i>AND/OR</i> Three month supply <i>AND/OR</i> Other</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Select Days or Months for Other supply for Out-of-Network Pharmacy drugs: <i>(Select one)</i></p> <p><input type="radio"/> Days</p> <p><input type="radio"/> Months</p>	<p>Days <i>OR</i> Months</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Enter number of Days or Months for Out-of-Network Pharmacy drugs:</p> <p>_____</p>	<p>Number</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Indicate prescription supply level(s) Mail Order Pharmacy drugs: <i>(Select one or more)</i></p> <p><input type="checkbox"/> One month supply</p> <p><input type="checkbox"/> Three month supply</p> <p><input type="checkbox"/> Other</p>	<p>One month supply <i>AND/OR</i> Three month supply <i>AND/OR</i> Other</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>

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Select Days or Months for Other supply for Mail Order Pharmacy drugs: <i>(Select one)</i> <input type="radio"/> Days <input type="radio"/> Months	Days <i>OR</i> Months	<i>(See below under Coinsurance/Copayment)</i>
Enter number of Days or Months for Mail Order Pharmacy drugs: _____	Number	<i>(See below under Coinsurance/Copayment)</i>
Is there an enrollee Coinsurance for Group (1-10)? <i>(Select one)</i> <input type="radio"/> Yes <input type="radio"/> No	Yes	
_ % for In-Network Preferred Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of <i>(Group (1-10) label)</i> drugs you get at an in-network preferred pharmacy.
_ % for In-Network Preferred Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of <i>(Group (1-10) label)</i> drugs you get at an in-network preferred pharmacy.
_ % for In-Network Preferred Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of <i>(Group (1-10) label)</i> drugs you get at an in-network preferred pharmacy.
_ % for In-Network Non-Preferred Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of <i>(Group (1-10) label)</i> drugs you get at an in-network non-preferred pharmacy.
_ % for In-Network Non-Preferred Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of <i>(Group (1-10) label)</i> drugs you get at an in-network non-preferred pharmacy.
_ % for In-Network Non-Preferred Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of <i>(Group (1-10) label)</i> drugs you get at an in-network non-preferred pharmacy.
_ % for Out-of -Network Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of <i>(Group (1-10) label)</i> drugs you get at an out-of-network pharmacy.

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_ % for Out-of-Network Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
_ % for Out-of-Network Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
_ % for Mail Order Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
_ % for Mail Order Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
_ % for Mail Order Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of mail order ( <i>Group (1-10) label</i> ) drugs.
Is there an enrollee Copayment for Group (1-10)? ( <i>Select one</i> ) o Yes o No	Yes	
\$ _ for In-Network Preferred Pharmacy one month supply	\$	- \$____ for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network preferred pharmacy.
\$ _ for In-Network Preferred Pharmacy three month supply	\$	- \$____ for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network preferred pharmacy.
\$ _ for In-Network Preferred Pharmacy other supply	\$	- \$____ for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network preferred pharmacy.
\$_ for In-Network Non-Preferred Pharmacy one month supply	\$	- \$____ for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.
\$_ for In-Network Non-Preferred Pharmacy three month supply	\$	- \$____ for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.

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\$_ for In-Network Non-Preferred Pharmacy other supply	\$	- \$____ for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.
\$_ for Out-of -Network Pharmacy one month supply	\$	- \$____ for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
\$_ for Out-of-Network Pharmacy three month supply	\$	- \$____ for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
\$_ for Out-of-Network Pharmacy other supply	\$	- \$____ for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
\$_ for Mail Order Pharmacy one month supply	\$	- \$____ for a one-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
\$_ for Mail Order Pharmacy three month supply	\$	- \$____ for a three-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
\$_ for Mail Order Pharmacy other supply	\$	- \$____ for a __ (day/month) supply of mail order ( <i>Group (1-10) label</i> ) drugs.
Enter Initial Coverage Limit Amount: \$2250 fixed amount	N/A	( <i>See above</i> )
Enter Annual Out-of-Pocket Cost Threshold: \$3600 fixed amount	N/A	After your total drug costs reach \$2,250, you pay 100% of your drug costs until your out-of-pocket drug costs reach \$3,600.
How do you apply your cost sharing beyond the \$3,600 annual out-of-pocket cost threshold? ( <i>Select one</i> )		
<ul style="list-style-type: none"> <li>The greater of \$2 for generic or a preferred drug that is a multiple source drug and \$5 for all other source drug and \$5 for</li> </ul>	- The greater of \$2 for generic or a preferred drug that is a multiple source drug and \$5 for all other drugs, or 5% coinsurance.	After your out-of-pocket drug costs reach \$3,600, you pay the greater of: <ul style="list-style-type: none"> <li>\$2 for generic or a preferred drug that is a multiple source drug and \$5 for all other drugs, or</li> <li>5% coinsurance.</li> </ul>

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<p>all other drugs, or 5% coinsurance.</p> <ul style="list-style-type: none"> <li>○ One or more groups of cost sharing</li> </ul>	<p>One or more groups of cost sharing</p>	<p>After your out-of-pocket drug costs reach \$3,600, you pay the following for prescription drugs:</p>
<p>Select number of cost share groups: 1-10</p>	<p>1-10</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Select label for Group (1-10): <i>(Select one)</i></p> <ul style="list-style-type: none"> <li>○ Formulary Generic</li> <li>○ Formulary Preferred Brand</li> <li>○ Formulary Brand</li> <li>○ Non-formulary Generic</li> <li>○ Non-formulary Brand</li> <li>○ Generic</li> <li>○ Preferred Brand</li> <li>○ Brand</li> <li>○ Tier 1</li> <li>○ Tier 2</li> <li>○ Tier 3</li> <li>○ Tier 4</li> <li>○ Tier 5</li> <li>○ Tier 6</li> <li>○ Tier 7</li> <li>○ Tier 8</li> <li>○ Tier 9</li> <li>○ Tier 10</li> </ul>	<p>Label</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>

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<p>If label is “Tier” then Enter Tier label for Group 1: <hr/></p>	<p>Label</p>	<p>(See below under Coinsurance/Copayment)</p>
<p>If label is “Tier” then Select drug types covered for Group (1-10): (Select one or more) <input type="checkbox"/> Generic <input type="checkbox"/> Preferred Brand <input type="checkbox"/> Brand</p>	<p>Generic AND/OR Preferred Brand AND/OR Brand</p>	<p>(See below under Coinsurance/Copayment)</p>
<p>Select location where drugs can be acquired for Group (1 -5): (Select one or more) <input type="checkbox"/> In-Network Preferred Pharmacy <input type="checkbox"/> In-Network Non-Preferred Pharmacy <input type="checkbox"/> Out-of-Network Pharmacy <input type="checkbox"/> Mail Order</p>	<p>In-Network Preferred Pharmacy AND/OR In-Network Non-Preferred Pharmacy AND/OR Out-of-Network Pharmacy AND/OR Mail Order</p>	<p>(See below under Coinsurance/Copayment)</p>
<p>Indicate prescription supply level(s) for In-Network Preferred Pharmacy drugs: (Select one or more) <input type="checkbox"/> One month supply <input type="checkbox"/> Three month supply <input type="checkbox"/> Other</p>	<p>One month supply AND/OR Three month supply AND/OR Other</p>	<p>(See below under Coinsurance/Copayment)</p>
<p>Select Days or Months for Other supply for In-Network Preferred Pharmacy drugs: (Select one) <input type="radio"/> Days <input type="radio"/> Months</p>	<p>Days OR Months</p>	<p>(See below under Coinsurance/Copayment)</p>
<p>Enter number of Days or Months for In-Network Preferred Pharmacy drugs: <hr/></p>	<p>Number</p>	<p>(See below under Coinsurance/Copayment)</p>
<p>Indicate prescription supply level(s) for In-Network Non- Preferred Pharmacy drugs:</p>	<p>One month supply AND/OR Three month supply</p>	<p>(See below under Coinsurance/Copayment)</p>

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<p><i>(Select one or more)</i></p> <p><input type="checkbox"/> One month supply</p> <p><input type="checkbox"/> Three month supply</p> <p><input type="checkbox"/> Other</p>	<p>AND/OR</p> <p>Other</p>	
<p>Select Days or Months for Other supply for In-Network Non-Preferred Pharmacy drugs: <i>(Select one)</i></p> <p><input type="radio"/> Days</p> <p><input type="radio"/> Months</p>	<p>Days OR Months</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Enter number of Days or Months for In-Network Non-Preferred Pharmacy drugs:</p> <p>_____</p>	<p>Number</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Indicate prescription supply level(s) for Out-of-Network Pharmacy drugs: <i>(Select one or more)</i></p> <p><input type="checkbox"/> One month supply</p> <p><input type="checkbox"/> Three month supply</p> <p><input type="checkbox"/> Other</p>	<p>One month supply</p> <p>AND/OR</p> <p>Three month supply</p> <p>AND/OR</p> <p>Other</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Select Days or Months for Other supply for Out-of-Network Pharmacy drugs: <i>(Select one)</i></p> <p><input type="radio"/> Days</p> <p><input type="radio"/> Months</p>	<p>Days OR Months</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Enter number of Days or Months for Out-of-Network Pharmacy drugs:</p> <p>_____</p>	<p>Number</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Indicate prescription supply level(s) Mail Order Pharmacy drugs: <i>(Select one or more)</i></p> <p><input type="checkbox"/> One month supply</p> <p><input type="checkbox"/> Three month supply</p> <p><input type="checkbox"/> Other</p>	<p>One month supply</p> <p>AND/OR</p> <p>Three month supply</p> <p>AND/OR</p> <p>Other</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Select Days or Months for Other supply for Mail Order Pharmacy drugs: <i>(Select one)</i></p> <p><input type="radio"/> Days</p> <p><input type="radio"/> Months</p>	<p>Days OR Months</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Enter number of Days or</p>	<p>Number</p>	<p><i>(See below under</i></p>

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Months for Mail Order Pharmacy drugs: _____		<i>Coinsurance/Copayment</i>
Is there an enrollee Coinsurance for Group (1-10)? ( <i>Select one</i> ) <input type="radio"/> Yes <input type="radio"/> No	Yes	
_ % for In-Network Preferred Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network preferred pharmacy.
_ % for In-Network Preferred Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network preferred pharmacy.
_ % for In-Network Preferred Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network preferred pharmacy.
_ % for In-Network Non-Preferred Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.
_ % for In-Network Non-Preferred Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.
_ % for In-Network Non-Preferred Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.
_ % for Out-of -Network Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
_ % for Out-of-Network Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.

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_ % for Out-of-Network Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
_ % for Mail Order Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
_ % for Mail Order Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
_ % for Mail Order Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of mail order ( <i>Group (1-10) label</i> ) drugs.
Is there an enrollee Copayment for Group (1-10)? ( <i>Select one</i> ) o Yes o No	Yes	
\$ _ for In-Network Preferred Pharmacy one month supply	\$	- \$____ for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network preferred pharmacy.
\$ _ for In-Network Preferred Pharmacy three month supply	\$	- \$____ for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network preferred pharmacy.
\$ _ for In-Network Preferred Pharmacy other supply	\$	- \$____ for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network preferred pharmacy.
\$_ for In-Network Non-Preferred Pharmacy one month supply	\$	- \$____ for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.
\$_ for In-Network Non-Preferred Pharmacy three month supply	\$	- \$____ for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.
\$_ for In-Network Non-Preferred Pharmacy other supply	\$	- \$____ for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.

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\$_ for Out-of -Network Pharmacy one month supply	\$	- \$____ for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
\$_ for Out-of-Network Pharmacy three month supply	\$	- \$____ for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
\$_ for Out-of-Network Pharmacy other supply	\$	- \$____ for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
\$_ for Mail Order Pharmacy one month supply	\$	- \$____ for a one-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
\$_ for Mail Order Pharmacy three month supply	\$	- \$____ for a three-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
\$_ for Mail Order Pharmacy other supply	\$	- \$____ for a __ (day/month) supply of mail order ( <i>Group (1-10) label</i> ) drugs.
Are there quantity limits on certain prescription drugs? ( <i>Select one</i> ) <input type="radio"/> Yes <input type="radio"/> No	Yes	Certain prescription drugs will have maximum quantity limits. Contact plan for details.
	No	No sentence
Is Prior Authorization required for certain prescription drugs? ( <i>Select one</i> ) <input type="radio"/> Yes <input type="radio"/> No	Yes	Your provider must get prior authorization from <Plan Name> for certain prescription drugs. Contact plan for details.
	No	No sentence

**Basic Alternative Benefit SB Sentences**

PBP 2006 Data Entry	Plan Response		SB Sentence
Do you charge the Medicare \$250 Deductible? ( <i>Select one or more</i> ) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Waived	Yes		You pay a \$250 yearly deductible.
	Waived		There is no deductible.
<i>If No, then</i> Enter deductible amount: \$__	\$		You pay a \$__ yearly deductible.
How do you apply your cost sharing before the ICL is reached? ( <i>Select one or more</i> ) <input type="radio"/> No Cost Sharing <input type="radio"/> 25% Coinsurance amount <input type="radio"/> One or more groups of cost sharing	No Cost sharing	No deductible	Before your total drug costs reach \$__, there is no copayment for prescription drugs.
		\$ Deductible	After you have paid your yearly deductible and before your total drug costs reach \$__, there is no copayment for prescription drugs.
	25% Coinsurance amount	No deductible	Before your total drug costs reach \$__, you pay 25% of your yearly drug costs.
		\$ Deductible	After you have paid your yearly deductible and before your total drug costs reach \$__, you pay 25% of your yearly drug costs.
	One or more groups of cost sharing	No deductible	Before your total drug costs reach \$__, you pay the following for prescription drugs:
		\$ Deductible	After you have paid your yearly deductible and before your total drug costs reach \$__, you pay the following for prescription drugs:

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Select number of cost share groups: 1-10	1-10	<i>(See below under Coinsurance/Copayment)</i>
Select label for Group (1-10): <i>(Select one)</i> <ul style="list-style-type: none"> <li>○ Formulary Generic</li> <li>○ Formulary Preferred Brand</li> <li>○ Formulary Brand</li> <li>○ Non-formulary Generic</li> <li>○ Non-formulary Brand</li> <li>○ Generic</li> <li>○ Preferred Brand</li> <li>○ Brand</li> <li>○ Tier 1</li> <li>○ Tier 2</li> <li>○ Tier 3</li> <li>○ Tier 4</li> <li>○ Tier 5</li> <li>○ Tier 6</li> <li>○ Tier 7</li> <li>○ Tier 8</li> <li>○ Tier 9</li> <li>○ Tier 10</li> </ul>	Label	<i>(See below under Coinsurance/Copayment)</i>

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<p>If label is “Tier” then Enter Tier label for Group 1: <hr/></p>	<p>Label</p>	<p>(See below under Coinsurance/Copayment)</p>
<p>If label is “Tier” then Select drug types covered for Group (1-10): (Select one or more) <input type="checkbox"/> Generic <input type="checkbox"/> Preferred Brand <input type="checkbox"/> Brand</p>	<p>Generic AND/OR Preferred Brand AND/OR Brand</p>	<p>(See below under Coinsurance/Copayment)</p>
<p>Select location where drugs can be acquired for Group (1 -10): (Select one or more) <input type="checkbox"/> In-Network Preferred Pharmacy <input type="checkbox"/> In-Network Non-Preferred Pharmacy <input type="checkbox"/> Out-of-Network Pharmacy <input type="checkbox"/> Mail Order</p>	<p>In-Network Preferred Pharmacy AND/OR In-Network Non-Preferred Pharmacy AND/OR Out-of-Network Pharmacy AND/OR Mail Order</p>	<p>(See below under Coinsurance/Copayment)</p>
<p>Indicate prescription supply level(s) for In-Network Preferred Pharmacy drugs: (Select one or more) <input type="checkbox"/> One month supply <input type="checkbox"/> Three month supply <input type="checkbox"/> Other</p>	<p>One month supply AND/OR Three month supply AND/OR Other</p>	<p>(See below under Coinsurance/Copayment)</p>
<p>Select Days or Months for Other supply for In-Network Preferred Pharmacy drugs: (Select one) o Days o Months</p>	<p>Days OR Months</p>	<p>(See below under Coinsurance/Copayment)</p>
<p>Enter number of Days or Months for In-Network Preferred Pharmacy drugs: <hr/></p>	<p>Number</p>	<p>(See below under Coinsurance/Copayment)</p>

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<p>Indicate prescription supply level(s) for In-Network Non-Preferred Pharmacy drugs: <i>(Select one or more)</i></p> <p><input type="checkbox"/> One month supply</p> <p><input type="checkbox"/> Three month supply</p> <p><input type="checkbox"/> Other</p>	<p>One month supply AND/OR Three month supply AND/OR Other</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Select Days or Months for Other supply for In-Network Non-Preferred Pharmacy drugs: <i>(Select one)</i></p> <p><input type="radio"/> Days</p> <p><input type="radio"/> Months</p>	<p>Days OR Months</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Enter number of Days or Months for In-Network Non-Preferred Pharmacy drugs:</p> <p>_____</p>	<p>Number</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Indicate prescription supply level(s) for Out-of-Network Pharmacy drugs: <i>(Select one or more)</i></p> <p><input type="checkbox"/> One month supply</p> <p><input type="checkbox"/> Three month supply</p> <p><input type="checkbox"/> Other</p>	<p>One month supply AND/OR Three month supply AND/OR Other</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Select Days or Months for Other supply for Out-of-Network Pharmacy drugs: <i>(Select one)</i></p> <p><input type="radio"/> Days</p> <p><input type="radio"/> Months</p>	<p>Days OR Months</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Enter number of Days or Months for Out-of-Network Pharmacy drugs:</p> <p>_____</p>	<p>Number</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Indicate prescription supply level(s) Mail Order Pharmacy drugs: <i>(Select one or more)</i></p> <p><input type="checkbox"/> One month supply</p> <p><input type="checkbox"/> Three month supply</p> <p><input type="checkbox"/> Other</p>	<p>One month supply AND/OR Three month supply AND/OR Other</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>

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Select Days or Months for Other supply for Mail Order Pharmacy drugs: <i>(Select one)</i> <input type="radio"/> Days <input type="radio"/> Months	Days <i>OR</i> Months	<i>(See below under Coinsurance/Copayment)</i>
Enter number of Days or Months for Mail Order Pharmacy drugs: _____	Number	<i>(See below under Coinsurance/Copayment)</i>
Is there an enrollee Coinsurance for Group (1-10)? <i>(Select one)</i> <input type="radio"/> Yes <input type="radio"/> No	Yes	
_ % for In-Network Preferred Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of <i>(Group (1-10) label)</i> drugs you get at an in-network preferred pharmacy.
_ % for In-Network Preferred Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of <i>(Group (1-10) label)</i> drugs you get at an in-network preferred pharmacy.
_ % for In-Network Preferred Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of <i>(Group (1-10) label)</i> drugs you get at an in-network preferred pharmacy.
_ % for In-Network Non-Preferred Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of <i>(Group (1-10) label)</i> drugs you get at an in-network non-preferred pharmacy.
_ % for In-Network Non-Preferred Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of <i>(Group (1-10) label)</i> drugs you get at an in-network non-preferred pharmacy.
_ % for In-Network Non-Preferred Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of <i>(Group (1-10) label)</i> drugs you get at an in-network non-preferred pharmacy.

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_ % for Out-of -Network Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
_ % for Out-of-Network Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
_ % for Out-of-Network Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
_ % for Mail Order Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
_ % for Mail Order Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
_ % for Mail Order Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of mail order ( <i>Group (1-10) label</i> ) drugs.
Is there an enrollee Copayment for Group (1-10)? ( <i>Select one</i> ) o Yes o No	Yes	
\$ _ for In-Network Preferred Pharmacy one month supply	\$	- \$____ for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network preferred pharmacy.
\$ _ for In-Network Preferred Pharmacy three month supply	\$	- \$____ for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network preferred pharmacy.
\$ _ for In-Network Preferred Pharmacy other supply	\$	- \$____ for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network preferred pharmacy.
\$ _ for In-Network Non-Preferred Pharmacy one month supply	\$	- \$____ for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.

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\$_ for In-Network Non-Preferred Pharmacy three month supply	\$	- \$____ for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.
\$_ for In-Network Non-Preferred Pharmacy other supply	\$	- \$____ for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.
\$_ for Out-of -Network Pharmacy one month supply	\$	- \$____ for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
\$_ for Out-of-Network Pharmacy three month supply	\$	- \$____ for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
\$_ for Out-of-Network Pharmacy other supply	\$	- \$____ for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
\$_ for Mail Order Pharmacy one month supply	\$	- \$____ for a one-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
\$_ for Mail Order Pharmacy three month supply	\$	- \$____ for a three-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
\$_ for Mail Order Pharmacy other supply	\$	- \$____ for a __ (day/month) supply of mail order ( <i>Group (1-10) label</i> ) drugs.
Do you apply the Medicare \$2250 Initial Coverage Limit? ( <i>Select one</i> ) <input type="radio"/> Yes <input type="radio"/> No	Yes	After your total drug costs reach \$2,250, you pay 100% of your prescription drug costs.
<i>If No, then</i> Enter Initial Coverage Limit Amount: \$__	\$	After your out-of-pocket drug costs reach \$____, you pay 100% of your prescription drug costs up until your out-of-pocket drug costs reach \$3,600.
Enter Annual Out-of-Pocket Cost Threshold: \$3600 fixed amount	N/A	( <i>See above</i> )

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<p>How do you apply your cost sharing beyond the \$3,600 annual out-of-pocket cost threshold? (<i>Select one</i>)</p> <ul style="list-style-type: none"> <li>o No cost sharing</li> <li>o: The greater of \$2 for generic or a preferred drug that is a multiple source drug and \$5 for all other drugs, or 5% coinsurance.</li> <li>o One or more groups of cost sharing</li> </ul>	No cost sharing	After your out-of-pocket drug costs reach \$3,600, there is no copayment for prescription drugs.
	- The greater of \$2 for generic or a preferred drug that is a multiple source drug and \$5 for all other drugs, or 5% coinsurance.	After your out-of-pocket drug costs reach \$3,600, you pay the greater of: <ul style="list-style-type: none"> <li>- \$2 for generic or a preferred drug that is a multiple source drug and \$5 for all other drugs, or</li> <li>- 5% coinsurance.</li> </ul>
	One or more groups of cost sharing	After your out-of-pocket drug costs reach \$3,600, you pay:
Select number of cost share groups: 1-10	1-10	( <i>See below under Coinsurance/Copayment</i> )
<p>Select label for Group (1-10): (<i>Select one</i>)</p> <ul style="list-style-type: none"> <li>o Formulary Generic</li> <li>o Formulary Preferred Brand</li> <li>o Formulary Brand</li> <li>o Non-formulary Generic</li> <li>o Non-formulary Brand</li> <li>o Generic</li> <li>o Preferred Brand</li> <li>o Brand</li> <li>o Tier 1</li> <li>o Tier 2</li> <li>o Tier 3</li> <li>o Tier 4</li> <li>o Tier 5</li> <li>o Tier 6</li> <li>o Tier 7</li> <li>o Tier 8</li> <li>o Tier 9</li> <li>o Tier 10</li> </ul>	Label	( <i>See below under Coinsurance/Copayment</i> )

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<p><i>If label is “Tier” then</i> Enter Tier label for Group 1: <hr/></p>	<p>Label</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p><i>If label is “Tier” then</i> Select drug types covered for Group (1-10): <i>(Select one or more)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Generic</li> <li><input type="checkbox"/> Preferred Brand</li> <li><input type="checkbox"/> Brand</li> </ul>	<p>Generic <i>AND/OR</i> Preferred Brand <i>AND/OR</i> Brand</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Select location where drugs can be acquired for Group (1 -10): <i>(Select one or more)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> In-Network Preferred Pharmacy</li> <li><input type="checkbox"/> In-Network Non-Preferred Pharmacy</li> <li><input type="checkbox"/> Out-of-Network Pharmacy</li> <li><input type="checkbox"/> Mail Order</li> </ul>	<p>In-Network Preferred Pharmacy <i>AND/OR</i> In-Network Non-Preferred Pharmacy <i>AND/OR</i> Out-of-Network Pharmacy <i>AND/OR</i> Mail Order</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Indicate prescription supply level(s) for In-Network Preferred Pharmacy drugs: <i>(Select one or more)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> One month supply</li> <li><input type="checkbox"/> Three month supply</li> <li><input type="checkbox"/> Other</li> </ul>	<p>One month supply <i>AND/OR</i> Three month supply <i>AND/OR</i> Other</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Select Days or Months for Other supply for In-Network Preferred Pharmacy drugs: <i>(Select one)</i></p> <ul style="list-style-type: none"> <li><input type="radio"/> Days</li> <li><input type="radio"/> Months</li> </ul>	<p>Days <i>OR</i> Months</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Enter number of Days or Months for In-Network Preferred Pharmacy drugs: <hr/></p>	<p>Number</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>

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<p>Indicate prescription supply level(s) for In-Network Non-Preferred Pharmacy drugs: <i>(Select one or more)</i></p> <p><input type="checkbox"/> One month supply</p> <p><input type="checkbox"/> Three month supply</p> <p><input type="checkbox"/> Other</p>	<p>One month supply <i>AND/OR</i> Three month supply <i>AND/OR</i> Other</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Select Days or Months for Other supply for In-Network Non-Preferred Pharmacy drugs: <i>(Select one)</i></p> <p><input type="radio"/> Days</p> <p><input type="radio"/> Months</p>	<p>Days <i>OR</i> Months</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Enter number of Days or Months for In-Network Non-Preferred Pharmacy drugs:</p> <p>_____</p>	<p>Number</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Indicate prescription supply level(s) for Out-of-Network Pharmacy drugs: <i>(Select one or more)</i></p> <p><input type="checkbox"/> One month supply</p> <p><input type="checkbox"/> Three month supply</p> <p><input type="checkbox"/> Other</p>	<p>One month supply <i>AND/OR</i> Three month supply <i>AND/OR</i> Other</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Select Days or Months for Other supply for Out-of-Network Pharmacy drugs: <i>(Select one)</i></p> <p><input type="radio"/> Days</p> <p><input type="radio"/> Months</p>	<p>Days <i>OR</i> Months</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Enter number of Days or Months for Out-of-Network Pharmacy drugs:</p> <p>_____</p>	<p>Number</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Indicate prescription supply level(s) Mail Order Pharmacy drugs: <i>(Select one or more)</i></p> <p><input type="checkbox"/> One month supply</p> <p><input type="checkbox"/> Three month supply</p> <p><input type="checkbox"/> Other</p>	<p>One month supply <i>AND/OR</i> Three month supply <i>AND/OR</i> Other</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>

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Select Days or Months for Other supply for Mail Order Pharmacy drugs: <i>(Select one)</i> <input type="radio"/> Days <input type="radio"/> Months	Days <i>OR</i> Months	<i>(See below under Coinsurance/Copayment)</i>
Enter number of Days or Months for Mail Order Pharmacy drugs: _____	Number	<i>(See below under Coinsurance/Copayment)</i>
Is there an enrollee Coinsurance for Group (1-10)? <i>(Select one)</i> <input type="radio"/> Yes <input type="radio"/> No	Yes	
_ % for In-Network Preferred Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of <i>(Group (1-10) label)</i> drugs you get at an in-network preferred pharmacy.
_ % for In-Network Preferred Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of <i>(Group (1-10) label)</i> drugs you get at an in-network preferred pharmacy.
_ % for In-Network Preferred Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of <i>(Group (1-10) label)</i> drugs you get at an in-network preferred pharmacy.
_ % for In-Network Non-Preferred Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of <i>(Group (1-10) label)</i> drugs you get at an in-network non-preferred pharmacy.
_ % for In-Network Non-Preferred Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of <i>(Group (1-10) label)</i> drugs you get at an in-network non-preferred pharmacy.
_ % for In-Network Non-Preferred Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of <i>(Group (1-10) label)</i> drugs you get at an in-network non-preferred pharmacy.

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_ % for Out-of -Network Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
_ % for Out-of-Network Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
_ % for Out-of-Network Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
_ % for Mail Order Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
_ % for Mail Order Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
_ % for Mail Order Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of mail order ( <i>Group (1-10) label</i> ) drugs.
Is there an enrollee Copayment for Group (1-10)? ( <i>Select one</i> ) o Yes o No	Yes	
\$ _ for In-Network Preferred Pharmacy one month supply	\$	- \$____ for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network preferred pharmacy.
\$ _ for In-Network Preferred Pharmacy three month supply	\$	- \$____ for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network preferred pharmacy.
\$ _ for In-Network Preferred Pharmacy other supply	\$	- \$____ for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network preferred pharmacy.
\$ _ for In-Network Non-Preferred Pharmacy one month supply	\$	- \$____ for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.

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\$_ for In-Network Non-Preferred Pharmacy three month supply	\$	- \$____ for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.
\$_ for In-Network Non-Preferred Pharmacy other supply	\$	- \$____ for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.
\$_ for Out-of -Network Pharmacy one month supply	\$	- \$____ for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
\$_ for Out-of-Network Pharmacy three month supply	\$	- \$____ for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
\$_ for Out-of-Network Pharmacy other supply	\$	- \$____ for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
\$_ for Mail Order Pharmacy one month supply	\$	- \$____ for a one-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
\$_ for Mail Order Pharmacy three month supply	\$	- \$____ for a three-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
\$_ for Mail Order Pharmacy other supply	\$	- \$____ for a __ (day/month) supply of mail order ( <i>Group (1-10) label</i> ) drugs.
Are there quantity limits on certain prescription drugs? ( <i>Select one</i> ) <input type="radio"/> Yes <input type="radio"/> No	Yes	Certain prescription drugs will have maximum quantity limits. Contact plan for details.
	No	No sentence
Is Prior Authorization required for certain prescription drugs? ( <i>Select one</i> ) <input type="radio"/> Yes <input type="radio"/> No	Yes	Your provider must get prior authorization from <Plan Name> for certain prescription drugs. Contact plan for details.
	No	No sentence

**Enhanced Alternative Benefit SB Sentences**

PBP 2006 Data Entry	Plan Response		SB Sentence
Do you charge the Medicare \$250 Deductible?( <i>Select one</i> ) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Waived	Yes		You pay a \$250 yearly deductible.
	Waived		There is no deductible.
If No, then Enter deductible amount: \$__	\$__		You pay a \$__ yearly deductible.
How do you apply your cost sharing before the ICL is reached? ( <i>Select one</i> ) <input type="radio"/> No Cost Sharing <input type="radio"/> 25% Coinsurance amount <input type="radio"/> One or more groups of cost sharing	No Cost sharing	No deductible	Before your total drug costs reach \$__, there is no copayment for prescription drugs.
		\$ Deductible	After you have paid your yearly deductible and before your total drug costs reach \$__, there is no copayment for prescription drugs.
	25% Coinsurance amount	No deductible	Before your total drug costs reach \$____, you pay 25% of your yearly drug costs.
		\$ Deductible	After you have paid your yearly deductible and before your total drug costs reach \$____, you pay 25% of your yearly drug costs.
	One or more groups of cost sharing	No deductible	Before your total drug costs reach \$__, you pay the following for prescription drugs:
		\$ Deductible	After you have paid your yearly deductible and before your total drug costs reach \$__, you pay the following for prescription drugs:

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Select number of cost share groups: 1-10	1-10	<i>(See below under Coinsurance/Copayment)</i>
Select label for Group (1-10): <i>(Select one)</i> <ul style="list-style-type: none"> <li>○ Formulary Generic</li> <li>○ Formulary Preferred Brand</li> <li>○ Formulary Brand</li> <li>○ Non-formulary Generic</li> <li>○ Non-formulary Brand</li> <li>○ Generic</li> <li>○ Preferred Brand</li> <li>○ Brand</li> <li>○ Tier 1</li> <li>○ Tier 2</li> <li>○ Tier 3</li> <li>○ Tier 4</li> <li>○ Tier 5</li> <li>○ Tier 6</li> <li>○ Tier 7</li> <li>○ Tier 8</li> <li>○ Tier 9</li> <li>○ Tier 10</li> </ul>	Label	<i>(See below under Coinsurance/Copayment)</i>

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<p>If label is “Tier” then Enter Tier label for Group 1: <hr/></p>	<p>Label</p>	<p>(See below under Coinsurance/Copayment)</p>
<p>If label is “Tier” then Select drug types covered for Group (1-10): (Select one or more) <input type="checkbox"/> Generic <input type="checkbox"/> Preferred Brand <input type="checkbox"/> Brand</p>	<p>Generic AND/OR Preferred Brand AND/OR Brand</p>	<p>(See below under Coinsurance/Copayment)</p>
<p>Select location where drugs can be acquired for Group (1 -10): (Select one or more) <input type="checkbox"/> In-Network Preferred Pharmacy <input type="checkbox"/> In-Network Non-Preferred Pharmacy <input type="checkbox"/> Out-of-Network Pharmacy <input type="checkbox"/> Mail Order</p>	<p>In-Network Preferred Pharmacy AND/OR In-Network Non-Preferred Pharmacy AND/OR Out-of-Network Pharmacy AND/OR Mail Order</p>	<p>(See below under Coinsurance/Copayment)</p>
<p>Indicate prescription supply level(s) for In-Network Preferred Pharmacy drugs: (Select one or more) <input type="checkbox"/> One month supply <input type="checkbox"/> Three month supply <input type="checkbox"/> Other</p>	<p>One month supply AND/OR Three month supply AND/OR Other</p>	<p>(See below under Coinsurance/Copayment)</p>
<p>Select Days or Months for Other supply for In-Network Preferred Pharmacy drugs: (Select one) O Days O Months</p>	<p>Days OR Months</p>	<p>(See below under Coinsurance/Copayment)</p>
<p>Enter number of Days or Months for In-Network Preferred Pharmacy drugs: <hr/></p>	<p>Number</p>	<p>(See below under Coinsurance/Copayment)</p>

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<p>Indicate prescription supply level(s) for In-Network Non-Preferred Pharmacy drugs: <i>(Select one or more)</i></p> <p><input type="checkbox"/> One month supply</p> <p><input type="checkbox"/> Three month supply</p> <p><input type="checkbox"/> Other</p>	<p>One month supply <i>AND/OR</i> Three month supply <i>AND/OR</i> Other</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Select Days or Months for Other supply for In-Network Non-Preferred Pharmacy drugs: <i>(Select one)</i></p> <p><input type="radio"/> Days</p> <p><input type="radio"/> Months</p>	<p>Days <i>OR</i> Months</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Enter number of Days or Months for In-Network Non-Preferred Pharmacy drugs:</p> <p>_____</p>	<p>Number</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Indicate prescription supply level(s) for Out-of-Network Pharmacy drugs: <i>(Select one or more)</i></p> <p><input type="checkbox"/> One month supply</p> <p><input type="checkbox"/> Three month supply</p> <p><input type="checkbox"/> Other</p>	<p>One month supply <i>AND/OR</i> Three month supply <i>AND/OR</i> Other</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Select Days or Months for Other supply for Out-of-Network Pharmacy drugs: <i>(Select one)</i></p> <p><input type="radio"/> Days</p> <p><input type="radio"/> Months</p>	<p>Days <i>OR</i> Months</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Enter number of Days or Months for Out-of-Network Pharmacy drugs:</p> <p>_____</p>	<p>Number</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Indicate prescription supply level(s) Mail Order Pharmacy drugs: <i>(Select one or more)</i></p> <p><input type="checkbox"/> One month supply</p> <p><input type="checkbox"/> Three month supply</p> <p><input type="checkbox"/> Other</p>	<p>One month supply <i>AND/OR</i> Three month supply <i>AND/OR</i> Other</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>

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Select Days or Months for Other supply for Mail Order Pharmacy drugs: <i>(Select one)</i> <input type="radio"/> Days <input type="radio"/> Months	Days <i>OR</i> Months	<i>(See below under Coinsurance/Copayment)</i>
Enter number of Days or Months for Mail Order Pharmacy drugs: _____	Number	<i>(See below under Coinsurance/Copayment)</i>
Is there an enrollee Coinsurance for Group (1-10)? <i>(Select one)</i> <input type="radio"/> Yes <input type="radio"/> No	Yes	
_ % for In-Network Preferred Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of <i>(Group (1-10) label)</i> drugs you get at an in-network preferred pharmacy.
_ % for In-Network Preferred Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of <i>(Group (1-10) label)</i> drugs you get at an in-network preferred pharmacy.
_ % for In-Network Preferred Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of <i>(Group (1-10) label)</i> drugs you get at an in-network preferred pharmacy.
_ % for In-Network Non-Preferred Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of <i>(Group (1-10) label)</i> drugs you get at an in-network non-preferred pharmacy.
_ % for In-Network Non-Preferred Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of <i>(Group (1-10) label)</i> drugs you get at an in-network non-preferred pharmacy.
_ % for In-Network Non-Preferred Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of <i>(Group (1-10) label)</i> drugs you get at an in-network non-preferred pharmacy.
_ % for Out-of -Network Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of <i>(Group (1-10) label)</i> drugs you get at an out-of-network pharmacy.

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_ % for Out-of-Network Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
_ % for Out-of-Network Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
_ % for Mail Order Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
_ % for Mail Order Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
_ % for Mail Order Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of mail order ( <i>Group (1-10) label</i> ) drugs.
Is there an enrollee Copayment for Group (1-10)? ( <i>Select one</i> ) o Yes o No	Yes	
\$ _ for In-Network Preferred Pharmacy one month supply	\$	- \$____ for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network preferred pharmacy.
\$ _ for In-Network Preferred Pharmacy three month supply	\$	- \$____ for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network preferred pharmacy.
\$ _ for In-Network Preferred Pharmacy other supply	\$	- \$____ for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network preferred pharmacy.
\$_ for In-Network Non-Preferred Pharmacy one month supply	\$	- \$____ for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.
\$_ for In-Network Non-Preferred Pharmacy three month supply	\$	- \$____ for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.

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\$_ for In-Network Non-Preferred Pharmacy other supply	\$	- \$____ for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.
\$_ for Out-of -Network Pharmacy one month supply	\$	- \$____ for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
\$_ for Out-of-Network Pharmacy three month supply	\$	- \$____ for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
\$_ for Out-of-Network Pharmacy other supply	\$	- \$____ for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
\$_ for Mail Order Pharmacy one month supply	\$	- \$____ for a one-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
\$_ for Mail Order Pharmacy three month supply	\$	- \$____ for a three-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
\$_ for Mail Order Pharmacy other supply	\$	- \$____ for a __ (day/month) supply of mail order ( <i>Group (1-10) label</i> ) drugs.
Do you apply the Medicare \$2250 Initial Coverage Limit? ( <i>Select one</i> ) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Waived	Yes	( <i>See above</i> )
	Waived	There is no coverage limit for your prescription drugs.
<i>If No, then</i> Enter Initial Coverage Limit amount: \$____	\$	( <i>See above</i> )
Do you apply the Medicare \$3600 Annual Out-of-Pocket Threshold? ( <i>Select one</i> ) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Waived	Yes	( <i>See below</i> )
	Waived	There is no yearly out-of-pocket cost limit for your prescription drugs.
<i>If No, then</i> Enter Annual Out-of-Pocket	\$	<b><i>See below</i></b>

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Threshold amount: \$____		
<p>How do you apply your cost after the initial Annual Out-of-Pocket Cost amount? (<i>Select one</i>)</p> <ul style="list-style-type: none"> <li>○ No Cost Sharing</li> <li>○ The greater of \$2 for generic or a preferred drug that is a multiple source drug and \$5 for all other drugs, or 5% coinsurance. One or more groups of cost sharing</li> </ul>	No cost sharing	After your out-of-pocket drug costs reach \$____, there is no copayment for your prescription drugs
	The greater of \$2 for generic or a preferred drug that is a multiple source drug and \$5 for all other drugs, or 5% coinsurance.	After your out-of-pocket drug costs reach \$____, you pay the greater of:
	One or more groups of cost sharing	<ul style="list-style-type: none"> <li>- \$2 for generic or a preferred drug that is a multiple source drug and \$5 for all other drugs, or</li> <li>- 5% coinsurance.</li> </ul> <p>After your out-of-pocket drug costs reach \$____, you pay the following for your prescription drugs until your out-of-pocket drug costs reach \$____: (<i>See below under Coinsurance/Copayment</i>)</p>
Select Number of Cost Share Groups after the initial Annual Out-of-Pocket Cost Threshold: 1-10	1-10	( <i>See below under Coinsurance/Copayment</i> )
Select label for Group after the initial Annual Out-of-Pocket Cost Threshold: ( <i>Select one</i> )	Label	( <i>See below under Coinsurance/Copayment</i> )
<ul style="list-style-type: none"> <li>○ Formulary Generic</li> <li>○ Formulary Preferred Brand</li> <li>○ Formulary Brand</li> <li>○ Non-formulary Generic</li> <li>○ Non-formulary Brand</li> <li>○ Generic</li> <li>○ Preferred Brand</li> <li>○ Brand</li> <li>○ Tier 1</li> <li>○ Tier 2</li> <li>○ Tier 3</li> <li>○ Tier 4</li> <li>○ Tier 5</li> </ul>		

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<ul style="list-style-type: none"> <li>○ Tier 6</li> <li>○ Tier 7</li> <li>○ Tier 8</li> <li>○ Tier 9</li> <li>○ Tier 10</li> </ul>		
<p><i>If label is “Tier” then</i> Enter Tier label for Group 1 (Optional):</p> <hr/>	Label	<i>(See below under Coinsurance/Copayment)</i>
<p><i>If label is “Tier” then</i> Select the drug type(s) covered for Group 1: <i>(Select one or more)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Generic</li> <li><input type="checkbox"/> Preferred Brand</li> <li><input type="checkbox"/> Brand</li> </ul>	Generic <i>AND/OR</i> Preferred Brand <i>AND/OR</i> Brand	<i>(See below under Coinsurance/Copayment)</i>
<p>Select Location where drugs can be acquired for Group 1 after the initial Annual Out-of-Pocket Cost Threshold: <i>(Select one or more)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> In-Network Preferred Pharmacy</li> <li><input type="checkbox"/> In-Network Non- Preferred Pharmacy</li> <li><input type="checkbox"/> Out-of-Network Pharmacy</li> <li><input type="checkbox"/> Mail Order</li> </ul>	In-Network Preferred Pharmacy <i>AND/OR</i> In-Network Non-Preferred Pharmacy <i>AND/OR</i> Out-of-Network Pharmacy <i>AND/OR</i> Mail Order	<i>(See below under Coinsurance/Copayment)</i>
<p>Indicate prescription supply level(s) for In-Network Preferred Pharmacy drugs: <i>(Select one or more)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> One month supply</li> <li><input type="checkbox"/> Three month supply</li> <li><input type="checkbox"/> Other</li> </ul>	One month supply <i>AND/OR</i> Three month supply <i>AND/OR</i> Other	<i>(See below under Coinsurance/Copayment)</i>

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Select Days or Months for Other supply for In-Network Preferred Pharmacy drugs: <i>(Select one)</i> <input type="radio"/> Days <input type="radio"/> Months	Days <i>OR</i> Months	<i>(See below under Coinsurance/Copayment)</i>
Enter number of Days or Months for In-Network Preferred Pharmacy drugs: _____	Number	<i>(See below under Coinsurance/Copayment)</i>
Indicate prescription supply level(s) for In-Network Non-Preferred Pharmacy drugs: <i>(Select one or more)</i> <input type="checkbox"/> One month supply <input type="checkbox"/> Three month supply <input type="checkbox"/> Other	One month supply <i>AND/OR</i> Three month supply <i>AND/OR</i> Other	<i>(See below under Coinsurance/Copayment)</i>
Select Days or Months for Other supply for In-Network Non-Preferred Pharmacy drugs: <i>(Select one)</i> <input type="radio"/> Days <input type="radio"/> Months	Days <i>OR</i> Months	<i>(See below under Coinsurance/Copayment)</i>
Enter number of Days or Months for In-Network Non-Preferred Pharmacy drugs: _____	Number	<i>(See below under Coinsurance/Copayment)</i>
Indicate prescription supply level(s) for Out-of-Network Pharmacy drugs: <i>(Select one or more)</i> <input type="checkbox"/> One month supply <input type="checkbox"/> Three month supply <input type="checkbox"/> Other	One month supply <i>AND/OR</i> Three month supply <i>AND/OR</i> Other	<i>(See below under Coinsurance/Copayment)</i>
Select Days or Months for Other supply for Out-of-Network Pharmacy drugs: <i>(Select one)</i> <input type="radio"/> Days <input type="radio"/> Months	Days <i>OR</i> Months	<i>(See below under Coinsurance/Copayment)</i>
Enter number of Days or Months for Out-of-Network Pharmacy drugs: _____	Number	<i>(See below under Coinsurance/Copayment)</i>

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<p>Indicate prescription supply level(s) Mail Order Pharmacy drugs: <i>(Select one or more)</i></p> <p><input type="checkbox"/> One month supply</p> <p><input type="checkbox"/> Three month supply</p> <p><input type="checkbox"/> Other</p>	<p>One month supply <i>AND/OR</i> Three month supply <i>AND/OR</i> Other</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Select Days or Months for Other supply for Mail Order Pharmacy drugs: <i>(Select one)</i></p> <p><input type="radio"/> Days</p> <p><input type="radio"/> Months</p>	<p>Days <i>OR</i> Months</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Enter number of Days or Months for Mail Order Pharmacy drugs:</p> <p>_____</p>	<p>Number</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Is there an enrollee Coinsurance for Group (1-10) after the initial Annual Out-of-Pocket Cost Threshold? <i>(Select one)</i></p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p>	<p>Yes</p>	
<p>__ % for In-Network Preferred Pharmacy one month supply</p>	<p>%</p>	<p>- ____% coinsurance for a one-month supply of <i>(Group (1-10) label)</i> drugs you get at an in-network preferred pharmacy.</p>
<p>__ % for In-Network Preferred Pharmacy three month supply</p>	<p>%</p>	<p>- ____% coinsurance for a three-month supply of <i>(Group (1-10) label)</i> drugs you get at an in-network preferred pharmacy.</p>
<p>__ % for In-Network Preferred Pharmacy other supply</p>	<p>%</p>	<p>- ____% coinsurance for a __ <i>(day/month)</i> supply of <i>(Group (1-10) label)</i> drugs you get at an in-network preferred pharmacy.</p>
<p>__ % for In-Network Non-Preferred Pharmacy one month supply</p>	<p>%</p>	<p>- ____% coinsurance for a one-month supply of <i>(Group (1-10) label)</i> drugs you get at an in-network non-preferred pharmacy.</p>

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_ % for In-Network Non-Preferred Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.
_ % for In-Network Non-Preferred Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.
_ % for Out-of -Network Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
_ % for Out-of-Network Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
_ % for Out-of-Network Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
_ % for Mail Order Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
_ % for Mail Order Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
_ % for Mail Order Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of mail order ( <i>Group (1-10) label</i> ) drugs.
Is there an enrollee Copayment for Group (1-10) after the initial Annual Out-of-Pocket Cost Threshold? ( <i>Select one</i> ) o Yes o No	Yes	
\$ _ for In-Network Preferred Pharmacy one month supply	\$	- \$____ for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network preferred pharmacy.

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\$ _ for In-Network Preferred Pharmacy three month supply	\$	- \$ ___ for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network preferred pharmacy.
\$ _ for In-Network Preferred Pharmacy other supply	\$	- \$ ___ for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network preferred pharmacy.
\$ _ for In-Network Non-Preferred Pharmacy one month supply	\$	- \$ ___ for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.
\$ _ for In-Network Non-Preferred Pharmacy three month supply	\$	- \$ ___ for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.
\$ _ for In-Network Non-Preferred Pharmacy other supply	\$	- \$ ___ for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.
\$ _ for Out-of -Network Pharmacy one month supply	\$	- \$ ___ for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
\$ _ for Out-of-Network Pharmacy three month supply	\$	- \$ ___ for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
\$ _ for Out-of-Network Pharmacy other supply	\$	- \$ ___ for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
\$ _ for Mail Order Pharmacy one month supply	\$	- \$ ___ for a one-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
\$ _ for Mail Order Pharmacy three month supply	\$	- \$ ___ for a three-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
\$ _ for Mail Order Pharmacy other supply	\$	- \$ ___ for a __ (day/month) supply of mail order ( <i>Group (1-10) label</i> ) drugs.
Do you apply a Secondary Coverage Limit after the Initial Coverage Limit and Threshold? ( <i>Select one</i> )		

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<input type="radio"/> Yes <input type="radio"/> No		
<i>If Yes, then</i> Enter Secondary Coverage Limit amount:	\$	
Do you apply a Secondary Annual Out-of-Pocket Cost Threshold? ( <i>Select one</i> ) <input type="radio"/> Yes <input type="radio"/> No		
<i>If Yes, then</i> Enter Secondary Annual Out-of-Pocket Cost Threshold amount:	\$	
How do you apply your cost after the secondary Annual Out-of-Pocket Cost amount? ( <i>Select one</i> ) <input type="radio"/> No Cost Sharing <input type="radio"/> : The greater of \$2 for generic or a preferred drug that is a multiple source drug and \$5 for all other drugs, or 5% coinsurance. <input type="radio"/> One or more groups of cost sharing	No cost sharing	After your out-of-pocket drug costs reach \$____, there is no copayment for your prescription drugs.
	: - The greater of \$2 for generic or a preferred drug that is a multiple source drug and \$5 for all other drugs, or 5% coinsurance.	After your out-of-pocket drug costs reach \$____, you pay the greater of: - \$2 for generic or a preferred drug that is a multiple source drug and \$5 for all other drugs, or - 5% coinsurance.
	One or more groups of cost sharing	After your out-of-pocket drug costs reach \$____, you pay the following for your prescription drugs: <i>(See below under Coinsurance/Copayment)</i>
Select Number of Cost Share Groups after the secondary Annual Out-of-Pocket Cost Threshold: 1-10	1-10	

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<p>Select label for Group after the secondary Annual Out-of-Pocket Cost Threshold: <i>(Select one)</i></p> <ul style="list-style-type: none"> <li>○ Formulary Generic</li> <li>○ Formulary Preferred Brand</li> <li>○ Formulary Brand</li> <li>○ Non-formulary Generic</li> <li>○ Non-formulary Brand</li> <li>○ Generic</li> <li>○ Preferred Brand</li> <li>○ Brand</li> <li>○ Tier 1</li> <li>○ Tier 2</li> <li>○ Tier 3</li> <li>○ Tier 4</li> <li>○ Tier 5</li> <li>○ Tier 6</li> <li>○ Tier 7</li> <li>○ Tier 8</li> <li>○ Tier 9</li> <li>○ Tier 10</li> </ul>	<p>Label</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
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<p><i>If label is “Tier” then</i> Enter Tier label for Group 1 (Optional): <hr/></p>	<p>Label</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p><i>If label is “Tier” then</i> Select the drug type(s) covered for Group 1: <i>(Select one or more)</i> <input type="checkbox"/> Generic <input type="checkbox"/> Preferred Brand <input type="checkbox"/> Brand</p>	<p>Generic <i>AND/OR</i> Preferred Brand <i>AND/OR</i> Brand</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Select Location where drugs can be acquired for Group 1 after the secondary Annual Out-of-Pocket Cost Threshold: <i>(Select one or more)</i> <input type="checkbox"/> In-Network Preferred Pharmacy <input type="checkbox"/> In-Network Non-Preferred Pharmacy <input type="checkbox"/> Out-of-Network Pharmacy <input type="checkbox"/> Mail Order</p>	<p>In-Network Preferred Pharmacy <i>AND/OR</i> In-Network Non-Preferred Pharmacy <i>AND/OR</i> Out-of-Network Pharmacy <i>AND/OR</i> Mail Order</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Indicate prescription supply level(s) for In-Network Preferred Pharmacy drugs: <i>(Select one or more)</i> <input type="checkbox"/> One month supply <input type="checkbox"/> Three month supply <input type="checkbox"/> Other</p>	<p>One month supply <i>AND/OR</i> Three month supply <i>AND/OR</i> Other</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Select Days or Months for Other supply for In-Network Preferred Pharmacy drugs: <i>(Select one)</i> o Days o Months</p>	<p>Days <i>OR</i> Months</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Enter number of Days or Months for In-Network Preferred Pharmacy drugs: <hr/></p>	<p>Number</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>

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<p>Indicate prescription supply level(s) for In-Network Non-Preferred Pharmacy drugs: <i>(Select one or more)</i></p> <p><input type="checkbox"/> One month supply</p> <p><input type="checkbox"/> Three month supply</p> <p><input type="checkbox"/> Other</p>	<p>One month supply <i>AND/OR</i> Three month supply <i>AND/OR</i> Other</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Select Days or Months for Other supply for In-Network Non-Preferred Pharmacy drugs: <i>(Select one)</i></p> <p><input type="radio"/> Days</p> <p><input type="radio"/> Months</p>	<p>Days <i>OR</i> Months</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Enter number of Days or Months for In-Network Non-Preferred Pharmacy drugs:</p> <p>_____</p>	<p>Number</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Indicate prescription supply level(s) for Out-of-Network Pharmacy drugs: <i>(Select one or more)</i></p> <p><input type="checkbox"/> One month supply</p> <p><input type="checkbox"/> Three month supply</p> <p><input type="checkbox"/> Other</p>	<p>One month supply <i>AND/OR</i> Three month supply <i>AND/OR</i> Other</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Select Days or Months for Other supply for Out-of-Network Pharmacy drugs: <i>(Select one)</i></p> <p><input type="radio"/> Days</p> <p><input type="radio"/> Months</p>	<p>Days <i>OR</i> Months</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Enter number of Days or Months for Out-of-Network Pharmacy drugs:</p> <p>_____</p>	<p>Number</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>
<p>Indicate prescription supply level(s) Mail Order Pharmacy drugs: <i>(Select one or more)</i></p> <p><input type="checkbox"/> One month supply</p> <p><input type="checkbox"/> Three month supply</p> <p><input type="checkbox"/> Other</p>	<p>One month supply <i>AND/OR</i> Three month supply <i>AND/OR</i> Other</p>	<p><i>(See below under Coinsurance/Copayment)</i></p>

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Select Days or Months for Other supply for Mail Order Pharmacy drugs: <i>(Select one)</i> <input type="radio"/> Days <input type="radio"/> Months	Days <i>OR</i> Months	<i>(See below under Coinsurance/Copayment)</i>
Enter number of Days or Months for Mail Order Pharmacy drugs: _____	Number	<i>(See below under Coinsurance/Copayment)</i>
Is there an enrollee Coinsurance for Group (1-10) after the secondary Annual Out-of-Pocket Cost Threshold? <i>(Select one)</i> <input type="radio"/> Yes <input type="radio"/> No	Yes	
_ % for In-Network Preferred Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of <i>(Group (1-10) label)</i> drugs you get at an in-network preferred pharmacy.
_ % for In-Network Preferred Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of <i>(Group (1-10) label)</i> drugs you get at an in-network preferred pharmacy.
_ % for In-Network Preferred Pharmacy other supply	%	- ____% coinsurance for a __ <i>(day/month)</i> supply of <i>(Group (1-10) label)</i> drugs you get at an in-network preferred pharmacy.
_ % for In-Network Non-Preferred Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of <i>(Group (1-10) label)</i> drugs you get at an in-network non-preferred pharmacy.
_ % for In-Network Non-Preferred Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of <i>(Group (1-10) label)</i> drugs you get at an in-network non-preferred pharmacy.
_ % for In-Network Non-Preferred Pharmacy other supply	%	- ____% coinsurance for a __ <i>(day/month)</i> supply of <i>(Group (1-10) label)</i> drugs you get at an in-network non-preferred pharmacy.

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_ % for Out-of -Network Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
_ % for Out-of-Network Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
_ % for Out-of-Network Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
_ % for Mail Order Pharmacy one month supply	%	- ____% coinsurance for a one-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
_ % for Mail Order Pharmacy three month supply	%	- ____% coinsurance for a three-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
_ % for Mail Order Pharmacy other supply	%	- ____% coinsurance for a __ (day/month) supply of mail order ( <i>Group (1-10) label</i> ) drugs.
Is there an enrollee Copayment for Group (1-10) after the secondary Annual Out-of-Pocket Cost Threshold? ( <i>Select one</i> ) o Yes o No	Yes	
\$ _ for In-Network Preferred Pharmacy one month supply	\$	- \$____ for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network preferred pharmacy.
\$ _ for In-Network Preferred Pharmacy three month supply	\$	- \$____ for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network preferred pharmacy.
\$ _ for In-Network Preferred Pharmacy other supply	\$	- \$____ for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network preferred pharmacy.

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\$_ for In-Network Non-Preferred Pharmacy one month supply	\$	- \$____ for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.
\$_ for In-Network Non-Preferred Pharmacy three month supply	\$	- \$____ for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.
\$_ for In-Network Non-Preferred Pharmacy other supply	\$	- \$____ for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an in-network non-preferred pharmacy.
\$_ for Out-of -Network Pharmacy one month supply	\$	- \$____ for a one-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
\$_ for Out-of-Network Pharmacy three month supply	\$	- \$____ for a three-month supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
\$_ for Out-of-Network Pharmacy other supply	\$	- \$____ for a __ (day/month) supply of ( <i>Group (1-10) label</i> ) drugs you get at an out-of-network pharmacy.
\$_ for Mail Order Pharmacy one month supply	\$	- \$____ for a one-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
\$_ for Mail Order Pharmacy three month supply	\$	- \$____ for a three-month supply of mail order ( <i>Group (1-10) label</i> ) drugs.
\$_ for Mail Order Pharmacy other supply	\$	- \$____ for a __ (day/month) supply of mail order ( <i>Group (1-10) label</i> ) drugs.
Are there quantity limits on certain prescription drugs? ( <i>Select one</i> ) o Yes o No	Yes	Certain prescription drugs will have maximum quantity limits. Contact plan for details.
	No	No sentence

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Is Prior Authorization required for certain prescription drugs? (Select one) <input type="radio"/> Yes <input type="radio"/> No	Yes	Your provider must get prior authorization from <Plan Name> for certain prescription drugs. Contact plan for details.
	No	No sentence