

SUMMARY OF BENEFITS 2006

I. CATEGORY LIST AND ORIGINAL MEDICARE SENTENCES

Important Information

Benefit Category		Original Medicare
1	Premium and Other Important Information	You pay the Medicare Part B premium of \$66.60 each month. (This is the 2005 amount and may change January 1, 2006.)
2	Doctor and Hospital Choice (For more information, see Emergency-#15 and Urgently Needed Care-#16.)	You may go to any doctor, specialist or hospital that accepts Medicare.

Summary of Benefits

If you have any questions about this plan's benefits or costs, please contact (<i>Medicare Advantage Org. Marketing Name</i>).	
Benefit Category	Original Medicare
Inpatient Care	
3 Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	<p>You pay for each benefit period(3):</p> <ul style="list-style-type: none"> • Days 1 - 60: an initial deductible of \$876 • Days 61 - 90: \$219 each day • Days 91 - 150: \$438 each lifetime reserve day(4) <p>[These are 2005 amounts and may change January 1, 2006.]</p> <p>Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. (4)</p>
4 Inpatient Mental Health Care	<p>You pay the same deductible and copayments as inpatient hospital care (above) except Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.</p>
5 Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	<p>You pay for each benefit period(3), following at least a 3-day covered hospital stay:</p> <ul style="list-style-type: none"> • Days 1 - 20: \$0 for each day • Days 21 - 100: \$109.50 for each day <p>[These are 2005 amounts and may change January 1, 2006.]</p> <p>There is a limit of 100 days for each benefit period.(3)</p>

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If you have any questions about this plan's benefits or costs, please contact (<i>Medicare Advantage Org. Marketing Name</i>).		
Benefit Category		Original Medicare
6	Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	There is no copayment for all covered home health visits.
7	Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must receive care from a Medicare-certified hospice.
Outpatient Care		
8	Doctor Office Visits	You pay 20% of Medicare approved amounts. (1)(2)
9	Chiropractic Services	You pay 20% of Medicare approved amounts.(1)(2) You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers. You pay 100% for routine care.
10	Podiatry Services	You pay 20% of the Medicare-approved amounts. (1)(2) You are covered for medically necessary foot care, including care for medical conditions affecting the lower limbs.

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Benefit Category	
Original Medicare	
	You pay 100% for routine care.
11	Outpatient Mental Health Care
	You pay 50% of Medicare-approved amounts with the exception of certain situations and services for which you pay 20% of approved charges. (1)(2)
12	Outpatient Substance Abuse Care
	You pay 20% of Medicare-approved amounts. (1)(2)
13	Outpatient Services/Surgery
	You pay 20% of Medicare-approved amounts for the doctor. (1)(2) You pay 20% of outpatient facility charges. (1)(2)
14	Ambulance Services (medically necessary ambulance services)
	You pay 20% of Medicare-approved amounts or applicable fee schedule charge. (1)(2)
15	Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)
	You pay 20% of the facility charge or applicable Copayment for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. (1)(2) You pay 20% of doctor charges. (1)(2) NOT covered outside the U.S. except under limited circumstances.
16	Urgently Needed Care (This is NOT emergency care, and in most cases, is out of
	You pay 20% of Medicare-approved amounts or applicable Copayment. (1)(2)

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Benefit Category		Original Medicare
	the service area.)	NOT covered outside the U.S. except under limited circumstances.
17	Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	You pay 20% of Medicare-approved amounts. (1)(2)
Outpatient Medical Services and Supplies		
18	Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)
19	Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)
20	Diabetes Self-Monitoring Training and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	You pay 20% of Medicare-approved amounts. (1)(2)
21	Diagnostic Tests, X-Rays, and Lab Services	You pay 20% of Medicare-approved amounts, except for approved lab services. (1)(2) There is no copayment for Medicare-approved lab services.
Preventive Services		
22	Bone Mass Measurement	You pay 20% of Medicare-approved amounts. (1)(2)

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If you have any questions about this plan's benefits or costs, please contact (<i>Medicare Advantage Org. Marketing Name</i>).	
Benefit Category	Original Medicare
	(for people with Medicare who are at risk)
23	Colorectal Screening Exams (for people with Medicare age 50 and older)
24	Immunizations (Flu vaccine, Hepatitis B vaccine - <i>for people with Medicare who are at risk</i> , Pneumonia vaccine)
25	Mammograms (Annual Screening) (for women with Medicare age 40 and older)
26	Pap Smears and Pelvic Exams (for women with Medicare)
27	Prostate Cancer Screening Exams (for men with Medicare age 50 and older)

You pay 20% of Medicare-approved amounts. (1)(2)

There is no copayment for the Pneumonia and Flu vaccines.
You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine. (1)(2)
You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.

You pay 20% of Medicare-approved amounts. (2)
No referral necessary for Medicare-covered screenings.

There is no copayment for a Pap Smear once every 2 years, annually for beneficiaries at high risk. (2)
You pay 20% of Medicare-approved amounts for Pelvic Exams. (2)

There is no copayment for approved lab services and a copayment of 20% of Medicare-approved amounts for other related services. (1)(2)

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If you have any questions about this plan's benefits or costs, please contact (<i>Medicare Advantage Org. Marketing Name</i>).	
Benefit Category	Original Medicare
Additional Benefits	
28	Outpatient Prescription Drugs
	You pay 100% for most prescription drugs.
29	Dental Services
	In general, you pay 100% for dental services.
30	Hearing Services
	You pay 100% for routine hearing exams and hearing aids. You pay 20% of Medicare-approved amounts for diagnostic hearing exams. (1)(2)
31	Vision Services
	You are covered for one pair of eyeglasses or contact lenses after each cataract surgery. (1)(2) For people with Medicare who are at risk, you are covered for annual glaucoma screenings. (1) (2) You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye. (1)(2) You pay 100% for routine eye exams and glasses.
32	Routine Physical Exams
	If your coverage to Medicare Part B begins on or after January 1,2005, you may receive a one time physical exam within the first six months of your new Part B coverage. This will not include laboratory tests. Please contact your physician for further details. You pay 20% of the Medicare-approved amount. You pay 100% for routine physical exams.

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If you have any questions about this plan's benefits or costs, please contact (<i>Medicare Advantage Org. Marketing Name</i>).		
Benefit Category		
Original Medicare		
	Health/Wellness Education	You pay 100%.
	Transportation (Routine)	You pay 100%.
	Acupuncture	You pay 100%.
	Point of Service	

SECTION 2 - PLAN SENTENCES

<p>1 PREMIUM AND OTHER IMPORTANT INFORMATION</p>	<p align="center"><i>Sentences are for ALL plan types, unless noted below.</i></p>
<p>You pay \$___ each month. You also continue to pay the Medicare Part B premium of \$66.60 each month. (This is the 2005 amount and may change January 1, 2006) <i>OR</i> There is no additional premium beyond the Medicare Part B premium of \$66.60 each month. (This is the 2005 amount and may change January 1, 2006)</p>	
<p>Please note that <i>(Medicare Advantage Org. Marketing Name)</i> is reducing your monthly Medicare Part B premium by up to \$___. (This may be a rounded number.) Please contact <i>(Medicare Advantage Org. Marketing Name)</i> for details.</p>	
<p>You pay a \$___ yearly deductible for all plan services when received in network only. <i>OR</i> You pay a \$___ yearly deductible for all Medicare-covered plan services when received in network only. <i>OR</i> You pay a \$___ yearly deductible for all non-Medicare covered plan services when received in network only. OR You pay a \$___ yearly deductible for the following plan services when received in network only: <i>(pick list)</i> <i>OR</i> You pay a \$___ yearly deductible for the following Medicare-covered plan services when received in network only: <i>(pick list)</i> <i>OR</i> You pay a \$___ yearly deductible for the following non-Medicare covered plan services when received in network only: <i>(pick list)</i></p>	

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<p>You pay a \$__ yearly deductible for the following Medicare covered plan services when received out of network only.</p> <p>You pay a \$__ yearly deductible for the following non-Medicare covered plan services when received out of network only.</p>	<p><i>Sentence for PPOs only</i></p>
<p>After you have paid \$__ in any calendar year, you do not have to pay any more for in-network Medicare covered services.</p> <p>After you have paid \$__ in any calendar year, you do not have to pay any more for out-of-network Medicare covered services.</p>	<p><i>Sentence for PPOs only.</i></p>
<p>There is a \$__ maximum out-of-pocket limit every (<i>select periodicity</i>) for all plan services when received in network only. <i>OR</i></p> <p>There is a \$__ maximum out-of-pocket limit for all plans services when received in network only. <i>OR</i></p> <p>There is a \$__ maximum out-of-pocket limit every (<i>select periodicity</i>) for the following plan services when received in network only: <i>OR</i></p> <p>There is a \$__ maximum out-of-pocket limit for the following plan services when received in network only: <i>OR</i></p> <p>There is a \$__ maximum out-of-pocket limit every (<i>select periodicity</i>) for Medicare-covered plan services when received in network only. <i>OR</i></p> <p>There is a \$__ maximum out-of-pocket limit for Medicare-covered plan services when received in network only. <i>OR</i></p> <p>There is a \$__ maximum out-of-pocket limit every (<i>select periodicity</i>) for the</p>	

<p>following Medicare-covered plan services when received in network only: <i>OR</i> There is a \$__ maximum out-of-pocket limit for the following Medicare-covered plan services when received in network only: <i>OR</i> There is a \$__ maximum out-of-pocket limit every (<i>select periodicity</i>) for non-Medicare covered plan services when received in network only. <i>OR</i> There is a \$__ maximum out-of-pocket limit for non-Medicare covered plan services when received in network only. <i>OR</i> There is a \$__ maximum out-of-pocket limit every (<i>select periodicity</i>) for the following non-Medicare covered plan services when received in network only: <i>OR</i> There is a \$__ maximum out-of-pocket limit for the following non-Medicare covered plan services when received in network only:</p>	
<p>There is a \$__ maximum out-of-pocket limit every (<i>select periodicity</i>) for all plan services when received out of network only. <i>OR</i> There is a \$__ maximum out-of-pocket limit for all plans services when received out of network only. <i>OR</i> There is a \$__ maximum out-of-pocket limit every (<i>select periodicity</i>) for the following plan services when received out of network only: <i>OR</i> There is a \$__ maximum out-of-pocket limit for the following plan services when received out of network only:</p>	<p><i>Sentence for PPOs only</i></p>
<p>There is a \$__ maximum (<i>Specified period</i>) that your plan will cover for plan</p>	

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<p>services when received in network only. <i>OR</i> There is a \$__ maximum (<i>Specified period</i>) that your plan will cover for the following plan services when received in network only : (<i>pick list</i>) <i>OR</i> There is a \$__ maximum that your plan will cover for plan services when received in network only. <i>OR</i> There is a \$__ maximum that your plan will cover for the following plan services when received in network only : (<i>pick list</i>)</p>	
<p>There is a \$__ maximum (<i>Specified period</i>) that your plan will cover for plan services when received out of network only. <i>OR</i> There is a \$__ maximum that your plan will cover for plan services when received out of network only.</p>	<i>Sentence for PPOs only</i>
<p>There is a \$__ maximum (<i>Specified period</i>) that you plan will cover for the following plan services when received out of network only: (<i>pick list</i>) <i>OR</i> There is a \$__ maximum that you plan will cover for the following plan services when received out of network only: (<i>pick list</i>)</p>	<i>Sentence for PPOs only</i>
<p>If there is no note on an out of network service, then the note describes the in-network service. Contact plan for details on the covered out of network service.</p>	<i>Sentence for PPOs only</i>
<p>2 DOCTOR AND HOSPITAL CHOICE</p>	
<p>You must go to network doctors, specialists, and hospitals.</p>	<p><i>Delete sentence for PPOs</i> <i>Delete sentence for PFFS</i> <i>Delete sentence for Cost Plans</i></p>

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You can go to doctors, specialists, and hospitals in or out of the network. Higher costs apply for out of network services.	<i>Sentence for PPOs only</i>
You may go to any doctor, specialist, or hospital that accepts the plan's payment.	<i>Sentence for PFFS only</i>
You can use any doctor who is part of our network. You may also go to doctors outside of our network.	<i>Sentence for Cost plans only</i>
You need a referral to go to network hospitals and certain doctors, including specialists for certain services. <i>OR</i> You need a referral to go to network specialists for certain services. <i>OR</i> You need a referral to go to network hospitals. <i>OR</i> You do NOT need a referral to go to network doctors, specialists, and hospitals.	<i>Delete all sentences for PFFS</i>
A separate doctor office visit copayment may apply for certain services.	<i>Delete sentence for PFFS,</i>
A Visitor/Travel program is available.	<i>Delete sentence for PFFS</i>
3 INPATIENT HOSPITAL CARE	
You pay one initial deductible of \$ ___ for services received at a network hospital.	
There is no copayment for Inpatient Hospital services at a network hospital.	<i>Delete 'network' for PFFS</i>
You pay \$ ___[or ___% of the cost] for each Medicare-covered stay at a network hospital.	<i>Delete 'network' for PFFS</i>

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<p>You pay: - \$ ___ [or ___% of the cost] each day for day(s) __-__ - \$ ___ [or ___% of the cost] each day for day(s) __-__ - \$ ___ [or ___% of the cost] each day for day(s) __-__ for a Medicare-covered stay at a network hospital.</p>	<p><i>Delete ‘network’ for PFFS</i></p>
<p>You pay \$ ___ [or ___% of the cost] for each stay at a network hospital.</p>	<p><i>Delete ‘network’ for PFFS</i></p>
<p>You pay: - \$ ___ [or ___% of the cost] each day for day(s) __-__ - \$ ___ [or ___% of the cost] each day for day(s) __-__ - \$ ___ [or ___% of the cost] each day for day(s) __-__ for a stay at a network hospital.</p>	<p><i>Delete ‘network’ for PFFS</i></p>
<p>Cost sharing may vary for each Medicare-covered stay according to the hospital at which services are received.</p>	
<p>You pay \$ ___ [or ___% of the cost] for each stay at an out of network hospital.</p>	<p><i>Sentence for PPOs only</i></p>
<p>You pay: - \$ ___ [or ___% of the cost] each day for day(s) __-__ - \$ ___ [or ___% of the cost] each day for day(s) __-__ - \$ ___ [or ___% of the cost] each day for day(s) __-__ for a stay at an out of network hospital.</p>	<p><i>Sentence for PPOs only</i></p>
<p>You pay \$ ___ [or ___% of the cost] for each non-Medicare-covered stay at a network hospital.</p>	<p><i>Delete ‘network’ for PFFS</i></p>
<p>You pay \$ ___ [or ___% of the cost] each day for a non-Medicare-covered stay at a network hospital.</p>	<p><i>Delete ‘network’ for PFFS</i></p>

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<p>You pay: - \$ ___ [or ___ % of the cost] each day for day(s) ___ - ___ - \$ ___ [or ___ % of the cost] each day for day(s) ___ - ___ - \$ ___ [or ___ % of the cost] each day for day(s) ___ - ___ (-999 = 'and beyond') for a non-Medicare-covered stay at a network hospital.</p>	<p><i>Delete 'network' for PFFS</i></p>
<p>There is no copayment for additional days at a network hospital.</p>	<p><i>Delete 'network' for PFFS</i></p>
<p>You pay \$ ___ [or ___ % of the cost] for each additional day at a network hospital.</p>	<p><i>Delete 'network' for PFFS</i></p>
<p>You pay: - \$ ___ [or ___ % of the cost] each day for additional day(s) ___ - ___ - \$ ___ [or ___ % of the cost] each day for additional day(s) ___ - ___ - \$ ___ [or ___ % of the cost] each day for additional day(s) ___ - ___ (-999 = 'and beyond') at a network hospital.</p>	<p><i>Delete 'network' for PFFS</i></p>
<p>If you do not notify the plan of a planned inpatient admission, you will have to pay \$ ___ each day, up to a maximum of \$ ___ per admission. Contact plan for additional information.</p>	<p><i>Sentences for PFFS only</i></p>
<p>There is a \$ ___ maximum out of pocket limit every (<i>Specified period</i>). OR There is a \$ ___ maximum out of pocket limit.</p>	
<p>You are covered for 90 days each benefit period. OR You are covered for unlimited days each benefit period. OR You are covered for (<i>90+number of additional days</i>) days each benefit period.</p>	

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You may go to any doctor, specialist, or hospital that accepts the plan's payment.	<i>Sentence for PFFS only</i>
Except in an emergency, your provider must obtain authorization from <MA org>.	
4 INPATIENT MENTAL HEALTH CARE	
You pay one initial deductible of \$___ for services received at a network hospital.	
There is no copayment for services at a network hospital.	<i>Delete 'network' for PFFS</i>
You pay \$___[or ___% of the cost] for each Medicare-covered stay at a network hospital.	<i>Delete 'network' for PFFS</i>
You pay: - \$ ___ [or ___% of the cost] each day for day(s) __-__ - \$ ___ [or ___% of the cost] each day for day(s) __-__ - \$ ___ [or ___% of the cost] each day for day(s) __-__ for a Medicare-covered stay at a network hospital.	<i>Delete 'network' for PFFS</i>
You pay \$___ [or ___% of the cost] for each stay at a network hospital.	<i>Delete 'network' for PFFS</i>
You pay: - \$___[or ___% of the cost] each day for day(s) __-__ - \$___[or ___% of the cost] each day for day(s) __-__ - \$___[or ___% of the cost] each day for day(s) __-__ for a stay at a network hospital.	<i>Delete 'network' for PFFS</i>

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Cost sharing may vary for each Medicare-covered stay according to the hospital at which services are received.	
You pay \$ ___ [or ___% of the cost] for each stay at an out of network hospital.	<i>Sentence for PPOs only</i>
You pay: - \$ ___[or ___% of the cost] each day for day(s) ___ - ___ - \$ ___[or ___% of the cost] each day for day(s) ___ - ___ - \$ ___[or ___% of the cost] each day for day(s) ___ - ___ for a stay at an out of network hospital.	<i>Sentence for PPOs only</i>
You pay \$ ___ [or ___% of the cost] for each non-Medicare-covered stay at a network hospital.	<i>Delete 'network' for PFFS</i>
You pay \$ ___[or ___% of the cost] each day for a non-Medicare-covered stay at a network hospital.	<i>Delete 'network' for PFFS</i>
You pay: - \$ ___[or ___% of the cost] each day for day(s) ___ - ___ - \$ ___[or ___% of the cost] each day for day(s) ___ - ___ - \$ ___[or ___% of the cost] each day for day(s) ___ - ___ (-999 = 'and beyond') for a non-Medicare-covered stay at a network hospital.	<i>Delete 'network' for PFFS</i>
There is no copayment for additional days in a network hospital.	<i>Delete 'network' for PFFS</i>
You pay \$ ___ [or ___% of the cost] for each additional day at a network hospital.	<i>Delete 'network' for PFFS</i>

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<p>You pay: - \$ ___[or ___% of the cost] each day for additional day(s) __-__ - \$ ___[or ___% of the cost] each day for additional day(s) __-__ - \$ ___[or ___% of the cost] each day for additional day(s) __-__ (-999 = 'and beyond') at a network hospital.</p>	<p><i>Delete 'network' for PFFS</i></p>
<p>If you do not notify the plan of a planned inpatient admission, you will have to pay \$___ each day, up to a maximum of \$___ per admission. Contact plan for additional information.</p>	<p><i>Sentences for PFFS only</i></p>
<p>The maximum out of pocket limit is covered under Inpatient Hospital Care. OR There is a \$___ maximum out of pocket limit every (Specified period). OR There is a \$___ maximum out of pocket limit.</p>	
<p>Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime. OR Contact plan for details about benefits beyond 190 days.</p>	
<p>Except in an emergency, your provider must obtain authorization from <MA Org>.</p>	
<p>5 SKILLED NURSING FACILITY</p>	
<p>You pay a deductible of \$___.</p>	
<p>There is no copayment for services in a Skilled Nursing Facility.</p>	

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<p>You pay \$ ___ [or ___% of the cost] for each Medicare-covered stay at a Skilled Nursing Facility.</p>	
<p>You pay: - \$ ___ [or ___% of the cost] each day for day(s) ___ - ___ - \$ ___ [or ___% of the cost] each day for day(s) ___ - ___ - \$ ___ [or ___% of the cost] each day for day(s) ___ - ___ for a Medicare-covered stay in a Skilled Nursing Facility.</p>	
<p>You pay \$ ___ to \$ ___ [or ___% to ___% of the cost] for Medicare-covered services at an out of network Skilled Nursing Facility.</p>	<p><i>Sentence for PPOs only</i></p>
<p>You pay \$ ___ [or ___% of the cost] for each stay at a Skilled Nursing Facility.</p>	
<p>You pay: - \$ ___ [or ___% of the cost] each day for day(s) ___ - ___ - \$ ___ [or ___% of the cost] each day for day(s) ___ - ___ - \$ ___ [or ___% of the cost] each day for day(s) ___ - ___ (-999 = 'and beyond') for a stay at a Skilled Nursing Facility.</p>	
<p>You pay \$ ___ to \$ ___ [or ___% to ___% of the cost] for services at an out of network Skilled Nursing Facility.</p>	<p><i>Sentence for PPOs only</i></p>
<p>You pay \$ ___ [or ___% of the cost] for each non-Medicare-covered stay at a Skilled Nursing Facility.</p>	
<p>You pay \$ ___ [or ___% of the cost] each day for a non-Medicare-covered stay at a Skilled Nursing Facility.</p>	

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<p>You pay: - \$ ___ [or ___ % of the cost] each day for day(s) ___ - ___ - \$ ___ [or ___ % of the cost] each day for day(s) ___ - ___ - \$ ___ [or ___ % of the cost] each day for day(s) ___ - ___ (-999 = 'and beyond') for a non-Medicare-covered stay at a Skilled Nursing Facility.</p>	
<p>You pay \$ ___ to \$ ___ [or ___ % to ___ % of the cost] for non-Medicare-covered services at an out of network Skilled Nursing Facility.</p>	<p><i>Sentence for PPOs only</i></p>
<p>There is no copayment for additional days at a Skilled Nursing Facility.</p>	
<p>You pay \$ ___ [or ___ % of the cost] for each additional day at a Skilled Nursing Facility.</p>	
<p>You pay: - \$ ___ [or ___ % of the cost] each day for additional day(s) ___ - ___ - \$ ___ [or ___ % of the cost] each day for additional day(s) ___ - ___ - \$ ___ [or ___ % of the cost] each day for additional day(s) ___ - ___ (-999 = 'and beyond') at a Skilled Nursing Facility.</p>	
<p>If you do not notify the plan of a planned inpatient admission, you will have to pay \$ ___ each day, up to a maximum of \$ ___ per admission. Contact plan for additional information.</p>	<p><i>Sentences for PFFS only</i></p>
<p>There is a \$ ___ maximum out of pocket limit every (<i>Specified period</i>). OR There is a \$ ___ maximum out of pocket limit.</p>	

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<p>You are covered for 100 days each benefit period. <i>OR</i> You are covered for unlimited days each benefit period. <i>OR</i> You are covered for (100 + number of additional days) days each benefit period.</p>	
<p>3-day prior hospital stay is required. <i>OR</i> (1 or 2, whichever is applicable) -day prior hospital stay is required. <i>OR</i> No prior hospital stay is required.</p>	
<p>Authorization rules may apply for services. Contact plan for details.</p>	
<p>6 HOME HEALTH CARE</p>	
<p>There is no copayment for Medicare-covered home health visits.</p>	
<p>You pay \$__ to \$__ [or __% to __% of the cost] for Medicare-covered home health visits.</p>	
<p>You pay \$__ to \$__ [or __% to __% of the cost] for out of network home health visits.</p>	<p><i>Sentence for PPOs only</i></p>
<p>There is no copayment for:</p> <ul style="list-style-type: none"> - Medicare-covered home health visits - Custodial Care - Respite Care - Homemaker Services 	

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<p>You pay: - \$__ to \$__ [or __% to __% of the cost] for Medicare-covered home health visits - \$__ to \$__ [or __% to __% of the cost] for Custodial Care - \$__ to \$__ [or __% to __% of the cost] for Respite Care - \$__ to \$__ [or __% to __% of the cost] for Homemaker services.</p>	
<p>Authorization rules may apply for services. Contact plan for details.</p>	
<p>7 HOSPICE</p>	
<p>You must receive care from a Medicare-certified hospice.</p>	
<p>8 DOCTOR OFFICE VISITS</p>	
<p>There is no copayment for each primary care doctor office visit for Medicare-covered services. <i>OR</i> You pay \$__ to \$__ [or __% to __% of the cost] for each primary care doctor office visit for Medicare-covered services.</p>	
<p>You pay \$__ to \$__ [or __% to __% of the cost] for each out of network primary care doctor office visit.</p>	<p><i>Sentence for PPOs only</i></p>
<p>There is no copayment for each specialist visit for Medicare-covered services. <i>OR</i> You pay \$__ to \$__ [or __% to __% of the cost] for each specialist visit for Medicare-covered services.</p>	
<p>You pay \$__ to \$__ [or __% to __% of the cost] for each out of network specialist visit.</p>	<p><i>Sentence for PPOs only</i></p>

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<p>You may go to any doctor, specialist, or hospital that accepts the plan's payment.</p>	<p><i>Sentence for PFFS only</i></p>
<p>See 32-Routine Physical Exams for more information.</p>	
<p>If your coverage to Medicare Part B begins on or after January 1, 2006, you may receive a one time physical exam within the first six months of your new Part B coverage. This will not include laboratory tests. Please contact your physician for further details.</p>	
<p>9 CHIROPRACTIC SERVICES</p>	
<p>There is no copayment for Medicare-covered chiropractic services (manual manipulation of the spine to correct subluxation).</p>	
<p>You pay \$__ to \$___ [or __% to __% of the cost] for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).</p>	
<p>There is no copayment for:</p> <ul style="list-style-type: none"> - Medicare-covered visits (manual manipulation of the spine to correct subluxation) - routine visits <p><i>OR</i></p> <ul style="list-style-type: none"> - routine visits up to ___ visit(s) every (<i>Specified period</i>) <p><i>OR</i></p> <ul style="list-style-type: none"> - routine visits up to ___ visit(s) 	

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<p>You pay:</p> <ul style="list-style-type: none"> - \$__ to \$___ [or __% to __% of the cost] for each Medicare-covered visit (manual manipulation of the spine to correct subluxation). - \$__ to \$__ [or __% to __% of the cost] for each routine visit up to ___ visit(s) every <i>(Specified period)</i> <i>OR</i> - \$__ to \$__ [or __% to __% of the cost] for each routine visit up to ___ visit(s) <i>OR</i> - \$__ to \$__ [or __% to __% of the cost] for each routine visit 	
<p>You pay \$__ to \$___ [or __% to __% of the cost] for out of network chiropractic services.</p>	<p><i>Sentence for PPOs only</i></p>
<p>10 PODIATRY SERVICES</p>	
<p>There is no copayment for Medicare-covered podiatry services (medically necessary foot care).</p>	
<p>You pay \$__ to \$___ [or __% to __% of the cost] for each Medicare-covered visit (medically necessary foot care).</p>	
<p>There is no copayment for:</p> <ul style="list-style-type: none"> - Medicare-covered visits (medically necessary foot care) - routine visits <i>OR</i> - routine visits up to ___ visit(s) every <i>(Specified period)</i> <i>OR</i> - routine visits up to ___ visits 	

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<p>You pay:</p> <ul style="list-style-type: none"> - \$__ to \$__ [or __% to __% of the cost] for each Medicare-covered visit (medically necessary foot care). - \$__ to \$__ [or __% to __% of the cost] for each routine visit up to __ visit(s) every <i>(Specified period)</i> <p><i>OR</i></p> <ul style="list-style-type: none"> - \$__ to \$__ [or __% to __% of the cost] for each routine visit up to __ visit(s) <p><i>OR</i></p> <ul style="list-style-type: none"> - \$__ to \$__ [or __% to __% of the cost] for each routine visit 	
<p>You pay \$__ to \$__ [or __% to __% of the cost] for out of network podiatry services.</p>	<p><i>Sentence for PPOs only</i></p>
<p align="center">11 OUTPATIENT MENTAL HEALTH CARE</p>	
<p>There is no copayment for each Medicare-covered visit for Mental Health services.</p>	
<p>For Medicare-covered Mental Health services, you pay \$__ [or __% of the cost] for each individual therapy visit.</p>	
<p>For Medicare-covered Mental Health services, you pay:</p> <ul style="list-style-type: none"> - \$__ [or __% of the cost] for each individual therapy visit(s) __ - __ - \$__ [or __% of the cost] for each individual therapy visit(s) __ - __ - \$__ [or __% of the cost] for each individual therapy visit(s) __ - __ (-999 = 'and beyond') 	
<p>For Medicare-covered Mental Health services, you pay \$__ [or __% of the cost] for each group therapy visit.</p>	

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<p>For Medicare-covered Mental Health services, you pay: - \$__ [or __% of the cost] for each group therapy visit(s) __-__ - \$__ [or __% of the cost] for each group therapy visit(s) __-__ - \$__ [or __% of the cost] for each group therapy visit(s) __-__ (-999 = 'and beyond')</p>	
<p>For Medicare-covered Mental Health services, you pay \$__ [or __% of the cost] for each individual/group therapy visit.</p>	
<p>For Medicare-covered Mental Health services, you pay: - \$__ [or __% of the cost] for each individual/group therapy visit(s) __-__ - \$__ [or __% of the cost] for each individual/group therapy visit(s) __-__ - \$__ [or __% of the cost] for each individual/group therapy visit(s) __-__ (-999 = 'and beyond')</p>	
<p>You pay \$__ to \$__ [or __% to __% of the cost] for out of network Mental Health services.</p>	<p><i>Sentence for PPOs only</i></p>
<p>There is no copayment for each Medicare-covered visit for Mental Health services with a psychiatrist.</p>	
<p>For Medicare-covered Mental Health services with a psychiatrist, you pay \$__ [or __% of the cost] for each individual therapy visit.</p>	
<p>For Medicare-covered Mental Health services with a psychiatrist, you pay: - \$__ [or __% of the cost] for each individual therapy visit(s) __-__ - \$__ [or __% of the cost] for each individual therapy visit(s) __-__ - \$__ [or __% of the cost] for each individual therapy visit(s) __-__ (-999 = 'and beyond')</p>	

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<p>For Medicare-covered Mental Health services with a psychiatrist, you pay \$ ___ [or ___ % of the cost] for each group therapy visit.</p>	
<p>For Medicare-covered Mental Health services with a psychiatrist, you pay: - \$ ___ [or ___ % of the cost] for each group therapy visit(s) ___ - ___ - \$ ___ [or ___ % of the cost] for each group therapy visit(s) ___ - ___ - \$ ___ [or ___ % of the cost] for each group therapy visit(s) ___ - ___ (-999 = 'and beyond')</p>	
<p>For Medicare-covered Mental Health services with a psychiatrist, you pay \$ ___ [or ___ % of the cost] for each individual/group therapy visit.</p>	
<p>For Medicare-covered Mental Health services with a psychiatrist, you pay: - \$ ___ [or ___ % of the cost] for each individual/group therapy visit(s) ___ - ___ - \$ ___ [or ___ % of the cost] for each individual/group therapy visit(s) ___ - ___ - \$ ___ [or ___ % of the cost] for each individual/group therapy visit(s) ___ - ___ (-999 = 'and beyond')</p>	
<p>You pay \$ ___ to \$ ___ [or ___ % to ___ % of the cost] for out of network Mental Health services with a psychiatrist.</p>	<p><i>Sentence for PPOs only</i></p>
<p>Authorization rules may apply for services. Contact plan for details.</p>	
<p>12 OUTPATIENT SUBSTANCE ABUSE CARE</p>	
<p>There is no copayment for each Medicare-covered visit.</p>	
<p>For Medicare-covered services, you pay \$ ___ [or ___ % of the cost] for each individual visit.</p>	

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<p>For Medicare-covered services, you pay: - \$__ [or __% of the cost] for each individual visit(s) __-__ - \$__ [or __% of the cost] for each individual visit(s) __-__ - \$__ [or __% of the cost] for each individual visit(s) __-__ (-999 = 'and beyond')</p>	
<p>For Medicare-covered services, you pay \$__ [or __% of the cost] for each group visit.</p>	
<p>For Medicare-covered services, you pay: - \$__ [or __% of the cost] for each group visit(s) __-__ - \$__ [or __% of the cost] for each group visit(s) __-__ - \$__ [or __% of the cost] for each group visit(s) __-__ (-999 = 'and beyond')</p>	
<p>For Medicare-covered services, you pay \$__ [or __% of the cost] for each individual/group visit.</p>	
<p>For Medicare-covered services, you pay: - \$__ [or __% of the cost] for each individual/group visit(s) __-__ - \$__ [or __% of the cost] for each individual/group visit(s) __-__ - \$__ [or __% of the cost] for each individual/group visit(s) __-__ (-999 = 'and beyond')</p>	
<p>An additional facility charge may be included in the cost for services.</p>	
<p>You pay \$__ to \$__ [or __% to __% of the cost] for out of network outpatient substance abuse services.</p>	<p><i>Sentence for PPOs only</i></p>
<p>Authorization rules may apply for services. Contact plan for details.</p>	

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13 OUTPATIENT SERVICES/SURGERY	
<p>There is no copayment for each Medicare-covered visit to an ambulatory surgical center. <i>OR</i> You pay \$__ to \$__ [or __% to __% of the cost] for each Medicare-covered visit to an ambulatory surgical center.</p>	
<p>There is no copayment for each Medicare-covered visit to an outpatient hospital facility. <i>OR</i> You pay \$__ to \$__ [or __% to __% of the cost] for each Medicare-covered visit to an outpatient hospital facility.</p>	
<p>An additional facility charge may be included in the cost for services.</p>	
<p>You pay \$__ to \$__ [or __% to __% of the cost] for services at an out of network ambulatory surgical center.</p>	<i>Sentence for PPOs only</i>
<p>You pay \$__ to \$__ [or __% to __% of the cost] for services at an out of network outpatient hospital facility.</p>	<i>Sentence for PPOs only</i>
<p>Authorization rules may apply for services. Contact plan for details.</p>	

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14 AMBULANCE SERVICES	
There is no copayment for Medicare-covered ambulance services.	
You pay ___% of the cost for Medicare-covered ambulance services. ; you do not pay this amount if you are admitted to the hospital. <i>AND/OR</i> You pay \$__ for Medicare-covered ambulance services. ; you do not pay this amount if you are admitted to the hospital.	
You pay \$__ to \$__ [or __% to __% of the cost] for out of network ambulance services.	<i>Sentence for PPOs only</i>

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15 EMERGENCY CARE	
<p>There is no copayment for each Medicare-covered emergency room visit. <i>OR</i> You pay ___% to ___ % of the cost (up to \$50) for each Medicare-covered emergency room visit. <i>AND/OR</i> You pay \$__ to \$__ for each Medicare-covered emergency room visit.</p>	<i>Delete '(up to \$50)' for Cost Plans (see below)</i>
<p>You pay ___% to ___ % of the cost for each Medicare-covered emergency room visit. <i>AND/OR</i> You pay \$__ to \$__ for each Medicare-covered emergency room visit.</p>	<i>Sentence for Cost Plans only</i>
<p>; you do not pay this amount if you are admitted to the hospital within __ day(s) [or __ hour(s)] for the same condition. <i>OR</i> ; you do not pay this amount if you are immediately admitted to the hospital.</p>	
<p>NOT covered outside the U.S. except under limited circumstances. <i>OR</i> Worldwide coverage.</p>	

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16 URGENTLY NEEDED CARE	
<p>There is no copayment for each Medicare-covered urgently needed care visit. <i>OR</i> You pay ___% to ___% of the cost for each Medicare-covered urgently needed care visit. <i>AND/OR</i> You pay \$__ to \$__ for each Medicare-covered urgently needed care visit.</p>	
<p>; you do not pay this amount if you are admitted to the hospital within __ day(s) [or __ hour(s)] for the same condition. <i>OR</i> ; you do not pay this amount if you are immediately admitted to the hospital.</p>	
<p>You pay \$__ to \$__ [or ___% to ___% of the cost] for out of network urgent care services.</p>	<i>Sentence for PPOs only</i>
<p>NOT covered outside the U.S. except under limited circumstances. <i>OR</i> Worldwide coverage.</p>	

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17 OUTPATIENT REHABILITATION SERVICES	
<p>There is no copayment for each Medicare-covered Occupational Therapy visit. <i>OR</i> You pay \$__ to \$___ [or __% to __% of the cost] for each Medicare-covered Occupational Therapy visit.</p>	
<p>There is no copayment for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit. <i>OR</i> You pay \$__ to \$___ [or __% to __% of the cost] for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit.</p>	
An additional facility charge may be included in the cost for services.	
You pay \$__ to \$__ [or __% to __% of the cost] for out of network Occupational Therapy services.	<i>Sentence for PPOs only</i>
You pay \$__ to \$__ [or __% to __% of the cost] for out of network Physical Therapy and/or Speech language therapy services.	<i>Sentence for PPOs only</i>
Authorization rules may apply for services. Contact plan for details	

18 DURABLE MEDICAL EQUIPMENT	
<p>There is no copayment for Medicare-covered items. <i>OR</i> You pay \$__ to \$___ [or __% to __% of the cost] for each Medicare-covered item.</p>	
<p>You pay \$__ to \$__ [or __% to __% of the cost] for durable medical equipment purchased out of network.</p>	<i>Sentence for PPOs only</i>
<p>If you do not notify the plan of an equipment or device purchase over \$___, you will have to pay __% of the billed charges. Contact plan for additional information.</p>	<i>Sentences for PFFS only</i>
<p>Authorization rules may apply for services. Contact plan for details</p>	
19 PROSTHETIC DEVICES	
<p>There is no copayment for Medicare-covered items. <i>OR</i> You pay \$__ to \$___ [or __% to __% of the cost] for each Medicare-covered item.</p>	
<p>You pay \$__ to \$__ [or __% to __% of the cost] for prosthetic devices purchased out of network.</p>	<i>Sentence for PPOs only</i>
<p>If you do not notify the plan of an equipment or device purchase over \$___, you will have to pay __% of the billed charges. Contact plan for additional information.</p>	<i>Sentences for PFFS only</i>

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20 DIABETES SELF-MONITORING TRAINING AND SUPPLIES	
<p>There is no copayment for Diabetes self-monitoring training. <i>OR</i> You pay \$___ to \$___ [or ___% to ___% of the cost] for Medicare-covered Diabetes self-monitoring training.</p>	
<p>You pay \$___ to \$___ [or ___% to ___% of the cost] for out of network Diabetes self-monitoring training.</p>	<i>Sentence for PPOs only</i>
<p>There is no copayment for Diabetes supplies. <i>OR</i> You pay \$___ to \$___ [or ___% to ___% of the cost] for each Medicare-covered Diabetes Supply item.</p>	
<p>You pay \$___ to \$___ [or ___% to ___% of the cost] for each Diabetes Supply item purchased out of network.</p>	<i>Sentence for PPOs only</i>

21 DIAGNOSTIC TESTS, X-RAYS, AND LAB SERVICES	
<p>There is no copayment for the following Medicare-covered service(s):</p> <ul style="list-style-type: none"> - clinical/diagnostic lab services - radiation therapy - X-ray visits 	
<p>You pay:</p> <ul style="list-style-type: none"> - \$__ to \$ __ [or __% to __% of the cost] for each Medicare-covered clinical/diagnostic lab service - \$__ to \$ __ [or __% to __% of the cost] for each Medicare-covered radiation therapy service - \$__ to \$ __ [or __% to __% of the cost] for each Medicare-covered X-ray visit 	
<p>An additional facility charge may be included in the cost for services.</p>	
<p>(You pay:)</p> <ul style="list-style-type: none"> - \$__ to \$ __ [or __% to __% of the cost] for each out of network clinical/diagnostic lab service - \$__ to \$ __ [or __% to __% of the cost] for each out of network radiation therapy service - \$__ to \$ __ [or __% to __% of the cost] for out of network X-ray services 	<i>Sentence for PPOs only</i>

22 BONE MASS MEASUREMENT	
<p>There is no copayment for each Medicare-covered Bone Mass Measurement. <i>OR</i> You pay \$___ [or ___% of the cost] for each Medicare-covered Bone Mass Measurement.</p>	
An additional facility charge may be included in the cost for services.	
You pay \$__ to \$__ [or __% to __% of the cost] for each out of network Bone Mass measurement.	<i>Sentence for PPOs only</i>
23 COLORECTAL SCREENING EXAMS	
There is no copayment for Medicare-covered Colorectal Screening Exams.	
You pay \$__ to \$__ [or __% to __% of the cost] for each Medicare-covered Colorectal Screening exam.	

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<p>There is no copayment for:</p> <ul style="list-style-type: none"> - Medicare-covered Colorectal Screening Exams -additional screening exams <i>OR</i> - additional screening exams up to ___ exam(s) every (<i>Specified period</i>) <i>OR</i> - additional screening exams up to ___ exam(s) 	
<p>You pay:</p> <ul style="list-style-type: none"> - \$__ to \$__ [or __% to __% of the cost] for each Medicare-covered Colorectal Screening exam. - \$__ to \$__ [or __% to __% of the cost] for each additional screening exam up to exam(s) every (<i>Specified period</i>) <i>OR</i> - \$__ to \$__ [or __% to __% of the cost] for each additional screening exam up to __ exam(s) <i>OR</i> - \$__ to \$__ [or __% to __% of the cost] for each additional screening exam 	
<p>An additional facility charge may be included in the cost for services.</p>	
<p>You pay \$__ to \$__ [or __% to __% of the cost] for each out of network Colorectal Screening exam.</p>	<p><i>Sentence for PPOs only</i></p>
<p>You are covered for an unlimited number of Colorectal Screening exams.</p>	

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24 IMMUNIZATIONS	
There is no copayment for the Pneumonia and Flu vaccines.	
There is no copayment for the Hepatitis B vaccine. <i>OR</i> You pay \$___ [or ___% of the cost] for the Hepatitis B vaccine.	
You pay \$__ to \$__ [or __% to __% of the cost] for each out of network Immunization.	<i>Sentence for PPOs only</i>
No referral necessary for Medicare-covered influenza and pneumonia vaccines.	<i>Delete sentence for PFFS</i>
No referral necessary for other immunizations. <i>OR</i> Referral required for other immunizations. Please check with your plan for details.	<i>Delete sentence for PFFS</i>

25 MAMMOGRAMS (ANNUAL SCREENING)	
There is no copayment for Medicare-covered Screening Mammograms.	
<p>There is no copayment for:</p> <ul style="list-style-type: none"> - Medicare-covered screening mammograms - additional screening mammograms <p><i>OR</i></p> <ul style="list-style-type: none"> - additional screening mammograms up to __ mammogram(s) <p><i>OR</i></p> <ul style="list-style-type: none"> - additional screening mammograms up to __ mammogram(s) every (<i>Specified period</i>) 	
<p>You pay:</p> <ul style="list-style-type: none"> - \$__ to \$__ [or __% of the cost] for each Medicare-covered Screening Mammogram - \$__ [or __% of the cost] for each additional screening mammogram <p><i>OR</i></p> <ul style="list-style-type: none"> - \$__ [or __% of the cost] for each additional screening mammogram up to __ mammogram(s) <p><i>OR</i></p> <ul style="list-style-type: none"> - \$__ [or __% of the cost] for each additional screening mammogram up to __ mammogram(s) every (<i>Specified period</i>) 	
You pay \$__ to \$__ [or __% to __% of the cost] for each out of network Screening Mammogram.	<i>Sentence for PPOs only</i>
An additional facility charge may be included in the cost for services.	
You are covered for an unlimited number of Screening Mammograms.	

26 PAP SMEARS AND PELVIC EXAMS	
There is no copayment for Medicare-covered Pap Smears and Pelvic Exams.	
There is no copayment for: - Medicare-covered Pap Smears and Pelvic Exams - additional Pap Smears - additional Pelvic Exams - additional Pap Smears and Pelvic Exams <i>OR</i> - additional Pap Smears up to __ Pap Smear(s) - additional Pelvic Exams up to __ Pelvic Exam(s) - additional Pap Smears and Pelvic Exams up to __ Pap Smear(s) and Pelvic Exam(s) <i>OR</i> - additional Pap Smears up to __ Pap Smear(s) every (<i>Specified period</i>) - additional Pelvic Exams up to __ Pelvic Exam(s) every (<i>Specified period</i>) - additional Pap Smears and Pelvic Exams up to __ Pap Smear(s) and Pelvic Exam(s) every (<i>Specified period</i>)	

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<p>You pay:</p> <ul style="list-style-type: none"> - \$ ___ [or ___ % of the cost] for each Medicare-covered Pap Smear - \$ ___ [or ___ % of the cost] for each Medicare-covered Pelvic Exam - \$ ___ [or ___ % of the cost] for each Medicare-covered Pap Smear and Pelvic Exam - \$ ___ [or ___ % of the cost] for each additional Pap Smear up to ___ Pap Smear(s) every <i>(Specified period)</i> - \$ ___ [or ___ % of the cost] for each additional Pelvic Exam up to ___ Pelvic Exam(s) every <i>(Specified period)</i> - \$ ___ [or ___ % of the cost] for each additional Pap Smear and Pelvic Exam up to ___ Pap Smear(s) and Pelvic Exam(s) every <i>(Specified period)</i> <p><i>OR</i></p> <ul style="list-style-type: none"> - \$ ___ [or ___ % of the cost] for each additional Pap Smear up to ___ Pap Smear(s) - \$ ___ [or ___ % of the cost] for each additional Pelvic Exam up to ___ Pelvic Exam(s) - \$ ___ [or ___ % of the cost] for each additional Pap Smear and Pelvic Exam up to ___ Pap Smear(s) and Pelvic Exam(s) <p><i>OR</i></p> <ul style="list-style-type: none"> - \$ ___ [or ___ % of the cost] for each additional Pap Smear - \$ ___ [or ___ % of the cost] for each additional Pelvic Exam - \$ ___ [or ___ % of the cost] for each additional Pap Smear and Pelvic Exam 	
<p>An additional facility charge may be included in the cost for services.</p>	
<p>You pay \$ ___ to \$ ___ [or ___ % to ___ % of the cost] for each out of network Pap Smear and Pelvic Exam.</p>	<p><i>Sentence for PPOs only</i></p>
<p>You are covered for an unlimited number of Pap Smears. You are covered for an unlimited number of Pelvic Exams. <i>OR</i> You are covered for an unlimited number of Pap Smears and Pelvic Exams.</p>	

27 PROSTATE CANCER SCREENING EXAM	
There is no copayment for Medicare-covered Prostate Cancer Screening exams.	
You pay \$__ [or __% of the cost] for each Medicare-covered Prostate Cancer Screening Exam.	
<p>There is no copayment for:</p> <ul style="list-style-type: none"> - Medicare-covered Prostate Cancer Screening Exams - additional screening exams <p><i>OR</i></p> <ul style="list-style-type: none"> - additional screening exams up to __ exam(s) <p><i>OR</i></p> <ul style="list-style-type: none"> - additional screening exams up to __ exam(s) every (<i>Specified period</i>) 	
<p>You pay:</p> <ul style="list-style-type: none"> - \$__ [or __% of the cost] for each Medicare-covered Prostate Cancer Screening Exam. <ul style="list-style-type: none"> - \$__ [or __% of the cost] for each additional screening exam up to __ exam(s) every (<i>Specified period</i>) <p><i>OR</i></p> <ul style="list-style-type: none"> - \$__ [or __% of the cost] for each additional screening exam up to __ exam(s) <p><i>OR</i></p> <ul style="list-style-type: none"> - \$__ [or __% of the cost] for each additional screening exam 	

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An additional facility charge may be included in the cost for services.	
You pay \$__ to \$__ [or __% to __% of the cost] for each out of network Prostate Screening Exam.	<i>Sentence for PPOs only</i>
You are covered for an unlimited number of Prostate Cancer Screening exams.	
28 OUTPATIENT PRESCRIPTION DRUGS	
You pay 100% for most prescription drugs.	
You pay a deductible of \$__.	
29 DENTAL SERVICES	
In general, you pay 100% for dental services.	

<p>There is no copayment for the following:</p> <ul style="list-style-type: none">- oral exams- cleanings- fluoride treatments- dental x-rays <p><i>OR</i></p> <ul style="list-style-type: none">- oral exams up to __ visit(s)- cleanings up to __ visit(s)- fluoride treatments up to __ visit(s)- dental x-rays up to __ visit(s) <p><i>OR</i></p> <ul style="list-style-type: none">- oral exams up to __ visit(s) every (<i>Specified period</i>)- cleanings up to __ visit(s) every (<i>Specified period</i>)- fluoride treatments up to __ visit(s) every (<i>Specified period</i>)- dental x-rays up to __ visit(s) every (<i>Specified period</i>)	
<p>You pay:</p> <p>- \$__ [or __% of the cost] for an Office Visit that includes the following services:</p> <ul style="list-style-type: none">- oral exams- cleanings- fluoride treatments- dental x-rays <p><i>OR</i></p> <ul style="list-style-type: none">- oral exams up to __ visit(s)- cleanings up to __ visit(s)- fluoride treatments up to __ visit(s)- dental x-rays up to __ visit(s) <p><i>OR</i></p> <ul style="list-style-type: none">- oral exams up to __ visit(s) every (<i>Specified period</i>)- cleanings up to __ visit(s) every (<i>Specified period</i>)- fluoride treatments up to __ visit(s) every (<i>Specified period</i>)	

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<p>- dental x-rays up to __ visit(s) every (<i>Specified period</i>) <i>OR</i> - \$__ to \$__ [or __% to __% of the cost] for each oral exam - \$__ to \$__ [or __% to __% of the cost] for each cleaning - \$__ to \$__ [or __% to __% of the cost] for each fluoride treatment - \$__ to \$__ [or __% to __% of the cost] for dental x-rays <i>OR</i> - \$__ to \$__ [or __% to __% of the cost] for each oral exam up to __ visit(s) - \$__ to \$__ [or __% to __% of the cost] for each cleaning up to __ visit(s) - \$__ to \$__ [or __% to __% of the cost] for each fluoride treatment up to __ visit(s) - \$__ to \$__ [or __% to __% of the cost] for dental x-rays up to __ visit(s) <i>OR</i> - \$__ to \$__ [or __% to __% of the cost] for each oral exam up to __ visit(s) every (<i>Specified period</i>) - \$__ to \$__ [or __% to __% of the cost] for each cleaning up to __ visit(s) every (<i>Specified period</i>) - \$__ to \$__ [or __% to __% of the cost] for each fluoride treatment up to __ visit(s) every (<i>Specified period</i>) - \$__ to \$__ [or __% to __% of the cost] for dental x-rays up to __ visit(s) every (<i>Specified period</i>)</p>	
<p>You pay \$__ to \$__ [or __% to __% of the cost] for out of network Preventive dental services. You pay \$__ to \$__ [or __% to __% of the cost] for out of network Comprehensive dental services.</p>	<p><i>Sentence for PPOs only</i></p>
<p>You are covered up to \$__ for Preventive dental services every (<i>Specified period</i>). <i>OR</i> You are covered up to \$__ for Preventive dental services.</p>	
<p>You are covered up to \$__ for Comprehensive dental services every (<i>Specified period</i>).</p>	

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<p><i>OR</i> You are covered up to \$___ for Comprehensive dental services.</p>	
<p>You are covered up to \$___ for dental services every (<i>Specified period</i>). <i>OR</i> You are covered up to \$___ for dental services.</p>	
<p>Additional dental benefits are available.</p>	
<p>30 HEARING SERVICES</p>	
<p>In general, you pay 100% for routine hearing exams and hearing aids.</p>	
<p>You pay 100% for hearing aids.</p>	
<p>There is no copayment for the following services:</p> <ul style="list-style-type: none"> - Medicare-covered hearing exams (diagnostic hearing exams) - routine hearing tests - fittings-evaluations for a hearing aid <p><i>OR</i></p> <ul style="list-style-type: none"> - routine hearing tests up to __ visit(s) - fittings-evaluations for a hearing aid up to __ visit(s) <p><i>OR</i></p> <ul style="list-style-type: none"> - routine hearing tests up to __ visit(s) every (<i>Specified period</i>) - fittings-evaluations for a hearing aid up to __ visit(s) every (<i>Specified period</i>) 	

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<p>There is no copayment for hearing aids. <i>OR</i> There is no copayment for hearing aids up to __ aid(s). <i>OR</i> There is no copayment for hearing aids up to __ aid(s) every (<i>Specified period</i>).</p>	
<p>There is no copayment for the following items:</p> <ul style="list-style-type: none">- hearing aids-inner ear- hearing aids-outer ear- hearing aids-over the ear <p><i>OR</i></p> <ul style="list-style-type: none">- hearing aids-inner ear up to __ aid(s)- hearing aids-outer ear up to __ aid(s)- hearing aids-over the ear up to __ aid(s) <p><i>OR</i></p> <ul style="list-style-type: none">- hearing aids-inner ear up to __ aid(s) every (<i>Specified period</i>)- hearing aids-outer ear up to __ aid(s) every (<i>Specified period</i>)- hearing aids-over the ear up to __ aid(s) every (<i>Specified period</i>)	
<p>You pay:</p> <ul style="list-style-type: none">- \$__ [or __% of the cost] for each Medicare-covered hearing exam (diagnostic hearing exams)- \$__ to \$__ [or __% to __% of the cost] for each routine hearing test- \$__ to \$__ [or __% to __% of the cost] for each fitting-evaluation for a hearing aid <p><i>OR</i></p> <ul style="list-style-type: none">- \$__ to \$__ [or __% to __% of the cost] for each routine hearing test up to __ test(s)- \$__ to \$__ [or __% to __% of the cost] for each fitting-evaluation for a hearing aid up to __ fitting(s)-evaluation(s) <p><i>OR</i></p> <ul style="list-style-type: none">- \$__ to \$__ [or __% to __% of the cost] for each routine hearing test up to __ test(s) every (<i>Specified period</i>)- \$__ to \$__ [or __% to __% of the cost] for each fitting-evaluation for a hearing aid	

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<p>up to __ fitting(s)-evaluation(s) every (<i>Specified period</i>)</p>	
<p>(You pay:) - \$ __ to \$ __ [or __% to __% of the cost] for out of network hearing exams.</p>	<p><i>Sentence for PPOs only</i></p>
<p>- \$ __ to \$ __ [or __% of the cost] for each hearing aid - \$ __ [or __% of the cost] for each hearing aid-inner ear - \$ __ [or __% of the cost] for each hearing aid-outer ear - \$ __ [or __% of the cost] for each hearing aid-over the ear <i>OR</i> - \$ __ to \$ __ [or __% of the cost] for each hearing aid up to __ aid(s) - \$ __ [or __% of the cost] for each hearing aid-inner ear up to __ aid(s) - \$ __ [or __% of the cost] for each hearing aid-outer ear up to __ aid(s) - \$ __ [or __% of the cost] for each hearing aid-over the ear up to __ aid(s) <i>OR</i> - \$ __ to \$ __ [or __% of the cost] for each hearing aid up to __ aid(s) every (<i>Specified period</i>) - \$ __ [or __% of the cost] for each hearing aid-inner ear up to __ aid(s) every (<i>Specified period</i>) - \$ __ [or __% of the cost] for each hearing aid-outer ear up to __ aid(s) every (<i>Specified period</i>) - \$ __ [or __% of the cost] for each hearing aid-over the ear up to __ aid(s) every (<i>Specified period</i>)</p>	
<p>(You pay:) - \$ __ to \$ __ [or __% to __% of the cost] for out of network hearing aids.</p>	<p><i>Sentence for PPOs only</i></p>
<p>You are covered up to \$ __ for routine hearing tests every (<i>Specified period</i>). <i>OR</i> You are covered up to \$ __ for routine hearing tests.</p>	
<p>You are covered up to \$ __ for hearing aids every (<i>Specified period</i>).</p>	

<p><i>OR</i> You are covered up to \$ ___ for hearing aids.</p>	
<p>You are covered up to \$ ___ for routine hearing tests and hearing aids every <i>(Specified period)</i>. <i>OR</i> You are covered up to \$ ___ for routine hearing tests and hearing aids.</p>	
<p>31 VISION SERVICES</p>	
<p>You pay 100% for non-Medicare-covered eye exams and glasses.</p>	
<p>There is no copayment for the following services:</p> <ul style="list-style-type: none"> - Medicare-covered eye exams (diagnosis and treatment for diseases and conditions of the eye) - routine eye exams <p><i>OR</i></p> <ul style="list-style-type: none"> - routine eye exams up to ___ visit(s) <p><i>OR</i></p> <ul style="list-style-type: none"> - routine eye exams up to ___ visit(s) every <i>(Specified period)</i> 	

<p>There is no copayment for the following items:</p> <ul style="list-style-type: none">- Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery) - Glasses- Contacts- Lenses- Frames <p><i>OR</i></p> <ul style="list-style-type: none">- Glasses, limited to __ pair(s) of glasses- Contacts, limited to __ pair(s) of contacts- Lenses, limited to __ pair(s) of lenses- Frames, limited to __ frame(s) <p><i>OR</i></p> <ul style="list-style-type: none">- Glasses, limited to __ pair(s) of glasses every (<i>Specified period</i>)- Contacts, limited to __ pair(s) of contacts every (<i>Specified period</i>)- Lenses, limited to __ pair(s) of lenses every (<i>Specified period</i>)- Frames, limited to __ frame(s) every (<i>Specified period</i>)	
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<p>You pay:</p> <ul style="list-style-type: none"> - \$__ [or __% of the cost] for Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery) \$__ to \$__ [or __% to __% of the cost] for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye). - \$__ to \$__ [or __% to __% of the cost] for each routine eye exam <i>OR</i> - \$__ to \$__ [or __% to __% of the cost] for each routine eye exam, limited to ___ exams <i>OR</i> - \$__ to \$__ [or __% to __% of the cost] for each routine eye exam, limited to exam(s) every (<i>Specified period</i>) 	
<ul style="list-style-type: none"> - \$__ to \$__ [or __% to __% of the cost] for out of network eye exams 	<i>Sentence for PPOs only</i>
<ul style="list-style-type: none"> - \$ ___ [or __% of the cost] for glasses - \$ ___ [or __% of the cost] for contacts - \$ ___ [or __% of the cost] for lenses - \$ ___ [or __% of the cost] for frames <i>OR</i> - \$ ___ [or __% of the cost] for glasses, limited to ___ pair(s) of glasses - \$ ___ [or __% of the cost] for contacts, limited to ___ pair(s) of contacts - \$ ___ [or __% of the cost] for lenses, limited to ___ pair(s) of lenses - \$ ___ [or __% of the cost] for frames, limited to ___ frame(s) <i>OR</i> - \$ ___ [or __% of the cost] for glasses, limited to ___ pair(s) of glasses every (<i>Specified period</i>) - \$ ___ [or __% of the cost] for contacts, limited to ___ pair(s) of contacts every (<i>Specified period</i>) 	

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<p>- \$ ___ [or ___% of the cost] for lenses, limited to ___ pair(s) of lenses every (<i>Specified period</i>) - \$ ___ [or ___% of the cost] for frames, limited to ___ frame(s) every (<i>Specified period</i>)</p>	
<p>- \$ ___ to \$ ___ [or ___% to ___% of the cost] for out of network eye wear</p>	<p><i>Sentence for PPOs only</i></p>
<p>You are covered up to \$ ___ for eye exams every (<i>Specified period</i>). <i>OR</i> You are covered up to \$ ___ for eye exams.</p>	
<p>You are covered up to \$ ___ for eye wear every (<i>Specified period</i>). <i>OR</i> You are covered for \$ ___ for eye wear.</p>	
<p>You are covered up to \$ ___ for eye exams and eye wear every (<i>Specified period</i>). <i>OR</i> You are covered up to \$ ___ for eye exams and eye wear.</p>	
<p>Additional vision benefits are available.</p>	

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32 PHYSICAL EXAMS	
You pay \$__ [or __% of the cost] for Medicare covered services.	
You pay 100% for routine physical exams. <i>OR</i> There is no copayment for routine physical exams. <i>OR</i> You pay \$__ [or __% of the cost] for each exam.	
You pay \$__ to \$__ [or __% to __% of the cost] for each out of network routine physical exam.	<i>Sentence for PPOs only</i>
You are covered for an unlimited number of exams. <i>OR</i> You are covered up to __ exam(s). <i>OR</i> You are covered up to __ exam(s) every (<i>Specified period</i>).	

HEALTH/WELLNESS EDUCATION	
CATEGORY WILL NOT APPEAR IN SB REPORT <i>OR</i> You are covered for the following: <ul style="list-style-type: none">- Health Ed classes- Newsletter- Nutritional Training- Smoking Cessation- Congestive Heart Program- Alternative Medicine Program- Health Club Membership/ Fitness Classes- Nursing Hotline- Disease Management- Other Wellness Services	
Copayments may apply. Contact plan for details.	

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<p>TRANSPORTATION (Routine)</p>	
<p>CATEGORY WILL NOT APPEAR IN SB REPORT <i>OR</i> There is no copayment for each (one-way trip/round trip) to (Plan-approved location/Any location). <i>OR</i> There is no copayment for each (one-way trip/round trip) up to ___ trip(s) to (Plan-approved location/Any location). <i>OR</i> There is no copayment for each (one-way trip/round trip) up to ___trip(s) to (Plan-approved location/Any location) every (Specified period). <i>OR</i> You pay \$___ [or ___% of the cost] for each (one-way trip/round trip) to (Plan-approved location/Any location). <i>OR</i> You pay \$___ [or ___ % of the cost] for each (one-way trip/round trip) up to ___ trip(s) to (Plan-approved location/Any location). <i>OR</i> You pay \$___ [or ___% of the cost] for each (one-way trip/round trip) up to trip(s) to (Plan-approved location/Any location) every (Specified period).</p>	
<p>You pay \$__ to \$__ [or __% to __% of the cost] for out of network transportation services.</p>	<p><i>Sentence for PPOs only</i></p>

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ACUPUNCTURE	
<p>CATEGORY WILL NOT APPEAR IN SB REPORT <i>OR</i> There is no copayment for each acupuncture visit. <i>OR</i> There is no copayment for each acupuncture visit up to ____ visit(s). <i>OR</i> There is no copayment for each acupuncture visit up to ____ visit(s) every (<i>Specified period</i>). <i>OR</i> You pay \$__ [or __% of the cost] for each visit. <i>OR</i> You pay \$__ [or __% of the cost] for each visit up to ____ visit(s). <i>OR</i> You pay \$__ [or __% of the cost] for each visit up to ____ visit(s) every (<i>Specified period</i>).</p>	
<p>You pay \$__ to \$__ [or __% to __% of the cost] for each out of network acupuncture visit.</p>	<i>Sentence for PPOs only</i>
POINT OF SERVICE	
<p>CATEGORY WILL NOT APPEAR IN SB REPORT <i>OR</i> Point of Service is available for the following benefits: <i>(Selected categories from pick list).</i></p>	
<p>A referral may be necessary for the following Point of Service benefits: <i>(Selected categories from pick list).</i></p>	

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<p>There is no copayment for Inpatient Hospital services received at a non-network hospital.</p>	<p><i>Delete 'non-network' for PFFS</i></p>
<p>You pay \$ ___ [or ___% of the cost] for each stay at a non-network hospital.</p>	<p><i>Delete 'non-network' for PFFS</i></p>
<p>You pay \$ ___ [or ___% of the cost] for each day at a non-network hospital.</p>	<p><i>Delete 'non-network' for PFFS</i></p>
<p>You pay: - \$ ___ [or ___% of the cost] for each day for day(s) ___ - ___ - \$ ___ [or ___% of the cost] for each day for day(s) ___ - ___ - \$ ___ [or ___% of the cost] for each day for day(s) ___ - ___ (-999 = 'and beyond') in a non-network hospital.</p>	<p><i>Delete 'non-network' for PFFS</i></p>
<p>There is no copayment for services received at a non-network Inpatient Psychiatric Hospital.</p>	<p><i>Delete 'non-network' for PFFS</i></p>
<p>You pay \$ ___ [or ___% of the cost] for each stay at a non-network Inpatient Psychiatric Hospital.</p>	<p><i>Delete 'non-network' for PFFS</i></p>
<p>You pay \$ ___ [or ___% of the cost] each day at a non-network Inpatient Psychiatric Hospital.</p>	<p><i>Delete 'non-network' for PFFS</i></p>
<p>You pay: - \$ ___ [or ___% of the cost] for each day for day(s) ___ - ___ - \$ ___ [or ___% of the cost] for each day for day(s) ___ - ___ - \$ ___ [or ___% of the cost] for each day for day(s) ___ - ___ (-999 = 'and beyond') at a non-network Inpatient Psychiatric Hospital.</p>	<p><i>Delete 'non-network' for PFFS</i></p>

OPTIONAL BENEFITS

PACKAGE ___

PREMIUM	
You pay \$__ each month, in addition to your monthly plan premium of \$__ and the Medicare Part B premium, for these optional benefits.	
CHIROPRACTIC SERVICES	
<p>There is no copayment for:</p> <ul style="list-style-type: none"> - routine visits OR - routine visits up to ___ visit(s) every <i>(Specified period)</i> OR - routine visits up to ___ visit(s) 	
<p>You pay:</p> <ul style="list-style-type: none"> - \$__ to \$__ [or __% to __% of the cost] for each routine visit up to ___ visit(s) every <i>(Specified period)</i> OR - \$__ to \$__ [or __% to __% of the cost] for each routine visit up to ___ visit(s) OR - \$__ to \$__ [or __% to __% of the cost] for each routine visit 	

PODIATRY SERVICES	
<p>There is no copayment for:</p> <ul style="list-style-type: none"> - routine visits <i>OR</i> - routine visits up to ___ visit(s) every (<i>Specified period</i>) <i>OR</i> - routine visits up to ___ visits 	
<p>You pay:</p> <ul style="list-style-type: none"> - \$__ to \$__ [or __% to __% of the cost] for each routine visit up to ___ visit(s) every (<i>Specified period</i>) <i>OR</i> - \$__ to \$__ [or __% to __% of the cost] for each routine visit up to ___ visit(s) <i>OR</i> - \$__ to \$__ [or __% to __% of the cost] for each routine visit 	

DENTAL SERVICES	
<p>There is no copayment for the following:</p> <ul style="list-style-type: none"> - oral exams - cleanings - fluoride treatments - dental x-rays <p><i>OR</i></p> <ul style="list-style-type: none"> - oral exams up to __ visit(s) - cleanings up to __ visit(s) - fluoride treatments up to __ visit(s) - dental x-rays up to __ visit(s) <p><i>OR</i></p> <ul style="list-style-type: none"> - oral exams up to __ visit(s) every (<i>Specified period</i>) - cleanings up to __ visit(s) every (<i>Specified period</i>) - fluoride treatments up to __ visit(s) every (<i>Specified period</i>) - dental x-rays up to __ visit(s) every (<i>Specified period</i>) 	
<p>You pay:</p> <ul style="list-style-type: none"> - \$__ [or __% of the cost] for an Office Visit that includes the following services: - oral exams - cleanings - fluoride treatments - dental x-rays <p><i>OR</i></p> <ul style="list-style-type: none"> - oral exams up to __ visit(s) - cleanings up to __ visit(s) - fluoride treatments up to __ visit(s) - dental x-rays up to __ visit(s) 	

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<p><i>OR</i></p> <ul style="list-style-type: none"> - oral exams up to __ visit(s) every (<i>Specified period</i>) - cleanings up to __ visit(s) every (<i>Specified period</i>) - fluoride treatments up to __ visit(s) every (<i>Specified period</i>) - dental x-rays up to __ visit(s) every (<i>Specified period</i>) <p><i>OR</i></p> <ul style="list-style-type: none"> - \$__ to \$__ [or __% to __% of the cost] for each oral exam - \$__ to \$__ [or __% to __% of the cost] for each cleaning - \$__ to \$__ [or __% to __% of the cost] for each fluoride treatment - \$__ to \$__ [or __% to __% of the cost] for dental x-rays <p><i>OR</i></p> <ul style="list-style-type: none"> - \$__ to \$__ [or __% to __% of the cost] for each oral exam up to __ visit(s) - \$__ to \$__ [or __% to __% of the cost] for each cleaning up to __ visit(s) - \$__ to \$__ [or __% to __% of the cost] for each fluoride treatment up to __ visit(s) - \$__ to \$__ [or __% to __% of the cost] for dental x-rays up to __ visit(s) <p><i>OR</i></p> <ul style="list-style-type: none"> - \$__ to \$__ [or __% to __% of the cost] for each oral exam up to __ visit(s) every (<i>Specified period</i>) - \$__ to \$__ [or __% to __% of the cost] for each cleaning up to __ visit(s) every (<i>Specified period</i>) - \$__ to \$__ [or __% to __% of the cost] for each fluoride treatment up to __ visit(s) every (<i>Specified period</i>) - \$__ to \$__ [or __% to __% of the cost] for dental x-rays up to __ visit(s) every (<i>Specified period</i>) 	
<p>You are covered up to \$__ for Preventive dental services every (<i>Specified period</i>).</p> <p><i>OR</i></p> <p>You are covered up to \$__ for Preventive dental services.</p>	
<p>You are covered up to \$__ for Comprehensive dental services every (<i>Specified period</i>).</p> <p><i>OR</i></p> <p>You are covered up to \$__ for Comprehensive dental services.</p>	

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<p>You are covered up to \$___ for dental services every (<i>Specified period</i>). <i>OR</i> You are covered up to \$___ for dental services.</p>	
<p>Additional dental benefits are available.</p>	
<p>HEARING SERVICES</p>	
<p>There is no copayment for the following services:</p> <ul style="list-style-type: none"> - routine hearing tests - fittings-evaluations for a hearing aid <i>OR</i> - routine hearing tests up to ___ visit(s) - fittings-evaluations for a hearing aid up to ___ visit(s) <i>OR</i> - routine hearing tests up to ___ visit(s) every (<i>Specified period</i>) - fittings-evaluations for a hearing aid up to ___ visit(s) every (<i>Specified period</i>) 	

<p>There is no copayment for hearing aids. <i>OR</i> There is no copayment for hearing aids up to __ aid(s). <i>OR</i> There is no copayment for hearing aids up to __ aid(s) every (<i>Specified period</i>).</p>	
<p>There is no copayment for the following items:</p> <ul style="list-style-type: none">- hearing aids-inner ear- hearing aids-outer ear- hearing aids-over the ear <p><i>OR</i></p> <ul style="list-style-type: none">- hearing aids-inner ear up to __ aid(s)- hearing aids-outer ear up to __ aid(s)- hearing aids-over the ear up to __ aid(s) <p><i>OR</i></p> <ul style="list-style-type: none">- hearing aids-inner ear up to __ aid(s) every (<i>Specified period</i>)- hearing aids-outer ear up to __ aid(s) every (<i>Specified period</i>)- hearing aids-over the ear up to __ aid(s) every (<i>Specified period</i>)	
<p>You pay:</p> <ul style="list-style-type: none">- \$__ to \$__ [or __% to __% of the cost] for each routine hearing test- \$__ to \$__ [or __% to __% of the cost] for each fitting-evaluation for a hearing aid <p><i>OR</i></p> <ul style="list-style-type: none">- \$__ to \$__ [or __% to __% of the cost] for each routine hearing test up to __ test(s)- \$__ to \$__ [or __% to __% of the cost] for each fitting-evaluation for a hearing aid up to __ fitting(s)-evaluation(s) <p><i>OR</i></p> <ul style="list-style-type: none">- \$__ to \$__ [or __% to __% of the cost] for each routine hearing test up to __ test(s) every (<i>Specified period</i>)- \$__ to \$__ [or __% to __% of the cost] for each fitting-evaluation for a hearing aid up to __ fitting(s)-evaluation(s) every (<i>Specified period</i>)	

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<p>- \$__ to \$__ [or __% of the cost] for each hearing aid - \$__ [or __% of the cost] for each hearing aid-inner ear - \$__ [or __% of the cost] for each hearing aid-outer ear - \$__ [or __% of the cost] for each hearing aid-over the ear <i>OR</i> - \$__ to \$__ [or __% of the cost] for each hearing aid up to __ aid(s) - \$__ [or __% of the cost] for each hearing aid-inner ear up to __ aid(s) - \$__ [or __% of the cost] for each hearing aid-outer ear up to __ aid(s) - \$__ [or __% of the cost] for each hearing aid-over the ear up to __ aid(s) <i>OR</i> - \$__ to \$__ [or __% of the cost] for each hearing aid up to __ aid(s) every (<i>Specified period</i>) - \$__ [or __% of the cost] for each hearing aid-inner ear up to __ aid(s) every (<i>Specified period</i>) - \$__ [or __% of the cost] for each hearing aid-outer ear up to __ aid(s) every (<i>Specified period</i>) - \$__ [or __% of the cost] for each hearing aid-over the ear] up to __ aid(s) every (<i>Specified period</i>)</p>	
<p>You are covered up to \$__ for routine hearing tests every (<i>Specified period</i>). <i>OR</i> You are covered up to \$__ for routine hearing tests.</p>	
<p>You are covered up to \$__ for hearing aids every (<i>Specified period</i>). <i>OR</i> You are covered up to \$__ for hearing aids.</p>	
<p>You are covered up to \$__ for routine hearing tests and hearing aids every (<i>Specified period</i>). <i>OR</i> You are covered up to \$__ for routine hearing tests and hearing aids.</p>	

VISION SERVICES	
There is no copayment for the following services: - routine eye exams <i>OR</i> - routine eye exams up to __ visit(s) <i>OR</i> - routine eye exams up to __ visit(s) every (<i>Specified period</i>)	

<p>There is no copayment for the following items:</p> <ul style="list-style-type: none">- Glasses- Contacts- Lenses- Frames <p><i>OR</i></p> <ul style="list-style-type: none">- Glasses, limited to __ pair(s) of glasses- Contacts, limited to __ pair(s) of contacts- Lenses, limited to __ pair(s) of lenses- Frames, limited to __ frame(s) <p><i>OR</i></p> <ul style="list-style-type: none">- Glasses, limited to __ pair(s) of glasses every (<i>Specified period</i>)- Contacts, limited to __ pair(s) of contacts every (<i>Specified period</i>)- Lenses, limited to __ pair(s) of lenses every (<i>Specified period</i>)- Frames, limited to __ frame(s) every (<i>Specified period</i>)	
<p>You pay:</p> <ul style="list-style-type: none">- \$__ to __ [or __% to __% of the cost] for each routine eye exam <p><i>OR</i></p> <ul style="list-style-type: none">- \$__ to __ [or __% to __% of the cost] for each routine eye exam, limited to __ exams <p><i>OR</i></p> <ul style="list-style-type: none">- \$__ to __ [or __% to __% of the cost] for each routine eye exam, limited to exam(s) every (<i>Specified period</i>) <ul style="list-style-type: none">- \$ __ [or __% of the cost] for glasses- \$ __ [or __% of the cost] for contacts- \$ __ [or __% of the cost] for lenses- \$ __ [or __% of the cost] for frames <p><i>OR</i></p> <ul style="list-style-type: none">- \$ __ [or __% of the cost] for glasses, limited to __ pair(s) of glasses- \$ __ [or __% of the cost] for contacts, limited to __ pair(s) of contacts	

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<p>- \$ ___ [or ___% of the cost] for lenses, limited to ___ pair(s) of lenses - \$ ___ [or ___% of the cost] for frames, limited to ___ frame(s) <i>OR</i> - \$ ___ [or ___% of the cost] for glasses, limited to ___ pair(s) of glasses every <i>(Specified period)</i> - \$ ___ [or ___% of the cost] for contacts, limited to ___ pair(s) of contacts every <i>(Specified period)</i> - \$ ___ [or ___% of the cost] for lenses, limited to ___ pair(s) of lenses every <i>(Specified period)</i> - \$ ___ [or ___% of the cost] for frames, limited to ___ frame(s) every <i>(Specified period)</i></p>	
<p>You are covered up to \$ ___ for eye exams every <i>(Specified period)</i>. <i>OR</i> You are covered up to \$ ___ for eye exams.</p>	
<p>You are covered up to \$ ___ for eye wear every <i>(Specified period)</i>. <i>OR</i> You are covered for \$ ___ for eye wear.</p>	
<p>You are covered up to \$ ___ for eye exams and eye wear every <i>(Specified period)</i>. <i>OR</i> You are covered up to \$ ___ for eye exams and eye wear.</p>	
<p>Additional vision benefits are available.</p>	

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TRANSPORTATION (Routine)	
<p>There is no copayment for each (one-way trip/round trip) to (Plan-approved location/Any location). <i>OR</i> There is no copayment for each (one-way trip/round trip) up to ___ trip(s) to (Plan-approved location/Any location). <i>OR</i> There is no copayment for each (one-way trip/round trip) up to ___ trip(s) to (Plan-approved location/Any location) every (Specified period). <i>OR</i> You pay \$___ [or ___% of the cost] for each (one-way trip/round trip) to (Plan-approved location/Any location). <i>OR</i> You pay \$___ [or ___ % of the cost] for each (one-way trip/round trip) up to ___ trip(s) to (Plan-approved location/Any location). <i>OR</i> You pay \$___ [or ___% of the cost] for each (one-way trip/round trip) up to trip(s) to (Plan-approved location/Any location) every (Specified period).</p>	
POINT OF SERVICE	
<p>Point of Service is available for the following benefits: <i>(Selected categories from pick list).</i></p>	
<p>A referral may be necessary for the following Point of Service benefits: <i>(Selected categories from pick list).</i></p>	
There is no copayment for Inpatient Hospital services received at a non-network	<i>Delete 'non-network' for PFFS</i>

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hospital.	
You pay \$___ [or ___% of the cost] for each stay at a non-network hospital.	<i>Delete 'non-network' for PFFS</i>
You pay \$___ [or ___% of the cost] for each day at a non-network hospital.	<i>Delete 'non-network' for PFFS</i>
You pay: - \$___ [or ___% of the cost] for each day for day(s) __-__ - \$___ [or ___% of the cost] for each day for day(s) __-__ - \$___ [or ___% of the cost] for each day for day(s) __-__ (-999 = 'and beyond') at a non-network hospital.	<i>Delete 'non-network' for PFFS</i>
There is no copayment for services at a non-network Inpatient Psychiatric Hospital.	<i>Delete 'non-network' for PFFS</i>
You pay \$___ [or ___% of the cost] for each stay at a non-network Inpatient Psychiatric Hospital.	<i>Delete 'non-network' for PFFS</i>
You pay \$___ [or ___% of the cost] each day at a non-network Inpatient Psychiatric Hospital.	<i>Delete 'non-network' for PFFS</i>
You pay: - \$___ [or ___% of the cost] for each day for day(s) __-__ - \$___ [or ___% of the cost] for each day for day(s) __-__ - \$___ [or ___% of the cost] for each day for day(s) __-__ (-999 = 'and beyond') at a non-network Inpatient Psychiatric Hospital.	<i>Delete 'non-network' for PFFS</i>

Specific sentences for Part B Only Plans

3 INPATIENT HOSPITAL CARE	
You pay 100% for each hospital stay.	
You are covered for __ days every <i>specified period</i>. <i>OR</i> You are covered for unlimited days. <i>OR</i> You are covered for __ days.	
4 INPATIENT MENTAL HEALTH CARE	
You pay 100% for each hospital stay.	
You are covered for __ days every <i>specified period</i>. <i>OR</i> You are covered for unlimited days. <i>OR</i> You are covered for __ days.	
5 SKILLED NURSING FACILITY	
You pay 100% for each stay in a Skilled Nursing Facility.	

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You are covered for __ days every <i>specified period</i>. <i>OR</i> You are covered for unlimited days. <i>OR</i> You are covered for __ days.	
x-day prior hospital stay is required. <i>OR</i> No prior hospital stay is required.	
6 HOSPICE	
You pay 100% for Hospice care.	
You must receive care from a network hospice.	