Attachment C: Plan Benefit Sentences
2007 MPPF Benefit Sentences

Draft Date: May 2, 2006

Note: For Non-network PFFS plans, we will not include labels for In-Network and Out-of-Network.

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** * **Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** * **Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** * **Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** * **Plan Detail Report: These sentences display along with the "Default Sentences"**
1. Premium and other Important Information			
You pay $ __ each month for your plan benefits. **You also continue to pay the Medicare Part B premium of $<** ***plan must reflect actual 2007 amount when it becomes available*** **> each month.** *OR* **There is no additional premium beyond the Medicare Part B premium of $<** ***plan must reflect actual 2007 amount when it becomes available*** **> each month for your plan benefits.**	***Sentence for MA only plans***	General $___ monthly plan premium in addition to your $___ monthly Medicare Part B premium. [**Note**: for the "no additional premium" plans, we would insert $0 above]	
You pay $< ***plan must reflect actual 2007 amount when it becomes available*** **> each month for your plan benefits including Medicare Part D prescription benefits.** **You also continue to pay the**	***Sentence for MA-PD plans***	General $__ monthly plan premium in addition to your $___ monthly Medicare Part B premium. [**Note**: for the "no additional premium" plans, we would insert $0 above]	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
Medicare Part B premium of $< ***plan must reflect actual 2007 amount when it becomes available*** **> each month.** *OR* **There is no additional premium beyond the Medicare Part B premium of $<** ***plan must reflect actual 2007 amount when it becomes available*** **> each month for your plan benefits including your Medicare Part D prescription drug benefits.** B premium of $____ each month. ***OR*** **Please note that** ***(Medicare Advantage Org. Marketing Name)*** **is reducing your Medicare Part B premium by up to $___. Please contact plan for details.**		OR ***(Medicare Advantage Org. Marketing Name)*** will reduce your Medicare Part B premium by up to $___.	
Please note that ***(Medicare Advantage Org. Marketing Name)*** **is reducing your Medicare Part B premium by up to $___. Please contact plan for details.**	***Change for 2007***	General ***(Medicare Advantage Org. Marketing Name)*** will reduce your Medicare Part B premium by up to $___.	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
You pay a $___ yearly deductible for all plan services. *OR* **You pay a $___ yearly deductible for all Medicare-covered plan services.** *OR* **You pay a $___ yearly deductible for all non-Medicare-covered plan services.** *OR* **You pay a $___ yearly deductible for the following plan services : *(picklist)*** *OR* **You pay a $___ yearly deductible for the following Medicare-covered plan services : *(picklist)*** *OR* **You pay a $___ yearly deductible for the following non-Medicare-covered plan services : *(picklist)***	***Sentence for all plan types EXCEPT Local and Regional PPOs and Network PFFS*** ***Change for 2007***	**In-Network** $___ yearly deductible for all benefits. OR $___ yearly deductible for all Medicare-covered benefits. OR $___ yearly deductible for all non-Medicare-covered benefits. OR $___ yearly deductible for certain benefits. OR $___ yearly deductible for certain Medicare-covered benefits. OR $___ yearly deductible for certain non-Medicare-covered benefits.	**In-Network** Yearly deductible applies to the following benefits : *(picklist)* Yearly deductible applies to the following Medicare-covered benefits : *(picklist)* Yearly deductible applies to the following non- Medicare-covered benefits : *(picklist)*
You pay a $___ yearly deductible for all plan services when received in-network or out-of-network. *OR* **You pay a $___ yearly deductible**	***Sentence for Regional and Local PPOs and Network PFFS only*** ***Change for 2007***	**In Network (and) Out of Network** $___ yearly deductible for all benefits. This deductible applies to benefits you get in-network or out of network. OR	**In Network (and) Out of Network**

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
for the following plan services when received in-network or out-of-network. *OR* **You pay a $___ yearly deductible for all Medicare-covered plan services when received in-network or out-of-network.** *OR* **You pay a $___ yearly deductible for the following Medicare-covered plan services when received in-network or out-of-network.** *OR* **You pay a $___ yearly deductible for all non-Medicare-covered plan services when received in-network or out-of-network.** *OR* **You pay a $___ yearly deductible for the following non-Medicare-covered plan services when received in-network or out-of-network.**		$___ yearly deductible for certain benefits. This deductible applies to benefits you get in-network or out of network. OR $___ yearly deductible for all Medicare-covered benefits. This deductible applies to benefits you get in-network or out of network. OR $___ yearly deductible for certain Medicare-covered benefits. This deductible applies to benefits you get in-network or out of network. OR $___ yearly deductible for all non-Medicare-covered benefits. This deductible applies to benefits you get in-network or out of network. OR $___ yearly deductible for certain non-Medicare-covered benefits. This deductible applies to benefits you get in-network or out of network.	Yearly deductible applies to the following benefits : *(picklist)* Yearly deductible applies to the following Medicare-covered benefits: *(picklist)* Yearly deductible applies to the following non-Medicare-covered benefits: *(picklist)*
You pay a $___ yearly deductible for all plan services when received in-network only. *OR* **You pay a $___ yearly deductible**	***Sentence for Regional PPOs, Local PPOs and Network PFFS only***	**In-Network** $___ yearly deductible for all benefits. OR $___ yearly deductible for all Medicare-	

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for all Medicare-covered plan services when received in-network only. *OR* **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: *(picklist)*** *OR* **You pay a $___ yearly deductible for the following Medicare-covered plan services when received in-network only: *(picklist)*** *OR* **You pay a $___ yearly deductible for the following non-Medicare-covered plan services when received in-network only: *(picklist)***	***Change for 2007***	covered benefits. OR $___ yearly deductible for all non-Medicare-covered benefits. OR $___ yearly deductible for certain benefits. OR $___ yearly deductible for certain Medicare-covered plan benefits. OR $___ yearly deductible for certain non-Medicare-covered plan benefits.	**In-Network** Yearly deductible applies to the following benefits: *(picklist)* Yearly deductible applies to the following Medicare-covered benefits: *(picklist)* Yearly deductible applies to the following non-Medicare-covered benefits: *(picklist)*
You pay a $___ yearly deductible for all plan services when received out-of-network only. *OR* **You pay a $___ yearly deductible**	***Sentence for Regional PPOs, Local PPOs and Network PFFS only***	**Out of Network** $___ yearly deductible for all benefits. OR	

Benefit Category and SB Sentences	Plan Type (*Sentences are for ALL plan types, unless noted.)*	Default Sentence(s) * Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display. * Plan Detail Report: These sentences display along with the "Full Details Sentences"	Full Details Sentences * Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details" * Plan Detail Report: These sentences display along with the "Default Sentences"
for all Medicare-covered plan services when received out-of-network only. *OR* **You pay a $___ yearly deductible for all non-Medicare-covered plan services when received out-of-network only.** ***OR*** **You pay a $___ yearly deductible for the following plan services when received out-of-network only: *(picklist)*** *OR* **You pay a $___ yearly deductible for the following Medicare-covered plan services when received out-of-network only: *(picklist)*** *OR* **You pay a $___ yearly deductible for the following non-Medicare-covered plan services when received out-of-network only: *(picklist)***	***Change for 2007***	$___ yearly deductible for all Medicare-covered benefits OR $___ yearly deductible for all non-Medicare-covered benefits. OR $___ yearly deductible for certain benefits. OR $___ yearly deductible for certain Medicare-covered benefits. OR $___ yearly deductible for certain non-Medicare-covered benefits.	**Out of Network** Yearly deductible applies to the following benefits: *(picklist)* Yearly deductible applies to the following Medicare-covered benefits: *(picklist)* Yearly deductible applies to the following non-Medicare-covered benefits: *(picklist)*
There is a $__ maximum out-of-pocket limit every *(Specified period)* for all plan services. *OR* **There is a $__ maximum out-of-**	***Sentence for all plan types EXCEPT Local and Regional PPOs and Network PFFS***	**In-Network** $___ out-of-pocket limit every *(Specified period)* for all benefits. OR	**In-Network**

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
pocket limit for all plans services. *OR* **There is a $__ maximum out-of-pocket limit every *(Specified period)* for the following plan services:** *OR* **There is a $__ maximum out-of-pocket limit for the following plan services:** *OR* **There is a $__ maximum out-of-pocket limit every *(Specified period)* for Medicare-covered plan services.** *OR* **There is a $__ maximum out-of-pocket limit for Medicare-covered plan services.** *OR* **There is a $__ maximum out-of-pocket limit every *(Specified period)* for the following Medicare-covered plan services:** *OR* **There is a $__ maximum out-of-pocket limit for the following Medicare-covered plan services:** *OR*	***Change for 2007***	$___ out-of-pocket limit for all benefits. OR $___ out-of-pocket limit every *(Specified period)* for certain plan benefits. OR $___ out-of-pocket limit for certain plan benefits. OR $___ out-of-pocket limit every *(Specified period)* for Medicare-covered benefits. OR $___ out-of-pocket limit for Medicare-covered benefits. OR $___ out-of-pocket limit every *(Specified period)* for certain Medicare-covered benefits. OR $___ out-of-pocket limit for certain Medicare-covered benefits. ***OR*** $___ out-of-pocket limit every *(Specified*	 Out-of-pocket limit applies to the following benefits: *(picklist)* Out-of-pocket limit applies to the following benefits: *(picklist)* Out-of-pocket limit applies to the following Medicare-covered benefits: *(picklist)* Out-of-pocket limit applies to the following Medicare-covered benefits: *(picklist)*

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There is a $__ maximum out-of-pocket limit every *(Specified period)* for non-Medicare-covered plan services. *OR* **There is a $__ maximum out-of-pocket limit for non-Medicare-covered plan services.** *OR* **There is a $__ maximum out-of-pocket limit every *(Specified period)* for the following non-Medicare-covered plan services:** *OR* **There is a $__ maximum out-of-pocket limit for the following non-Medicare-covered plan services:**		*period)* for non-Medicare-covered benefits. OR $___ out-of-pocket limit for non-Medicare-covered benefits. OR $___ out-of-pocket limit every *(Specified period)* for certain non-Medicare-covered benefits. OR $___ out-of-pocket limit for certain non-Medicare-covered benefits.	Out-of-pocket limit applies to the following non-Medicare-covered benefits: *(picklist)* Out-of-pocket limit applies to the following non-Medicare-covered benefits: *(picklist)*
There is a $__ maximum out-of-pocket limit for Medicare-covered plan services when received in-network and out-of-network. ***OR*** **There is a $__ maximum out-of-pocket limit every *(Specified period)* for Medicare-covered plan services when received in-**	***Sentence for PPOs only*** ***Change for 2007***	**In Network (and) Out of Network** $___ out-of-pocket limit for Medicare-covered benefits. This limit applies to benefits you get in-network or out of network. OR $___ out-of-pocket limit every *(Specified period)* for all Medicare-covered benefits. This limit applies to benefits you get in-	**In Network (and) Out of Network**

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network and out-of-network. ***OR*** **There is a $__ maximum out-of-pocket limit for the following Medicare-covered plan services when received in-network and out-of-network:** ***OR*** **There is a $__ maximum out-of-pocket limit every *(Specified period)* for the following Medicare-covered plan services when received in-network and out-of-network:** ***OR*** **There is a $__ maximum out-of-pocket limit for non-Medicare-covered plan services when received in-network and out-of-network.** ***OR*** **There is a $__ maximum out-of-pocket limit every *(Specified period)* for non-Medicare-covered plan services when received in-network and out-of-network.**		network or out of network. OR $___ out-of-pocket limit for certain Medicare-covered benefits. This limit applies to benefits you get in-network or out of network. OR $___ out-of-pocket limit every *(Specified period)* for certain Medicare-covered benefits. This limit applies to benefits you get in-network or out of network. OR $___ out-of-pocket limit for non-Medicare-covered benefits. This limit applies to benefits you get in-network or out of network. OR $___ out-of-pocket limit every *(Specified period)* for non-Medicare-covered benefits. This limit applies to benefits you get in-network or out of network. OR	Out-of-pocket limit applies to the following Medicare-covered benefits: *(picklist)* Out-of-pocket limit applies to the following Medicare-covered benefits: *(picklist)*

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OR **There is a $__ maximum out-of-pocket limit for the following non-Medicare-covered plan services when received in-network and out-of-network:** *OR* **There is a $__ maximum out-of-pocket limit every *(Specified period)* for the following non-Medicare-covered plan services when received in-network and out-of-network:** *OR* **There is a $__ maximum out-of-pocket limit for the following non-Medicare-covered plan services when received in-network and out-of-network:** ***OR*** **There is a $_____maximum out-of-pocket limit for Medicare and non-Medicare-covered services when received in-network and out-of-network.** ***OR*** **There is a $_____maximum out-of-pocket limit every *(Specified***		$___ out-of-pocket limit*)* for certain non-Medicare-covered benefits. This limit applies to benefits you get in-network or out of network. OR $___ out-of-pocket limit every *(Specified period)* for certain non-Medicare covered benefits. This limit applies to benefits you get in-network or out of network. OR $___ out-of-pocket limit for certain non-Medicare-covered benefits. This limit applies to benefits you get in-network or out of network. OR $___ out-of-pocket limit for Medicare and non-Medicare-covered benefits. This limit applies to benefits you get in-network or out of network. OR $___ out-of-pocket limit every *(Specified period)* for Medicare and non-Medicare-covered benefits. This limit applies to benefits you get in-network or out of	Out-of-pocket limit applies to the following non-Medicare-covered benefits: *(picklist)* Out-of-pocket limit applies to the following non-Medicare-covered benefits: *(picklist)* Out-of-pocket limit applies to the following non-Medicare covered benefits: *(picklist)*

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period) **for Medicare and non-Medicare-covered services when received in-network and out-of-network.** ***OR*** **There is a $_____maximum out-of-pocket limit for the following Medicare and non-Medicare-covered services when received in-network and out-of-network:** ***OR*** **There is a $_____maximum out-of-pocket limit every *(Specified period)* for the following Medicare and non-Medicare-covered services when received in-network and out-of-network:**		network. OR $___ out-of-pocket limit*)* for certain Medicare and non- Medicare-covered benefits. This limit applies to benefits you get in-network or out of network. OR $___ out-of-pocket limit every *(Specified period)* for certain non-Medicare covered benefits. This limit applies to benefits you get in-network or out of network.	Out-of-pocket limit applies to the following non-Medicare covered benefits: *(picklist)* Out-of-pocket limit applies to the following non-Medicare covered benefits: *(picklist)*
There is a $__ maximum out-of-pocket limit every *(Specified period)* for all plan services when received in network only. *OR* **There is a $__ maximum out-of-pocket limit for all plans services when received in network only.** *OR* **There is a $__ maximum out-of-**	***Sentence for Regional PPOs, Local PPOs and Network PFFS only*** ***Change for 2007***	**In-Network** $___ out-of-pocket limit every *(Specified period)* for benefits. OR **In-Network** $___ out-of-pocket limit for benefits. OR $___ out-of-pocket limit every *(Specified*	**In-Network**

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pocket limit every *(Specified period)* for the following plan services when received in network only: *OR* **There is a $__ maximum out-of-pocket limit for the following plan services when received in network only:** *OR* **There is a $__ maximum out-of-pocket limit every *(Specified period)* for Medicare-covered plan services when received in network only.** *OR* **There is a $__ maximum out-of-pocket limit for Medicare-covered plan services when received in network only.** *OR* **There is a $__ maximum out-of-pocket limit every *(Specified period)* for the following Medicare-covered plan services when received in network only:**		*period)* for certain benefits. OR $___ out-of-pocket limit for certain benefits. OR $___ out-of-pocket limit every *(Specified period)* for Medicare-covered benefits. OR $___ out-of-pocket limit for Medicare-covered benefits. OR $___ out-of-pocket limit every *(Specified period)* for certain Medicare-covered benefits. OR	Out-of-pocket limit applies to the following benefits: *(picklist)* Out-of-pocket limit applies to the following plan benefits: *(picklist)* Out-of-pocket limit applies to the following Medicare-covered benefits: *(picklist)*

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** <u>Plan Comparison Report</u>: For the Top Benefit Categories, these sentences automatically display.** *** <u>Plan Detail Report</u>: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** <u>Plan Comparison Report</u>: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** <u>Plan Detail Report</u>: These sentences display along with the "Default Sentences"**
OR **There is a $__ maximum out-of-pocket limit for the following Medicare-covered plan services when received in network only:** *OR* **There is a $__ maximum out-of-pocket limit every *(Specified period)* for non-Medicare covered plan services when received in network only.** *OR* **There is a $__ maximum out-of-pocket limit for non-Medicare covered plan services when received in network only.** *OR* **There is a $__ maximum out-of-pocket limit every *(Specified period)* for the following non-Medicare covered plan services when received in network only:** *OR* **There is a $__ maximum out-of-**		$___ out-of-pocket limit for certain Medicare-covered benefits. ***OR*** $___ out-of-pocket limit every *(Specified period)* for non-Medicare covered benefits. OR $___ out-of-pocket limit for non-Medicare covered benefits. OR $___ out-of-pocket limit every *(Specified period)* for certain non-Medicare covered benefits. OR $___ out-of-pocket limit for certain non-Medicare covered benefits.	Out-of-pocket limit applies to the following Medicare-covered benefits: *(picklist)* Out-of-pocket limit applies to the following non- Medicare covered benefits: *(picklist)* Out-of-pocket limit applies to the following non-Medicare covered benefits: *(picklist)*

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pocket limit for the following non-Medicare covered plan services when received in network only:			
There is a $___ maximum *(Specified period)* that your plan will cover for plan services. *OR* **There is a $___maximum *(Specified period)* that your plan will cover for the following plan services: *(picklist)*** *OR* **There is a $___ maximum that your plan will cover for plan services.** *OR* **There is a $___maximum that your plan will cover for the following plan services : *(picklist)***	***Sentence for all plan types*** ***Change for 2007***	**In-Network** $___ limit every (specified period) for benefits. OR $___ limit every (specified period) for certain benefits. OR $___ limit for benefits. OR $___limit for certain benefits.	**In-Network** Plan limit applies to the following benefits: *(picklist)* Plan limit applies to the following benefits: *(picklist)*
Point of Service is available for the following benefits: *(Selected categories from pick list).*	*Sentence for plans offering mandatory POS benefits only*	**Out-of-Network** Point-of-Service coverage is available for the following benefits: *(Selected categories from pick list).*	
No sentence in SB	***HMO only***	**Out-of-Network** Unless otherwise noted, you pay 100% for out-of-network services.	
If there is no note on an out of	***Sentence for PPO and Network PFFS***	**Out-of-Network** Contact the plan for more details on what is	

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network service, then the note describes the in-network service. Contact plan for details on the covered out of network service.	***plans only***	covered out of network.	
2. Doctor and Hospital Choice			
You must go to network doctors, specialists, and hospitals.	***Delete sentence for HMOPOS plans*** ***Delete sentence for PPOs*** ***Delete sentence for PFFS*** ***Delete sentence for Cost Plans***	General You must go to network doctors, specialists, and hospitals.	
You can go to doctors, specialists, and hospitals in or out of the network. Higher costs apply for out of network services.	***Sentence for PPOs only***	General You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.	
You may go to any doctor, specialist, or hospital that accepts the plan's payment.	***Sentence for PFFS only***	General You may go to any doctor, specialist, or hospital that accepts the plan's payment.	
You can use any doctor who is part of our network. You may also go to doctors outside of our network.	***Sentence for Cost plans only***	General You can use any network doctor. You may also go to out-of-network doctors.	
You need a referral to go to network hospitals and certain	***Delete all sentences for PFFS***		**In-Network** Referral required for network hospitals

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doctors, including specialists for certain services. *OR* **You need a referral to go to network specialists for certain services.** *OR* **You need a referral to go to network hospitals.** *OR* **You do NOT need a referral to go to network doctors, specialists, and hospitals.**			and specialists (for certain benefits). *OR* Referral required for network specialists (for certain benefits). *OR* Referral required for network hospitals. *OR* No referral required for network doctors, specialists, and hospitals.
A referral may be necessary for the following Point of Service benefits: ***(Selected categories from pick list).***	*Sentence for plans offering mandatory POS benefits only*		**Out-of-Network** You may need a referral for the following Point-of-service benefits: *(Selected categories from pick list).*
Your cost sharing will be reduced if you voluntarily pre-notify or voluntarily obtain prior authorization for services out-of-network. Contact plan for details.	***Sentence for PPOs only*** ***Change for 2007***		**Out-of-Network** You will pay less if you get prior authorization or let the plan know before you get an out-of-network benefit.
A separate doctor office visit copayment may apply for certain services.	***Delete sentence for PFFS***		**In-Network** You may have to pay a separate copay for certain doctor office visits.
You are covered for U.S.	***Delete sentence for***		**Out-of-Network**

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visitor/travel benefits. Contact plan for details. ***OR*** **You are covered for foreign visitor/travel benefits. Contact plan for details.** ***OR*** **You are covered for U.S. and foreign visitor/travel benefits. Contact plan for details.**	***PFFS Change for 2007***		Plan covers you when you travel in the U.S. *OR* Plan covers you when you travel outside the U.S. *OR* Plan covers you when you travel inside or outside the U.S.
3. Inpatient Hospital Care			
You pay one initial deductible of $___ for services received at a network hospital.		**In-Network** $___ deductible for hospital benefits	
There is no copayment for Inpatient Hospital services at a network hospital.		**In-Network** $0 copay for inpatient hospital benefits	
There is no copayment for Inpatient Hospital services received at a non-network hospital.	*Sentence for plans offering mandatory POS benefits only*	**Out-of-Network** $0 copay for inpatient hospital benefits.	
You pay $__[or __% of the cost] for each Medicare-covered stay at a network hospital.		**In-Network** $___ copay [or __% of the cost] for each Medicare-covered hospital stay	
You pay: **- $___ [or ___% of the cost] each day for day(s) __-__** **- $___ [or ___% of the cost] each**		**In-Network** $___ copay [or ___% of the cost] per day for days __-__ in a Medicare-covered hospital.	**In-Network** For longer Medicare-covered hospital stays: Days __-__: $___ copay [or ___% of the

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
day for day(s) __-__ - $___ [or ___% of the cost] each day for day(s) __-__ for a Medicare-covered stay at a network hospital.			cost] per day Days __-__: $___ copay [or ___% of the cost] per day.
You pay $___ [or __% of the cost] for each stay at a network hospital.		**In-Network** $___ copay [or __% of the cost] for each hospital stay.	
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.		**In-Network** $___ copay [or ___% of the cost] per day for days __-__ in a hospital.	**In-Network** For longer hospital stays: Days __-__: $___ copay [or ___% of the cost] per day Days __-__: $___ copay [or ___% of the cost] per day.
You are covered for 60 life time reserve days. You pay: - $___[or ___% of the cost] each day for lifetime reserve day(s) __-__ - $___[or ___% of the cost] each day for lifetime reserve day(s) __-__ - $___[or ___% of the cost] each day for lifetime reserve day(s) __-__	***New for 2007***		**In-Network** Plan covers 60 lifetime reserve days. Cost per lifetime reserve day: Days __-__: $___ copay [or ___% of the cost] per day Days __-__: $___ copay [or ___% of the cost] per day Days __-__: $___ copay [or ___% of the cost] per day

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
Cost sharing may vary for each Medicare-covered stay according to the hospital at which services are received.			**In-Network** The amount you pay for each Medicare-covered stay may vary depending on which hospital you go to.
You pay $___ [or __% of the cost] for each stay at a non-network hospital.	*Sentence for plans offering mandatory POS benefits only*	**Out-of-Network** $___ copay [or __% of the cost] per hospital stay.	
You pay $___ [or __% of the cost] for each stay at an out of network hospital.	***Sentence for PPOs only***	**Out of Network** $___ copay [or __% of the cost] for each hospital stay.	
You pay $___ [or ___% of the cost] for each day at a non-network hospital.	*Sentence for plans offering mandatory POS benefits only*	**Out-of-Network** $___ copay [or __% of the cost] per hospital day.	
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.**	***Sentence for PPOs only***	**Out of Network** $___ copay [or ___% of the cost] per day for days __-__ in a hospital.	**Out of Network** For longer hospital stays: Days __-__: $___ copay [or ___% of the cost] per day Days __-__: $___ copay [or ___% of the cost] per day.
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')*	*Sentence for plans offering mandatory POS benefits only*	**Out-of-Network** $___ copay [or ___% of the cost] per day for days __-__ in a hospital.	**Out-of-Network** For longer hospital stays: Days __-__: $___ copay [or ___% of the cost] per day Days __-__: $___ copay [or ___% of the cost] per day.

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
in a non-network hospital.			
You pay $___ [or __% of the cost] for each non-Medicare-covered stay at a network hospital.		**In-Network** $___ copay [or __% of the cost] for each non-Medicare-covered hospital stay.	
You pay $___[or ___% of the cost] each day for a non-Medicare-covered stay at a network hospital.		**In-Network** $___ copay [or ___% of the cost] per day for a non-Medicare-covered hospital stay.	
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.**		**In-Network** $___ copay [or ___% of the cost] per day for days __-__ of a non-Medicare-covered hospital stay.	**In-Network** For longer non-Medicare-covered hospital stays: Days __-__: $___ copay [or ___% of the cost] per day Days __-__: $___ copay [or ___% of the cost] per day *(If days = 999 = put 'and beyond')*
There is no copayment for additional days at a network hospital.		**In-Network** $0 copay for additional hospital days	
You pay $___ [or ___% of the cost] for each additional day at a network hospital.		**In-Network** $___ copay [or ___% of the cost] for each additional hospital day.	
You pay: **- $___[or ___% of the cost] each day for additional day(s) __-__** **- $___[or ___% of the cost] each day for additional day(s) _-__**		**In-Network** $___ copay [or ___% of the cost] per day for days __-__ for each additional hospital day.	**In-Network** For more hospital days: Days __-__: $___ copay [or ___% of the cost] per day Days __-__: $___ copay [or ___% of the

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
- $___[or ___% of the cost] each day for additional day(s) __-__ *(-999 = 'and beyond')* **at a network hospital.**			cost] per day *(If days = 999 = put 'and beyond')*
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.**	***Sentences for PFFS only***		**General** You must notify the plan if you plan to be admitted to the hospital. If you don't notify the plan, you will have to pay $___ each day, up to a maximum of $___ per admission.
There is a $___ maximum out of pocket limit every (*Specified period*). *OR* **There is a $___ maximum out of pocket limit.**		**In-Network** $___ out-of-pocket limit every *(specified period).* OR $___ out-of-pocket limit.	
You are covered for 90 days each benefit period. *OR* **You are covered for unlimited days each benefit period.** *OR* **You are covered for** (*90+number of additional days*) **days each benefit period.**			**In-Network** Plan covers 90 days each benefit period. *OR* No limit to the number of days covered by the plan each benefit period. *OR* Plan covers (*90+number of additional days)* days each benefit period.
You may go to any doctor, specialist, or hospital that accepts the plan's payment.	***Sentence for PFFS only***		General You may go to any doctor, specialist, or hospital that accepts the plan's payment.

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Except in an emergency, your provider must obtain authorization from <MA org>.			**In-Network** Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
4. Inpatient Mental Care			
You pay one initial deductible of $___ for services received at a network hospital.		**In-Network** $ ___ deductible for hospital benefits.	
There is no copayment for services at a network hospital.		**In-Network** $0 copay for hospital benefits.	
There is no copayment for services received at a non-network Inpatient Psychiatric Hospital.	*Sentence for plans offering mandatory POS benefits only*	**Out-of-Network** $0 copay for Inpatient Psychiatric Hospital benefits.	
You pay $___[or __% of the cost] for each Medicare-covered stay at a network hospital.		**In-Network** $___ copay [or __% of the cost] for each Medicare-covered hospital stay	
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.**		**In-Network** $___ copay [or ___% of the cost] per day for days __-__ in a Medicare-covered hospital.	**In-Network** For longer hospital stays: Days __-__: $___ copay [or ___% of the cost] per day Days __-__: $___ copay [or ___% of the cost] per day.
You pay $___ [or __% of the cost] for each stay at a network		**In-Network** $___ copay [or __% of the cost] for each	

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hospital.		hospital stay.	
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.**		**In-Network** $___ copay [or ___% of the cost] per day for days __-__ in a hospital.	**In-Network** For longer hospital stays: Days __-__: $___ copay [or ___% of the cost] per day Days __-__: $___ copay [or ___% of the cost] per day.
You are covered for 60 life time reserve days. **You pay:** **- $___[or ___% of the cost] each day for lifetime reserve day(s) __-__** **- $___[or ___% of the cost] each day for lifetime reserve day(s) __-__** **- $___[or ___% of the cost] each day for lifetime reserve day(s) __-__**	***New for 2007***		**In-Network** Plan covers 60 lifetime reserve days. Cost per lifetime reserve day: Days __-__: $___ copay [or ___% of the cost] per day Days __-__: $___ copay [or ___% of the cost] per day Days __-__: $___ copay [or ___% of the cost] per day
Cost sharing may vary for each Medicare-covered stay according to the hospital at which services are received.			**In-Network** The amount you pay for each Medicare-covered stay may vary depending on which hospital you go to.
You pay $___ [or __% of the cost] for each stay at an out of network hospital.	***Sentence for PPOs only***	**Out of Network** $___ copay [or __% of the cost] for each hospital stay.	
You pay $___ [or __% of the cost] for each stay at a non-	*Sentence for plans offering mandatory*	**Out-of-Network** $___ copay [or __% of the cost] per	

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network Inpatient Psychiatric Hospital.	*POS benefits only*	Inpatient Psychiatric Hospital stay.	
You pay $___ [or ___% of the cost] each day at a non-network Inpatient Psychiatric Hospital.	*Sentence for plans offering mandatory POS benefits only*	**Out-of-Network** $___ copay [or __% of the cost] per Inpatient Psychiatric Hospital day.	
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.**	*Sentence for plans offering mandatory POS benefits only*	**Out-of-Network** $___ copay [or ___% of the cost] per day for days __-__ in an Inpatient Psychiatric Hospital.	**Out-of-Network** For longer Inpatient Psychiatric Hospital stays: Days __-__: $___ copay [or ___% of the cost] per day Days __-__: $___ copay [or ___% of the cost] per day.
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.**	***Sentence for PPOs only***	**Out of Network** $___ copay [or ___% of the cost] per day for days __-__ in a hospital.	**Out of Network** For longer hospital stays: Days __-__: $___ copay [or ___% of the cost] per day Days __-__: $___ copay [or ___% of the cost] per day.
You pay $___ [or __% of the cost] for each non-Medicare-covered stay at a network hospital.		**In-Network** $___ copay [or __% of the cost] for each non-Medicare-covered hospital stay.	
You pay $___[or ___% of the cost] each day for a non-		**In-Network** $___ copay [or ___% of the cost] per day	

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Medicare-covered stay at a network hospital.		for a non-Medicare-covered hospital stay.	
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.**		**In-Network** $___ copay [or ___% of the cost] per day for days __-__ in a non-Medicare-covered hospital.	**In-Network** For longer non-Medicare-covered hospital stays: Days __-__: $___ copay [or ___% of the cost] per day Days __-__: $___ copay [or ___% of the cost] per day *(If days = 999 = put 'and beyond')*
There is no copayment for additional days in a network hospital.		**In-Network** $0 copay for additional hospital days	
You pay $___ [or ___% of the cost] for each additional day at a network hospital.		**In-Network** $___ copay [or ___% of the cost] for each additional hospital day.	
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.**		**In-Network** $___ copay [or ___% of the cost] per day for days __-__ for each additional hospital day.	**In-Network** For more hospital days: Days __-__: $___ copay [or ___% of the cost] per day Days __-__: $___ copay [or ___% of the cost] per day *(If days = 999 = put 'and beyond')*
If you do not notify the plan of a planned inpatient admission, you will have to pay $___each day,	***Sentences for PFFS only***		**In-Network** You must notify the plan if you plan to be admitted to the hospital. If you don't

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up to a maximum of $___ per admission. **Contact plan for additional information.**			notify the plan, you will have to pay $___ each day, up to a maximum of $___ per admission.
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.**		**In-Network** The out-of-pocket limit is covered under "Inpatient Hospital Care." OR $___ out-of-pocket limit every *(specified period).* OR $___ out-of-pocket limit.	
Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime. *OR* **Contact plan for details about benefits beyond 190 days.**			**In-Network** You get up to 190 days in a Psychiatric Hospital in a lifetime. OR Contact the plan for details about coverage in a Psychiatric Hospital beyond 190 days.
Except in an emergency, your provider must obtain authorization from <MA Org>.			**In-Network** Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
5. Skilled Nursing Facility (SNF)			
You pay a deductible of $___.		**In-Network** $___ deductible.	
There is no copayment for		**In-Network**	

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services in a Skilled Nursing Facility.		\$0 copay for SNF benefits	
You pay \$___ [or __% of the cost] for each Medicare-covered stay at a Skilled Nursing Facility.		**In-Network** \$___ copay [or __% of the cost] for each Medicare-covered SNF stay	
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.**		**In-Network** \$___ copay [or ___% of the cost] per day for days __-__ in a Medicare-covered SNF.	**In-Network** For longer Medicare-covered SNF stays: Days __-__: \$___ copay [or ___% of the cost] per day Days __-__: \$___ copay [or ___% of the cost] per day.
You pay \$___ [or __% of the cost] for each stay at a Skilled Nursing Facility.		**In-Network** \$___ copay [or __% of the cost] for each SNF stay.	
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.**		**In-Network** \$___ copay [or ___% of the cost] per day for days __-__ in a SNF.	**In-Network** For longer SNF stays: Days __-__: \$___ copay [or ___% of the cost] per day Days __-__: \$___ copay [or ___% of the cost] per day.
You pay \$___ to \$___ [or __% to __% of the cost] for services at an out of network Skilled	***Sentence for PPOs only***	**Out of Network** \$___ to \$___ copay [or __% to %___ of the cost] for SNF benefits.	

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Nursing Facility.			
You pay $___ [or __% of the cost] for each non-Medicare-covered stay at a Skilled Nursing Facility.		**In-Network** $___ copay [or __% of the cost] for each non-Medicare-covered SNF stay.	
You pay $___[or ___% of the cost] each day for a non-Medicare-covered stay at a Skilled Nursing Facility.		**In-Network** $___ copay [or __% of the cost] per day for each non-Medicare-covered SNF stay.	
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.**		**In-Network** $___ copay [or ___% of the cost] per day for days __-__ in a non-Medicare-covered SNF.	**In-Network** For longer non-Medicare covered SNF stays: Days __-__: $___ copay [or ___% of the cost] per day Days __-__: $___ copay [or ___% of the cost] per day.
There is no copayment for additional days at a Skilled Nursing Facility.		**In-Network** $0 copay for additional SNF days	
You pay $___ [or ___% of the cost] for each additional day at a Skilled Nursing Facility.		**In-Network** $___ copay [or ___% of the cost] for each additional SNF day.	
You pay: **- $___[or ___% of the cost] each day for additional day(s) __-__** **- $___[or ___% of the cost] each day for additional day(s) __-__**		**In-Network** $___ copay [or ___% of the cost] per day for days __-__ for each additional SNF day.	**In-Network** For more SNF days: Days __-__: $___ copay [or ___% of the cost] per day Days __-__: $___ copay [or ___% of the

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- $___[or ___% of the cost] each day for additional day(s) __-__ *(-999 = 'and beyond')* **at a Skilled Nursing Facility.**			cost] per day *(If days = 999 = put 'and beyond')*
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.	***Sentences for PFFS only***		**In-Network** You must notify the plan if you plan to be admitted to the hospital. If you don't notify the plan, you will have to pay $___ each day, up to a maximum of $___ per admission.
There is a $___ maximum out of pocket limit every (*Specified period*). *OR* **There is a $___ maximum out of pocket limit.**		**In-Network** $___ out-of-pocket limit every *(specified period)*. OR $___ out-of-pocket limit.	
You are covered for 100 days each benefit period. *OR* **You are covered for unlimited days each benefit period.** *OR* **You are covered for *(100 + number of additional days)* days each benefit period.**			**In-Network** 100 days covered for each benefit period. *OR* No limit on days covered each benefit period. *OR* *(100 + number of additional days)* days covered for each benefit period.
3-day prior hospital stay is required. *OR*			**In-Network** 3-day prior hospital stay is required.

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(1 or **2**, *whichever is applicable*) **- day prior hospital stay is required.** *OR* **No prior hospital stay is required.**			*OR* (1 or 2, *whichever is applicable*) -day prior hospital stay is required. *OR* No prior hospital stay is required.
Authorization rules may apply for services. Contact plan for details.			**General** Authorization rules may apply.
6. Home Health Care			
There is no copayment for Medicare-covered home health visits.		**In-Network** $0 copay for Medicare-covered home health visits.	
You pay $__ to $__ [or__% to __% of the cost] for Medicare-covered home health visits.		**In-Network** $___ copay [or __% of the cost] for each Medicare-covered home health visit.	
You pay $__ to $__ [or __% to __% of the cost] for out of network home health visits.	***Sentence for PPOs only***	**Out of Network** $___ to $___ copay [or __% to %___ of the cost] for home health visits.	
There is no copayment for: **- Medicare-covered home health visits** **- Custodial Care** **- Respite Care**	***Change for 2007***	**In-Network** $0 copay for *In combination with any of the following*: ▪ Medicare-covered home health visits, [,and] *OR* ▪ custodial care[,and] *OR* ▪ respite care.	**General** *[Only generates if "custodial care' is generated in prior column]* Custodial Care is nonskilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving round, and using the bathroom. It may also include care that most people do themselves, like using eye drops.

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
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**	***Change for 2007***	**In-Network** $___ to $___ copay [or __% to %___ of the cost] for Medicare-covered home health visits. $___ to $___ copay [or __% to %___ of the cost] for custodial care. $___ to $___ copay [or __% to %___ of the cost] for respite care.	**General** *[Only generates if "custodial care' is generated in prior column]* Custodial Care is nonskilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving round, and using the bathroom. It may also include care that most people do themselves, like using eye drops.
Authorization rules may apply for services. Contact plan for details.			**General** Authorization rules may apply.
7. Hospice			
You must receive care from a Medicare-certified hospice.		**In-Network** You must get care from a Medicare-certified hospice.	
8. Doctor Office Visits			
There is no copayment for each primary care doctor office visit for Medicare-covered services. *OR* **You pay $__ to $__ [or __% to __% of the cost] for each primary care doctor office visit for Medicare-covered services.**		**In-Network** $0 copay for each primary care doctor visit for Medicare-covered benefits. OR $___ to $___ copay [or __% to %___ of the cost] for each primary care doctor visit for Medicare-covered benefits.	
You pay $__ to $__ [or __% to __% of the cost] for each out of	***Sentence for PPOs only***	**Out of Network** $___ to $___ copay [or __% to %___ of the	

Benefit Category and SB Sentences	Plan Type (*Sentences are for ALL plan types, unless noted.)*	Default Sentence(s) * Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display. * Plan Detail Report: These sentences display along with the "Full Details Sentences"	Full Details Sentences * Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details" * Plan Detail Report: These sentences display along with the "Default Sentences"
network primary care doctor office visit.		cost] for each primary care doctor visit.	
There is no copayment for each specialist visit for Medicare-covered services. *OR* **You pay $__ to $__ [or __% to __% of the cost] for each specialist visit for Medicare-covered services.**		**In-Network** $0 copay for each specialist doctor visit for Medicare-covered benefits. OR $___ to $___ copay [or __% to %___ of the cost] for each specialist visit for Medicare-covered benefits.	
You pay $__ to $__ [or __% to __% of the cost] for each out of network specialist visit.	***Sentence for PPOs only***	**Out of Network** $___ to $___ copay [or __% to %___ of the cost] for each specialist visit.	
You may go to any doctor, specialist, or hospital that accepts the plan's payment.	***Sentence for PFFS only***		**General** You may go to any doctor, specialist, or hospital that accepts the plan's payment.
See 32-Routine Physical Exams for more information.			**General** See Section 32, "Routine Physical Exams," for more information.
Authorization rules may apply for services. Contact plan for details.			**General** Authorization rules may apply.
9. Chiropractic Benefits			
There is no copayment for Medicare-covered chiropractic services (manual manipulation of the spine to correct subluxation).		**In-Network** $0 copay for Medicare-covered visits.	**General** Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.
You pay $__ to $___ [or__% to		**In-Network**	**General**

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
% of the cost] for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).		$___ to $___ copay [or __% to %___ of the cost] for each Medicare-covered visit.	Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.
There is no copayment for: **- Medicare-covered visits (manual manipulation of the spine to correct subluxation)** **- routine visits** *OR* **- routine visits up to ___ visit(s) every *(Specified period)*** *OR* **- routine visits up to ___ visit(s)**		**In-Network** $0 copay for Medicare-covered visits [, and] *AND/OR any of the following* routine visits. *OR* up to ___ routine visit(s) every *(Specified period). OR* up to ___ routine visit(s).	**General** Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.
You pay: **- $__ 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 *(Specified period)*** *OR* **- $__ to $__ [or __% to __% of the cost] for each routine visit up to ___ visit(s)**		**In-Network** $___ to $___ copay [or __% to %___ of the cost] for Medicare-covered visits. $___ to $___ copay [or __% to %___ of the cost] for *In combination with any of the following:* up to ___ routine visits(s) every *(Specified period)* ***OR*** up to ___ routine visit(s) ***OR*** each routine visit.	**General** Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
OR **- $__ to $__ [or __% to __% of the cost] for each routine visit**			
You pay $__ to $___ [or__% to % of the cost] for out of network chiropractic services.	***Sentence for PPOs only***	**Out of Network** $___ to $___ copay [or __% to %___ of the cost] for chiropractic benefits.	
Authorization rules may apply for services. Contact plan for details.			**General** Authorization rules may apply.
10. Podiatry Benefits			
There is no copayment for Medicare-covered podiatry services (medically necessary foot care).		**In-Network** $0 copay for Medicare-covered podiatry benefits.	**General** Medicare-covered podiatry benefits are for medically-necessary foot care.
You pay $__ to $___ [or__% to % of the cost] for each Medicare-covered visit (medically necessary foot care).		**In-Network** $___ to $___ copay [or __% to %___ of the cost] for each Medicare-covered visit.	**General** Medicare-covered podiatry benefits are for medically-necessary foot care.
There is no copayment for: **- Medicare-covered visits (medically necessary foot care)** **- routine visits** *OR* **- routine visits up to ___ visit(s) every *(Specified period)*** *OR* **- routine visits up to ___ visits**		**In-Network** $0 copay for Medicare-covered visits [, and] *AND/OR any of the following* routine visits. *OR* up to ___ routine visit(s) every *(Specified period). OR* up to ___ routine visit(s).	**General** Medicare-covered podiatry benefits are for medically-necessary foot care.
You pay:		**In-Network** $___ to $___ copay [or __% to %___ of the	**General** Medicare-covered podiatry benefits are

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
- $__ 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 *(Specified period)*** *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**		cost] for Medicare-covered visits. $___ to $___ copay [or __% to %___ of the cost] for *In combination with any of the following:* up to ___ routine visits(s) every *(Specified period)* ***OR*** up to ___ routine visit(s) ***OR*** each routine visit.	for medically-necessary foot care.
You pay $__ to $___ [or__% to % of the cost] for out of network podiatry services.	***Sentence for PPOs only***	**Out of Network** $___ to $___ copay [or __% to %___ of the cost] for podiatry benefits.	
Authorization rules may apply for services. Contact plan for details.			**General** Authorization rules may apply.
11. Outpatient Mental Health Care			
There is no copayment for each Medicare-covered visit for Mental Health services.		**In-Network** $0 copay for Medicare-covered Mental Health visits.	
For Medicare-covered Mental Health services, you pay $___ [or ___% of the cost] for each individual therapy visit.		**In-Network** $___ to $___ copay [or __% to %___ of the cost] for each Medicare-covered individual therapy visit.	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
For Medicare-covered Mental Health services, 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')*		**In-Network** **For Medicare-covered individual therapy:** $___ copay [or ___% of the cost] per visit for visit(s) __-__	**In-Network** For more Medicare-covered individual therapy: Visit(s) __-__: $___ copay [or ___% of the cost] per visit Visit(s) __-__: $___ copay [or ___% of the cost] per visit *(If days = 999 = put 'and beyond')*
For Medicare-covered Mental Health services, you pay $___ [or ___% of the cost] for each group therapy visit.		**In-Network** $___ to $___ copay [or __% to %___ of the cost] for each Medicare-covered group therapy visit.	
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')*		**In-Network** For Medicare-covered group therapy: $___ copay [or ___% of the cost] per visit for visit(s) __-__	**In-Network** For more Medicare-covered group therapy: Visit(s) __-__: $___ copay [or ___% of the cost] per visit Visit(s) __-__: $___ copay [or ___% of the cost] per visit *(If days = 999 = put 'and beyond')*
For Medicare-covered Mental Health services, you pay $___ [or ___% of the cost] for each individual/group therapy visit.		**In-Network** $___ to $___ copay [or __% to %___ of the cost] for each Medicare-covered individual or group therapy visit.	
For Medicare-covered Mental Health services, you pay: **- $__ [or__% of the cost] for each individual/group therapy visit(s)**		**In-Network** $___ copay [or ___% of the cost] per visit for visit(s) __-__ of Medicare-covered individual or group therapy.	**In-Network** For more Medicare-covered individual or group therapy: Visit(s) __-__: $___ copay [or ___% of

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
__-__ **- $__ [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')*			the cost] per visit Visit(s) __-__: $___ copay [or ___% of the cost] per visit *(If days = 999 = put 'and beyond')*
You pay $__ to $__ [or __% to __% of the cost] for out of network Mental Health services.	***Sentence for PPOs only***	**Out of Network** $___ to $___ copay [or __% to %___ of the cost] for Mental Health benefits.	
There is no copayment for each Medicare-covered visit for Mental Health services with a psychiatrist.		**In-Network** $0 copay for each Medicare-covered visit with a psychiatrist.	
For Medicare-covered Mental Health services with a psychiatrist, you pay $___ [or ___% of the cost] for each individual therapy visit.		**In-Network** $__ copay [or ___% of the cost] for each Medicare-covered individual therapy visit with a psychiatrist.	
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**		**In-Network** For Medicare-covered individual therapy with a psychiatrist: $___ copay [or ___% of the cost] per visit for visit(s) __-__.	**In-Network** For more Medicare-covered individual therapy with a psychiatrist: Visit(s) __-__: $___ copay [or ___% of the cost] per visit Visit(s) __-__: $___ copay [or ___% of the cost] per visit *(If days = 999 = put 'and beyond')*

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
each individual therapy visit(s) __-__ *(-999 = 'and beyond')*			
For Medicare-covered Mental Health services with a psychiatrist, you pay $___ [or ___% of the cost] for each group therapy visit.		**In-Network** $__ copay [or ___% of the cost] for each Medicare-covered group therapy visit with a psychiatrist.	
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')*		**In-Network** For Medicare-covered group therapy with a psychiatrist: $___ copay [or ___% of the cost] per visit for visit(s) __-__	**In-Network** For more Medicare-covered group therapy with a psychiatrist: Visit(s) __-__: $___ copay [or ___% of the cost] per visit Visit(s) __-__: $___ copay [or ___% of the cost] per visit *(If days = 999 = put 'and beyond')*
For Medicare-covered Mental Health services with a psychiatrist, you pay $___ [or ___% of the cost] for each individual/group therapy visit.		**In-Network** $__ copay [or ___% of the cost] for each Medicare-covered individual or group therapy visit with a psychiatrist.	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
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')***		**In-Network** For Medicare-covered individual or group therapy with a psychiatrist: $___ copay [or ___% of the cost] per visit for visit(s) __-__	**In-Network** For more Medicare-covered individual or group therapy with a psychiatrist: Visit(s) __-__: $___ copay [or ___% of the cost] per visit Visit(s) __-__: $___ copay [or ___% of the cost] per visit *(If days = 999 = put 'and beyond')*
You pay $__ to $__ [or __% to __% of the cost] for out of network Mental Health services with a psychiatrist.	***Sentence for PPOs only***	**Out of Network** $___ to $___ copay [or __% to %___ of the cost] for Mental Health benefits with a psychiatrist.	
Authorization rules may apply for services. Contact plan for details.			**General** Authorization rules may apply.
12. Outpatient Substance Abuse Care			

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
There is no copayment for each Medicare-covered visit.		**In-Network** $0 copay for Medicare-covered visits.	
For Medicare-covered services, you pay $__ [or __% of the cost] for each individual visit.		**In-Network** $__ [or __% of the cost] for Medicare-covered individual visits.	
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')***		**In-Network** $___ copay [or ___% of the cost] per visit for visit(s) __-__ of Medicare-covered individual visits.	**In-Network** For more Medicare-covered individual visits: Visit(s) __-__: $___ copay [or ___% of the cost] per visit Visit(s) __-__: $___ copay [or ___% of the cost] per visit *(If days = 999 = put 'and beyond')*
For Medicare-covered services, you pay $__ [or __% of the cost] for each group visit.		**In-Network** $__ [or __% of the cost] for Medicare-covered group visits.	
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')***		**In-Network** $___ copay [or ___% of the cost] per visit for visit(s) __-__ of Medicare-covered group visits.	**In-Network** For more Medicare-covered group visits: Visit(s) __-__: $___ copay [or ___% of the cost] per visit Visit(s) __-__: $___ copay [or ___% of the cost] per visit *(If days = 999 = put 'and beyond')*
For Medicare-covered services, you pay $__ [or __% of the cost] for each individual/group visit.		**In-Network** $__ [or __% of the cost] for Medicare-covered individual or group visits.	
For Medicare-covered services,		**In-Network**	**In-Network**

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
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')***		$___ copay [or ___% of the cost] per visit for visit(s) __-__ of Medicare-covered individual or group visits.	For more Medicare-covered individual or group visits: Visit(s) __-__: $___ copay [or ___% of the cost] per visit Visit(s) __-__: $___ copay [or ___% of the cost] per visit *(If days = 999 = put 'and beyond')*
An additional facility charge may be included in the cost for services.			**In-Network** Additional facility charges may apply.
You pay $__to $__ [or __% to __% of the cost] for out of network outpatient substance abuse services.	***Sentence for PPOs only***	**Out of Network** $___ to $___ copay [or __% to %___ of the cost] for outpatient substance abuse benefits.	
Authorization rules may apply for services. Contact plan for details.			**General** Authorization rules may apply.
13. Outpatient Services/Surgery			
There is no copayment for each Medicare-covered visit to an ambulatory surgical center. *OR* **You pay $__ to $__ [or__% to __% of the cost] for each Medicare-covered visit to an ambulatory surgical center.**		**In-Network** $0 copay for each Medicare-covered ambulatory surgical center visit. OR $___ to $___ copay [or __% to %___ of the cost] for each Medicare-covered ambulatory surgical center visit.	
There is no copayment for each Medicare-covered visit to an outpatient hospital facility.		**In-Network** $0 copay for each Medicare-covered outpatient hospital facility visit.	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
OR **You pay $__ to $__ [or__% to __% of the cost] for each Medicare-covered visit to an outpatient hospital facility.**		OR $___ to $___ copay [or __% to %___ of the cost] for each Medicare-covered outpatient hospital facility visit.	
An additional facility charge may be included in the cost for services.			**In-Network** Additional facility charges may apply.
You pay $__ to $__ [or__% to __% of the cost] for services at an out of network ambulatory surgical center.	***Sentence for PPOs only***	**Out of Network** $___ to $___ copay [or __% to %___ of the cost] for ambulatory surgical center benefits.	
You pay $__ to $__ [or__% to __% of the cost] for services at an out of network outpatient hospital facility.	***Sentence for PPOs only***	**Out of Network** $___ to $___ copay [or __% to %___ of the cost] for outpatient hospital facility benefits.	
Authorization rules may apply for services. Contact plan for details.			**General** Authorization rules may apply.
14. Ambulance			

Benefit Category and SB Sentences	Plan Type (*Sentences are for ALL plan types, unless noted.)*	Default Sentence(s) * Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display. * Plan Detail Report: These sentences display along with the "Full Details Sentences"	Full Details Sentences * Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details" * Plan Detail Report: These sentences display along with the "Default Sentences"
There is no copayment for Medicare-covered ambulance services.		**In-Network** $0 copay for Medicare-covered ambulance benefits .	
You pay __% of the cost for Medicare-covered ambulance services. **; you do not pay this amount if you are admitted to the hospital.** *AND/OR* **You pay $__ for Medicare-covered ambulance services.** **; you do not pay this amount if you are admitted to the hospital.**		**In-Network** __% of the cost for Medicare-covered ambulance benefits. *AND/OR* $___ copay for Medicare-covered ambulance benefits.	**In-Network** If you are admitted to the hospital, you pay $0 for Medicare-covered ambulance benefits.
You pay $__ to $__ [or __% to __% of the cost] for out of network ambulance services.	***Sentence for PPOs only***	**Out of Network** $___ to $___ copay [or __% to %___ of the cost] for ambulance benefits.	
Authorization rules may apply for services. Contact plan for details.			**General** Authorization rules may apply.
15. Emergency Care			

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
There is no copayment for each Medicare-covered emergency room visit. *OR* **You pay __% to __ % of the cost (up to $50) for each Medicare-covered emergency room visit.** *AND/OR* **You pay $__ to $__for each Medicare-covered emergency room visit.**	***Delete '(up to $50)' for Cost Plans (see below)***	**In-Network** $0 copay for Medicare-covered emergency room visits. OR __% to __ % of the cost (up to $50) for Medicare-covered emergency room visits. *AND/OR* $__ to $___ copay for Medicare-covered emergency room visits.	
You pay __% to __ % of the cost for each Medicare-covered emergency room visit. *AND/OR* **You pay $__ to $__for each Medicare-covered emergency room visit.**	***Sentence for Cost Plans only***	**In-Network** __% to __ % of the cost for Medicare-covered emergency room visits. *AND/OR* $__ to $___ copay for Medicare-covered emergency room visits.	
; you do not pay this amount if you are admitted to the hospital within __ day(s) [or __ hour(s)] for the same condition. *OR* **; you do not pay this amount if you are immediately admitted to the hospital.**			**In Network (and) Out of Network** If you are admitted to the hospital within __-day(s) [or __ hour(s)] for the same condition, you pay $0 for the emergency room visit *OR* If you are immediately admitted to the hospital, you pay $0 for the emergency room visit.

Benefit Category and SB Sentences	Plan Type (*Sentences are for ALL plan types, unless noted.)*	Default Sentence(s) * Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display. * Plan Detail Report: These sentences display along with the "Full Details Sentences"	Full Details Sentences * Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details" * Plan Detail Report: These sentences display along with the "Default Sentences"
NOT covered outside the U.S. except under limited circumstances. *OR* **Worldwide coverage.**			**Out of Network** Not covered outside the U.S. except under limited circumstances. Contact the plan for more details. *OR* Worldwide coverage.
16. Urgently Needed Care			
There is no copayment for each Medicare-covered urgently needed care visit. *OR* **You pay __% to __% of the cost for each Medicare-covered urgently needed care visit.** *AND/OR* **You pay $__ to $__ for each Medicare-covered urgently needed care visit.**		**In-Network** $0 copay for Medicare-covered urgent-care visits. *OR* __% to __% of the cost for Medicare-covered urgent-care visits. *AND/OR* $__ to $__ copay for Medicare-covered urgent-care visits.	
; you do not pay this amount if you are admitted to the hospital within __ day(s) [or __ hour(s)] for the same condition. *OR* **; you do not pay this amount if you are immediately admitted to the hospital.**			**In Network (and) Out of Network** If you are admitted to the hospital within __-day(s) [or __ hour(s)] for the same condition, you pay $0 for the urgent-care visit. *OR* If you are immediately admitted to the hospital, you pay $0 for the emergency room visit. You do not pay for the urgent-care visit.

Benefit Category and SB Sentences	Plan Type (*Sentences are for ALL plan types, unless noted.)*	Default Sentence(s) * Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display. * Plan Detail Report: These sentences display along with the "Full Details Sentences"	Full Details Sentences * Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details" * Plan Detail Report: These sentences display along with the "Default Sentences"
NOT covered outside the U.S. except under limited circumstances. *OR* **Worldwide coverage.**			**Out of Network** Not covered outside the U.S. except under limited circumstances. Contact the plan for more details. *OR* Worldwide coverage.
17. Outpatient Rehabilitation			
There is no copayment for each Medicare-covered Occupational Therapy visit. *OR* **You pay $__ to $___ [or__% to % of the cost] for each Medicare-covered Occupational Therapy visit.**		**In-Network** $0 copay for Medicare-covered Occupational Therapy visits. OR $__ to $___ copay [or__% to ___% of the cost] for Medicare-covered Occupational Therapy visits.	
There is no copayment for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit. *OR* **You pay $__ to $___ [or__% to % of the cost] for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit.**		**In-Network** $0 copay for Medicare-covered Physical and/or Speech/Language Therapy visits. *OR* $__ to $___ copay [or__% to ___% of the cost] for Medicare-covered Physical and/or Speech/Language Therapy visits.	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
An additional facility charge may be included in the cost for services.			**In-Network** Additional facility charges may apply.
You pay $__ to $__ [or __% to __% of the cost] for out of network Occupational Therapy services.	***Sentence for PPOs only***	**Out of Network** $___ to $___ copay [or __% to %___ of the cost] for Occupational Therapy benefits.	
You pay $__ to $__ [or __% to __% of the cost] for out of network Physical Therapy and/or Speech language therapy services.	***Sentence for PPOs only***	**Out of Network** $___ to $___ copay [or __% to %___ of the cost] for Physical and/or Speech/Language Therapy visits.	
Authorization rules may apply for services. Contact plan for details			**General** Authorization rules may apply.
18. Durable Medical Equipment			
There is no copayment for Medicare-covered items. *OR* **You pay $__ to $___ [or__% to % of the cost] for each Medicare-covered item.**		**In-Network** $0 copay for Medicare-covered items. OR $___ to $___ copay [or __% to %___ of the cost] for Medicare-covered items.	
You pay $__ to $__ [or __% to __% of the cost] for durable medical equipment purchased out of network.	***Sentence for PPOs only***	**Out of Network** $___ to $___ copay [or __% to %___ of the cost] for durable medical equipment.	
If you do not notify the plan of an equipment or device purchase over $___, you will have to pay	***Sentences for PFFS only***		**General** If you buy equipment or a device that costs more than $___, you must notify

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___% of the billed charges. Contact plan for additional information.			the plan. If you don't notify the plan, you will have to pay ___% of the bill.
Authorization rules may apply for services. Contact plan for details			**General** Authorization rules may apply.
19. Prosthetic Devices			
There is no copayment for Medicare-covered items. *OR* **You pay $__ to $___ [or__% to % of the cost] for each Medicare-covered item.**		**In-Network** $0 copay for Medicare-covered items. OR $___ to $___ copay [or __% to %___ of the cost] for Medicare-covered items.	
You pay $__ to $__ [or __% to __% of the cost] for prosthetic devices purchased out of network.	***Sentence for PPOs only***	**Out of Network** $___ to $___ copay [or __% to %___ of the cost] for prosthetic devices.	
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.	***Sentences for PFFS only***		**General** If you buy equipment or a device that costs more than $___, you must notify the plan. If you don't notify the plan, you will have to pay ___% of the bill.
Authorization rules may apply for services. Contact plan for details.			**General** Authorization rules may apply.
20. Diabetes Self Monitoring Training and Supplies			

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There is no copayment for Diabetes self-monitoring training. *OR* **You pay $___ to $___ [or __% to __% of the cost] for Medicare-covered Diabetes self-monitoring training.**		**In-Network** $0 copay for Diabetes self-monitoring training. OR $___ to $___ copay [or __% to %___ of the cost] for Diabetes self-monitoring training.	
You pay $___ to $___ [or __% to __% of the cost] for out of network Diabetes self-monitoring training.	***Sentence for PPOs only***	**Out of Network** $___ to $___ copay [or __% to %___ of the cost] for Diabetes self-monitoring training.	
There is no copayment for Diabetes supplies. *OR* **You pay $___ to $___ [or ___% to ___% of the cost] for each Medicare-covered Diabetes Supply item.**		**In-Network** $0 copay for Diabetes supplies. OR $___ to $___ copay [or __% to %___ of the cost] for Diabetes supplies.	
You pay $___ to $___ [or ___% to ___% of the cost] for each Diabetes Supply item purchased out of network.	***Sentence for PPOs only***	**Out of Network** $___ to $___ copay [or __% to %___ of the cost] for Diabetes supplies.	
Authorization rules may apply for services. Contact plan for details.			**General** Authorization rules may apply.
21. Diagnostic X-Rays, Tests, and Lab			
There is no copayment for the following Medicare-covered service(s):		**In-Network** $0 copay for Medicare-covered *In combination with any of the following:*	

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- clinical/diagnostic lab services **- radiation therapy** **- X-ray visits**		▪ clinical/diagnostic lab benefits [, and] *OR* ▪ radiation therapy [, and] *OR* ▪ x-rays.	
You pay: **- $__ 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**		**In-Network** $__ to $ __ copay [or __% to __% of the cost] for Medicare-covered clinical/diagnostic lab benefits . $__ to $ __ copay [or __% to __ % of the cost] for Medicare-covered radiation therapy benefits . $__ to $___ copay [or __% to__% of the cost] for Medicare-covered X-rays.	
An additional facility charge may be included in the cost for services.			**In-Network** Additional facility charges may apply.
(You pay:) **- $__ 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**	***Sentence for PPOs only***	**Out of Network** $__ to $ __ copay [or __% to __% of the cost] for clinical/diagnostic lab benefits. $__ to $ __ copay [or __% to __ % of the cost] for radiation therapy benefits. $__ to $___ copay [or __% to__% of the cost] for X-rays.	
Authorization rules may apply			**General**

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for services. Contact plan for details.			Authorization rules may apply.
22. Bone Mass Measurement			
There is no copayment for each Medicare-covered Bone Mass Measurement. *OR* **You pay $___ to $___ [or ___% to ___% of the cost] for each Medicare-covered Bone Mass Measurement.**	***Change for 2007***	**In-Network** $0 copay OR $___ to $___ copay [or ___% to ___% of the cost].	
An additional facility charge may be included in the cost for services.			**In-Network** Additional facility charges may apply.
You pay $__ to $__ [or __% to __% of the cost] for each out of network Bone Mass measurement.	***Sentence for PPOs only***	**Out of Network** $___ to $___ copay [or ___% to ___% of the cost].	
Authorization rules may apply for services. Contact plan for details.			**General** Authorization rules may apply.
23. Colorectal Screening Exams			
There is no copayment for Medicare-covered Colorectal Screening Exams.		**In-Network** $0 copay for Medicare-covered colorectal screening.	
You pay $__ to $___ [or__% to % of the cost] for each Medicare-covered Colorectal Screening exam.		**In-Network** $__ to $___ copay [or__% to__% of the cost] for Medicare-covered colorectal screening.	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
There is no copayment for: **- Medicare-covered Colorectal Screening Exams** **-additional screening exams** *OR* **- additional screening exams up to ___ exam(s) every *(Specified period)*** *OR* **- additional screening exams up to ___ exam(s)**		**In-Network** $0 copay for *In combination with any of the following:* ▪ Medicare-covered colorectal screening [, and] OR ▪ up to __ Medicare-covered colorectal screening every *(Specified period)* [, and] OR ▪ up to ___ Medicare-covered colorectal screening [, and] AND/OR ▪ additional screening. OR ▪ up to ___ additional screening (s) every *(Specified period).* OR ▪ up to ___ additional screening (s).	
You pay: **- $__ 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 *(Specified period)*** *OR* **- $__ to $__ [or __% to __% of the cost] for each additional screening exam up to __ exam(s)**		**In-Network** $__ to $___ copay [or__% to__% of the cost] for Medicare-covered colorectal screenings. $__ to $__ copay [or __% to __% of the cost] for *In combination with one of the following:* up to ___ additional screening (s) every *(Specified period)* up to ___ additional screening (s) additional screenings.	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
OR **- $__ to $__ [or __% to __% of the cost] for each additional screening exam**			
An additional facility charge may be included in the cost for services.			**In-Network** Additional facility charges may apply.
You pay $__ to $__ [or __% to __% of the cost] for each out of network Colorectal Screening exam.	***Sentence for PPOs only***	**Out of Network** $___ to $___ copay [or ___% to ___% of the cost] for colorectal screenings.	
You are covered for an unlimited number of Colorectal Screening exams.			**In-Network** No limit on the number of covered colorectal screenings.
Authorization rules may apply for services. Contact plan for details.			**General** Authorization rules may apply.
24. Immunizations			
There is no copayment for the Pneumonia and Flu vaccines.		**In-Network** $0 copay for Flu and Pneumonia vaccines.	
There is no copayment for the Hepatitis B vaccine. *OR* **You pay $___ [or ___% of the cost] for the Hepatitis B vaccine.**		**In-Network** $0 copay for Hepatitis B vaccine. OR $___ copay [or ___% of the cost] for Hepatitis B vaccine.	
You pay $__ to $__ [or __% to __% of the cost] for each out of network Immunization.	***Sentence for PPOs only***	**Out of Network** $___ copay [or ___% of the cost] for immunizations.	
No referral necessary for Medicare-covered influenza	***Delete sentence for PFFS***		**In-Network** No referral needed for Flu vaccine.

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vaccine.			
No referral necessary for other immunizations. *OR* **Referral required for other immunizations. Please check with your plan for details.**	***Delete sentence for PFFS***		**In-Network** No referral needed for other immunizations. OR Referral needed for other immunizations.
Authorization rules may apply for services. Contact plan for details.			**General** Authorization rules may apply.
25. Mammograms (Annual Screening)			
There is no copayment for Medicare-covered Screening Mammograms.		**In-Network** $0 copay for Medicare-covered screening mammograms.	
There is no copayment for: **- Medicare-covered screening mammograms** **- additional screening mammograms** *OR* **- additional screening mammograms up to__ mammogram(s)** *OR* **- additional screening mammograms up to__ mammogram(s) every (*Specified period*)**		**In-Network** $0 copay for *In combination with any of the following:* ▪ Medicare-covered screening mammograms [, and] OR ▪ up to ___ Medicare-covered screening maammogram(s) every *(Specified period)* [, and] OR ▪ up to ___ Medicare-covered screening mammogram(s) [, and] AND/OR ▪ additional screening mammograms. OR ▪ up to ___ additional screening mammogram(s) every *(Specified period). OR*	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
		▪ up to ___ additional screening mammogram(s).	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
You pay: **- $___ to $__ [or ___% of the cost] for each Medicare-covered Screening Mammogram** **- $__ [or __% of the cost] for each additional screening mammogram** *OR* **- $__ [or __% of the cost] for each additional screening mammogram up to __ mammogram(s)** *OR* **- $__ [or __% of the cost] for each additional screening mammogram up to __ mammogram(s) every (Specified period)**		**In-Network** $__ to $___ copay [or__% of the cost] for Medicare-covered screening mammograms. $__ copay [or __% of the cost] for *In combination with one of the following:* additional screening mammograms. up to ___ additional screening mammogram(s) up to ___ additional screening mammogram(s) every *(Specified period)*.	
You pay $__ to $__ [or __% to __% of the cost] for each out of network Screening Mammogram.	***Sentence for PPOs only***	**Out of Network** $__ to $___ copay [or__% to__% of the cost] for screening mammograms.	
An additional facility charge may be included in the cost for services.			**In-Network** Additional facility charges may apply.
You are covered for an unlimited number of Screening Mammograms.			**In-Network** No limit on the number of covered screening mammograms.
Authorization rules may apply			**General**

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for services. Contact plan for details.			Authorization rules may apply.
26. Pap Smears and Pelvic Exams			
There is no copayment for Medicare-covered Pap Smears and Pelvic Exams.		**In-Network** $0 copay for 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** *OR* **- 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)** *OR* **- additional Pap Smears up to __ Pap Smear(s) every *(Specified period)*** **- additional Pelvic Exams up to __ Pelvic Exam(s) every *(Specified period)***		**In-Network** $0 copay for Medicare-covered pap smears and pelvic exams and *In combination with*: ▪ additional pap smears [, and] ▪ additional pelvic exams [, and] ▪ additional pap smears and pelvic exams. OR ▪ up to __ additional pap smear(s) [, and] ▪ up to __ additional pelvic exam(s) [, and] ▪ up to __ additional pap smear(s) and pelvic exam(s). OR ▪ up to __ additional pap smear(s) every *(Specified period)* [, and] ▪ up to __ additional pelvic exam(s) every *(Specified period)* [, and]	

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- additional Pap Smears and Pelvic Exams up to __ Pap Smear(s) and Pelvic Exam(s) every *(Specified period)*		▪ up to __ additional pap smear(s) and pelvic exam(s) every *(Specified period).*	
You pay: **- $___ [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 *(Specified period)*** **- $__ [or __% of the cost] for each additional Pelvic Exam up to __ Pelvic Exam(s) every *(Specified period)*** **- $__ [or __% of the cost] for each additional Pap Smear and Pelvic Exam up to __ Pap Smear(s) and Pelvic Exam(s) every *(Specified period)*** *OR* **- $__ [or __% of the cost] for**		**In-Network** *A combination of the following:* $___ copay [or ___% of the cost] for Medicare-covered pap smears. $___ copay [or ___% of the cost] for Medicare-covered pelvic exams. $ ___ copay [or ___ % of the cost] for Medicare-covered pap smears and pelvic exams. *In combination with:* $__ copay [or __% of the cost] for up to __ additional pap smear(s) every *(Specified period)* copay [or __% of the cost] for up to __ additional pelvic exam(s) every *(Specified period)* $__ copay [or __% of the cost] for up to __ additional pap smear(s) and pelvic exam(s) every *(Specified period)* OR $__ copay [or __% of the cost] for up to __	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** <u>Plan Comparison Report</u>: For the Top Benefit Categories, these sentences automatically display.** *** <u>Plan Detail Report</u>: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** <u>Plan Comparison Report</u>: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** <u>Plan Detail Report</u>: These sentences display along with the "Default Sentences"**
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)** *OR* **- $__ [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**		additional pap smear(s) $__ $__ copay [or __% of the cost] for up to __ additional pelvic exam(s) $__ copay [or __% of the cost] for up to __ additional pap smear(s) and pelvic exam(s) OR $__ copay [or __% of the cost] for additional pap smears. $__ copay [or __% of the cost] for additional pelvic exams $__ copay [or __% of the cost] for additional pap smears and pelvic exams.	

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An additional facility charge may be included in the cost for services.			**In-Network** Additional facility charges may apply.
You pay $__ to $__ [or __% to __% of the cost] for each out of network Pap Smear and Pelvic Exam.	***Sentence for PPOs only***	**Out of Network** $__ to $___ copay [or__% to__% of the cost] for pap smears and pelvic exams.	
You are covered for an unlimited number of Pap Smears. **You are covered for an unlimited number of Pelvic Exams.** *OR* **You are covered for an unlimited number of Pap Smears and Pelvic Exams.**			**In-Network** No limit on the number of covered pap smears. OR No limit on the number of covered pelvic exams. OR No limit on the number of covered pap smears and pelvic exams.
Authorization rules may apply for services. Contact plan for details.			**General** Authorization rules may apply.
27. Prostate Cancer Screening Exam			
There is no copayment for Medicare-covered Prostate Cancer Screening exams.		**In-Network** $0 copay for Medicare-covered prostate cancer screening.	
You pay $__ [or__% of the cost] for each Medicare-covered Prostate Cancer Screening Exam.		**In-Network** $__ copay [or__% of the cost] for Medicare-covered prostate cancer screening.	
There is no copayment for:		**In-Network** $0 copay for	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
- Medicare-covered Prostate Cancer Screening Exams **- additional screening exams** *OR* **- additional screening exams up to ___ exam(s)** *OR* **- additional screening exams up to ___ exam(s) every (*Specified period*)**		*In combination with any of the following*: ▪ Medicare-covered prostate cancer screening [, and] *OR* *One of the following:* ▪ additional screening. *OR* ▪ up to __ additional screening (s). *OR* ▪ up to __ additional screening (s) every *(Specified period)*.	
You pay: **- $__ [or__% of the cost] for each Medicare-covered Prostate Cancer Screening Exam.** **- $__ [or __% of the cost] for each additional screening exam up to ___ exam(s) every (*Specified period*)** ***OR*** **- $__ [or __% of the cost] for each additional screening exam up to ___ exam(s)** *OR* **- $__ [or __% of the cost] for each additional screening exam**		**In-Network** $__ copay [or__% of the cost] for Medicare-covered prostate cancer screening exams. AND $__ copay [or __% of the cost] for *In combination with one of the following:* up to ___ additional screening (s) every (*Specified period*). ***OR*** up to ___ additional screening(s). ***OR*** additional screening(s).	

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An additional facility charge may be included in the cost for services.			**In-Network** Additional facility charges may apply.
You pay $__ to $__ [or __% to __% of the cost] for each out of network Prostate Screening Exam.	***Sentence for PPOs only***	**Out of Network** $__ to $___ copay [or__% to__% of the cost] for prostate cancer screening.	
You are covered for an unlimited number of Prostate Cancer Screening exams.			**In-Network** No limit on the number of covered prostate cancer screening.
Authorization rules may apply for services. Contact plan for details.			**General** Authorization rules may apply.
28. Prescription Drugs			
Drugs covered under Medicare Part B (Original Medicare)			
You pay 100% for most prescription drugs.		**In-Network** You pay 100% for most drugs.	
You pay a deductible of $___ for Part B-covered drugs.		**In-Network** $____ deductible.	
You pay $__ to $__ [or __% of the cost] for Part B-covered drugs.	***New for 2007***	**In-Network** $__ to $__ copay [or __% of the cost] of drugs.	
Drugs covered under Medicare Part D (Prescription Drug Benefit)			
	The following sentences will NOT appear in SB-28 for Cost Plans offering Part D; they will be displayed in the SB		

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
	Opt Supp Packages category.		
This plan does not cover Medicare Part D prescription drugs.	*Part D Not Offered – MA Only plans*	**General** This plan does not offer prescription drug coverage.	
This plan uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at <web site address>.	*Sentence automatically generated if the Plan offers Part D and indicates a Formulary.*		**General** This plan uses a formulary. A formulary is a list of drugs covered by the plan. If a plan takes a drug off the list; changes a drug on its list to a more expensive tier; or places a prior authorization, step therapy or quantity limit requirement on a drug, the plan will tell you at least 60 days before the change is effective. The plan will send you the formulary. You can also see the formulary at <web site address> on the web.
People who have limited 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.	*Sentence automatically generated if the Plan offers Part D.* ** for all plans EXCEPT Exclusive Full Dual Eligible*		**General** Different out-of-pocket costs may apply for people who • have limited incomes, • live in long term care facilities, or • have access to

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
	SNPs AND Exclusive Partial Dual Eligible SNPs Change for 2007		Indian/Tribal/Urban (Indian Health Service).
You pay $___ each month for your Medicare Part D prescription benefits. **OR** **There is no premium for your Medicare Part D prescription benefits.**	*PDPs and Fallback plans*	**General** $__ monthly premium OR $0 monthly premium.	
	(2007 Sentences for Defined Std benefit)		
Deductible			
You pay a $___ yearly deductible.	**** for all plans EXCEPT Exclusive Full Dual Eligible SNPs AND Exclusive Partial Dual Eligible SNPs***	**In Network** $___ yearly deductible	
Initial Coverage			
After you have paid your yearly deductible and before the total yearly drug costs (paid by both you and your plan) reach $____, you pay __% of your drug costs.		**In Network** After you pay your yearly deductible, you pay __% until total yearly drug costs reach $____.	**General** Total yearly drug costs are the total drug costs paid by both you and the plan.
In-Network Retail Pharmacy			
You may receive drugs for the following: **- one month (x day) supply**			**In Network** You can get drugs the following way(s): ▪ one-month (__-day) supply

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
- three month (x day) supply **- x day supply**			▪ three-month (__-day) supply ▪ __-day supply
You may receive drugs from a preferred pharmacy for the following: **- one month (x day) supply** **- three month (x day) supply** **- x day supply**			**In Network** You can get drugs from a preferred pharmacy the following way(s): ▪ one-month (__-day) supply ▪ three-month (__**-day**) supply ▪ __-day supply
You may receive drugs from a non-preferred pharmacy for the following: **- one month (x day) supply** **- three month (x day) supply** **- x day supply**			**In Network** You can get drugs from a non-preferred pharmacy the following way(s): ▪ one-month (__-day) supply ▪ three-month (__**-day**) supply ▪ __-day supply
Mail Order			
You may receive drugs for the following: **- one month (x day) supply** **- three month (x day) supply** **- x day supply**			**In Network** You can get drugs the following way(s): ▪ one-month (__-day) supply ▪ three-month (__-day) supply ▪ __-day supply
You may receive drugs through a preferred mail order for the following: **- one month (x day) supply** **- three month (x day) supply** **- x day supply**			**In Network** You can get drugs from a preferred mail order pharmacy the following way(s): ▪ one-month (__-day) supply ▪ three-month (__**-day**) supply ▪ __-day supply
You may receive drugs through a non-preferred mail order for the following: **- one month (x day) supply**			**In Network** You can get drugs from a non-preferred mail order pharmacy the following way(s):

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
- three month (x day) supply **- x day supply**			▪ one-month (__-day) supply ▪ three-month (__**-day**) supply ▪ __-day supply
Coverage AfterYou Reach Your Initial Coverage Limit			
After the total yearly drug costs (paid by both you and your plan) reach $____, you pay 100% of your drug costs until your yearly out-of-pocket drug costs reach $____.		**In Network** After your total yearly drug costs reach $____, you pay 100% until your yearly out-of-pocket drug costs reach $___.	**General** Total yearly drug costs are the total drug costs paid by both you and the plan.
Catastrophic Coverage			
After your yearly out-of-pocket drug costs reach $___, you pay the greater of: **- $___ for generic (including brand drugs treated as generic) and $___ for all other drugs, or** **- ___% coinsurance.**		**In Network** After your yearly out-of-pocket drug costs reach $___ you pay the greater of: ▪ $___ copay for generic (including brand drugs treated as generic) and $___ copay for all other drugs, or ▪ ___% coinsurance.	
	(2007 Sentences for Exclusive Full Dual Eligible SNPs)		
This plan uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how	*Sentence automatically generated if the Plan offers Part D and indicates a Formulary.* Change for 2007		**General** This plan uses a formulary. A formulary is a list of drugs covered by the plan. If a plan takes a drug off the list; changes a drug on its list to a more expensive tier; or places a prior authorization, step therapy or quantity limit requirement on a

Benefit Category and SB Sentences	Plan Type (*Sentences are for ALL plan types, unless noted.)*	Default Sentence(s) * Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display. * Plan Detail Report: These sentences display along with the "Full Details Sentences"	Full Details Sentences * Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details" * Plan Detail Report: These sentences display along with the "Default Sentences"
much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at <web site address>.			drug, the plan will tell you at least 60 days before the change is effective. The plan will send you the formulary. You can also see the formulary at <web site address> on the web.
Initial Coverage			
Depending upon your income level, you pay $__to $__for generic drugs (including brand drugs treated as generic) and $__ to $__ for all other drugs.	***Exclusive Full Dual Eligible SNPs***	**In Network** $__to $__copay for generic drugs (including brand drugs treated as generic) and $__ to $__ copay for all other drugs. (Amount depends on your income).	
In-Network Retail Pharmacy			
You may receive drugs for the following: **- one month (x day) supply** **- three month (x day) supply** **- x day supply**			**In Network** You can get drugs the following way(s): ▪ one-month (__-day) supply ▪ three-month (__-day) supply ▪ __-day supply
You may receive drugs from a preferred pharmacy for the following: **- one month (x day) supply** **- three month (x day) supply** **- x day supply**			**In Network** You can get drugs from a preferred pharmacy the following way(s): ▪ one-month (__-day) supply ▪ three-month (__**-day**) supply ▪ __-day supply
You may receive drugs from a non-preferred pharmacy for the following:			**In Network** You can get drugs from a non-preferred pharmacy the following way(s):

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
- one month (x day) supply **- three month (x day) supply** **- x day supply**			▪ one-month (__-day) supply ▪ three-month (__**-day**) supply ▪ __-day supply
Mail Order			
You may receive drugs for the following: **- one month (x day) supply** **- three month (x day) supply** **- x day supply**			**In Network** You can get drugs the following way(s): ▪ one-month (__-day) supply ▪ three-month (__-day) supply ▪ __-day supply
You may receive drugs through a preferred mail order for the following: **- one month (x day) supply** **- three month (x day) supply** **- x day supply**			**In Network** You can get drugs from a preferred mail order pharmacy the following way(s): ▪ one-month (__-day) supply ▪ three-month (__**-day**) supply ▪ __-day supply
You may receive drugs through a non-preferred mail order for the following: **- one month (x day) supply** **- three month (x day) supply** **- x day supply**			**In Network** You can get drugs from a non-preferred mail order pharmacy the following way(s): ▪ one-month (__-day) supply ▪ three-month (__**-day**) supply ▪ __-day supply
Catastrophic Coverage			
After your yearly out-of-pocket drug costs reach $___, you pay $__ for your drugs.	***Exclusive Full Dual Eligible SNPs***	**In Network** After your yearly out-of-pocket drug costs reach $___, you pay a $___ copay.	
	(2007 Sentences for Exclusive Partial Dual Eligible SNPs)		
This plan uses a formulary. A	*Sentence*		**General**

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at <web site address>.	*automatically generated if the Plan offers Part D. Change for 2007*		This plan uses a formulary. A formulary is a list of drugs covered by the plan. If a plan takes a drug off the list; changes a drug on its list to a more expensive tier; or places a prior authorization, step therapy or quantity limit requirement on a drug, the plan will tell you at least 60 days before the change is effective. The plan will send you the formulary. You can also see the formulary at <web site address> on the web.
Deductible			
Depending upon your income level, you pay a $__ to $__ yearly deductible.		**In Network** $__ to $___ yearly deductible (amount depends on your income.)	
Initial Coverage			
Depending upon your income level, you pay the lesser of $__ to $__ or __% coinsurance for generic drugs (including brand drugs treated as generic) and the lesser of $__ to $__ or __% coinsurance for all other drugs.	***Exclusive Partial Dual Eligible SNPs***	**In Network** Depending on your income, you pay the lesser of $__ to $__ copay or __% coinsurance for generic drugs (including brand drugs treated as generic). You pay the lesser of $__ to $__ copay or __% coinsurance for all other drugs.	
In-Network Retail Pharmacy			
You may receive drugs for the			**In Network**

Benefit Category and SB Sentences	Plan Type (*Sentences are for ALL plan types, unless noted.)*	Default Sentence(s) * Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display. * Plan Detail Report: These sentences display along with the "Full Details Sentences"	Full Details Sentences * Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details" * Plan Detail Report: These sentences display along with the "Default Sentences"
following: **- one month (x day) supply** **- three month (x day) supply** **- x day supply**			You can get drugs the following way(s): ▪ one-month (__-day) supply ▪ three-month (__-day) supply ▪ __-day supply
You may receive drugs from a preferred pharmacy for the following: **- one month (x day) supply** **- three month (x day) supply** **- x day supply**			**In Network** You can get drugs from a preferred pharmacy the following way(s): ▪ one-month (__-day) supply ▪ three-month (__**-day**) supply ▪ __-day supply
You may receive drugs from a non-preferred pharmacy for the following: **- one month (x day) supply** **- three month (x day) supply** **- x day supply**			**In Network** You can get drugs from a non-preferred pharmacy the following way(s): ▪ one-month (__-day) supply ▪ three-month (__**-day**) supply ▪ __-day supply
Mail Order			
You may receive drugs for the following: **- one month (x day) supply** **- three month (x day) supply** **- x day supply**			**In Network** You can get drugs the following way(s): ▪ one-month (__-day) supply ▪ three-month (__-day) supply ▪ __-day supply
You may receive drugs through a preferred mail order for the following: **- one month (x day) supply** **- three month (x day) supply** **- x day supply**			**In Network** You can get drugs from a preferred mail order pharmacy the following way(s): ▪ one-month (__-day) supply ▪ three-month (__**-day**) supply ▪ __-day supply
You may receive drugs through a non-preferred mail order for the			**In Network** You can get drugs from a non-preferred

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
following: **- one month (x day) supply** **- three month (x day) supply** **- x day supply**			mail order pharmacy the following way(s): ▪ one-month (__-day) supply ▪ three-month (**__-day**) supply ▪ __-day supply
Catastrophic Coverage			
Depending upon your income level, after your yearly out-of-pocket drug costs reach $____, you pay the following for your drugs: **- $__ for any drugs; or** **- $__ for generic drugs (including brand drugs treated as generic) and $__ for all other drugs**	***Exclusive Partial Dual Eligible SNPs***	**In Network** After your yearly out-of-pocket costs reach $___, you pay the following (amount depends on your income): ▪ $__ copay for any drugs; or ▪ $__ copay for generic drugs (including brand drugs treated as generic) and $__ copay for all other drugs	
	(2007 Sentences for Actuarially Equivalent benefit)		
Deductible			
You pay a $___ yearly deductible.		**In Network** $___ yearly deductible	
Initial Coverage			
After you have paid your yearly deductible and before the total yearly drug costs (paid by both you and your plan) reach $____, you pay __% of your yearly drug costs.		**In Network** After you pay your yearly deductible, you pay __% until total yearly drug costs reach $____.	**General** Total yearly drug costs are the total drug costs paid by both you and the plan.

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
OR **After you have paid your yearly deductible and before the total yearly drug costs (paid by both you and your plan) reach $____, you pay the following for prescription drugs:**		OR After you pay your yearly deductible, you pay the following until total yearly drug costs reach $____:	
In-Network Retail Pharmacy			
- *{greater of; lesser of}* $___ [or ____% coinsurance] for a one month (x day) supply of *(Tier label)* drugs **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a three month (x day) supply of *(Tier label)* drugs** **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a x day supply of *(Tier label)* drugs**		▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a x-day supply of *(Tier label)* drugs	
- *{greater of; lesser of}* $___ [or ____% coinsurance] for a one month (x day) supply of *(Tier label)* drugs you get at a preferred pharmacy **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a three month (x day) supply of *(Tier label)* drugs you get at a preferred pharmacy** **- *{greater of; lesser of}* $___ [or**		▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a preferred pharmacy ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a preferred pharmacy ▪ $___ copay [or ____% coinsurance]	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
____% coinsurance] for a x day supply of *(Tier label)* drugs you get at a preferred pharmacy		[whichever costs [more/less]] for a x-day supply of *(Tier label)* drugs from a preferred pharmacy	
- *{greater of; lesser of}* $___ [or ____% coinsurance] for a one month (x day) supply of *(Tier label)* drugs you get at a non-preferred pharmacy **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a three month (x day) supply of *(Tier label)* drugs you get at a non-preferred pharmacy** **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a x day supply of *(Tier label)* drugs you get at a non-preferred pharmacy**		▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a non-preferred pharmacy ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a non-preferred pharmacy ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a x-day supply of *(Tier label)* drugs from a non-preferred pharmacy	
Mail Order			
- *{greater of; lesser of}* $___ [or ____% coinsurance] for a one month (x day) supply of *(Tier label)* drugs **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a three month (x day) supply of *(Tier label)* drugs** **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a x day supply of *(Tier label)* drugs**		▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a x-day supply of *(Tier label)* drugs	
- *{greater of; lesser of}* $___ [or		▪ $___ copay [or ____% coinsurance]	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
____% coinsurance] for a one month (x day) supply of *(Tier label)* drugs you get through a preferred mail order . **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a three month (x day) supply of *(Tier label)* drugs you get through a preferred mail order** **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a x day supply of *(Tier label)* drugs you get through a preferred mail order**		[whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a preferred mail order pharmacy. ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a preferred mail order pharmacy. ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a x-day supply of *(Tier label)* drugs from a preferred mail order pharmacy.	
- *{greater of; lesser of}* $___ [or ____% coinsurance] for a one month (x day) supply of *(Tier label)* drugs you get through a non-preferred mail order **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a three month (x day) supply of *(Tier label)* drugs you get through a non-preferred mail order** **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a (x day) supply of *(Tier label)* drugs you get through a non-preferred mail order**		▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a non-preferred mail order pharmacy. ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a non-preferred mail order pharmacy. ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a x-day supply of *(Tier label)* drugs from a non-preferred mail order pharmacy.	
Coverage AfterYou Reach Your			

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
Initial Coverage Limit			
After the total yearly drug costs (paid by both you and your plan) reach $2,250, you pay 100% of your drug costs until your yearly out-of-pocket drug costs reach $3,600.		**In Network** After your total yearly drug costs reach $____, you pay 100% until your yearly out-of-pocket drug costs reach $___.	**General** Total yearly drug costs are the total drug costs paid by both you and the plan.
Catastrophic Coverage			
After your yearly out-of-pocket drug costs reach $____, you pay the greater of: - **$__ for generic (including brand drugs treated as generic) and $__ for all other drugs, or** - **__% coinsurance.** *OR* **After your yearly out-of-pocket drug costs reach $____, you pay the following for prescription drugs:**		**In Network** After your yearly out-of-pocket drug costs reach $___ you pay the greater of: ▪ $___ copay for generic (including brand drugs treated as generic) and $___ copay for all other drugs, or ▪ ___% coinsurance. OR After your yearly out-of-pocket drug costs reach $____, you pay the following:	
- *{greater of; lesser of}* $___ [or ____% coinsurance] for *(Tier label)* drugs		- $___ copay [or ____% coinsurance] [whichever costs [more/less]] for *(Tier label)* drugs	
	(2007 Sentences for Basic Alternative benefit)		

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
Deductible			
You pay a $___ yearly deductible. ***OR*** **There is no deductible.** ***OR*** **You pay a $___ yearly deductible.**		**In Network** $___ yearly deductible OR $0 deductible	
Initial Coverage			
Before the total yearly drug costs (paid by both you and your plan) reach $___, you pay __% of your drug costs. ***OR*** **After you have paid your yearly deductible and before the total yearly drug costs (paid by both you and your plan) reach $___, you pay __% of your drug costs.** ***OR*** **Before the total yearly drug costs (paid by both you and your plan) reach $___, you pay the following for prescription drugs:** ***OR*** **After you have paid your yearly deductible and before the total yearly drug costs (paid by both**		**In Network** __% until total yearly drug costs reach $___. *OR* After you pay your yearly deductible, you pay __% until total yearly drug costs reach $___. *OR* You pay the following until total yearly drug costs reach $___: *OR* After you pay your yearly deductible, you pay the following until total yearly drug costs reach $___:	**General** Total yearly drug costs are the total drug costs paid by both you and the plan.

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
you and your plan) reach $___, you pay the following for prescription drugs:			
In-Network Retail Pharmacy			
- *{greater of; lesser of}* $___ [or ____% coinsurance] for a one month (x day) supply of *(Tier label)* drugs **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a three month (x day) supply of *(Tier label)* drugs** **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a x day supply of *(Tier label)* drugs**		▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a x-day supply of *(Tier label)* drugs	
- *{greater of; lesser of}* $___ [or ____% coinsurance] for a one month (x day) supply of *(Tier label)* drugs you get at a preferred pharmacy **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a three month (x day) supply of *(Tier label)* drugs you get at a preferred pharmacy** **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a x day supply of *(Tier label)* drugs you get at a preferred pharmacy**		▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a preferred pharmacy ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a preferred pharmacy ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a x-day supply of *(Tier label)* drugs from a preferred pharmacy	
- *{greater of; lesser of}* $___ [or		▪ $___ copay [or ____% coinsurance]	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** <u>Plan Comparison Report</u>: For the Top Benefit Categories, these sentences automatically display.** *** <u>Plan Detail Report</u>: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** <u>Plan Comparison Report</u>: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** <u>Plan Detail Report</u>: These sentences display along with the "Default Sentences"**
____% coinsurance] for a one month (x day) supply of *(Tier label)* drugs you get at a non-preferred pharmacy **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a three month (x day) supply of *(Tier label)* drugs you get at a non-preferred pharmacy** **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a x day supply of *(Tier label)* drugs you get at a non-preferred pharmacy**		[whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a non-preferred pharmacy ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a non-preferred pharmacy ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a x-day supply of *(Tier label)* drugs from a non-preferred pharmacy	
Mail Order			
- *{greater of; lesser of}* $___ [or ____% coinsurance] for a one month (x day) supply of *(Tier label)* drugs **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a three month (x day) supply of *(Tier label)* drugs** **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a x day supply of *(Tier label)* drugs**		▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a x-day supply of *(Tier label)* drugs	
- *{greater of; lesser of}* $___ [or ____% coinsurance] for a one month (x day) supply of *(Tier label)* drugs you get through a preferred mail order.		▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a preferred mail order pharmacy.	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
- *{greater of; lesser of}* $___ [or ____% coinsurance] for a three month (x day) supply of *(Tier label)* drugs you get through a preferred mail order **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a x day supply of *(Tier label)* drugs you get through a preferred mail order**		▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a preferred mail order pharmacy. ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a x-day supply of *(Tier label)* drugs from a preferred mail order pharmacy.	
- *{greater of; lesser of}* $___ [or ____% coinsurance] for a one month (x day) supply of *(Tier label)* drugs you get through a non-preferred mail order **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a three month (x day) supply of *(Tier label)* drugs you get through a non-preferred mail order** **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a (x day) supply of *(Tier label)* drugs you get through a non-preferred mail order**		▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a non-preferred mail order pharmacy. ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a non-preferred mail order pharmacy. ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a x-day supply of *(Tier label)* drugs from a non-preferred mail order pharmacy.	
Coverage After You Reach Your Initial Coverage Limit			
After the total yearly drug costs (paid by both you and your plan) reach $____, you pay 100% of		**In Network** After your total yearly drug costs reach $____, you pay 100% until your yearly out-	**General** Total yearly drug costs are the total drug costs paid by both you and the plan.

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
your prescription drug costs up until your yearly out-of-pocket drug costs reach $____.		of-pocket drug costs reach $___.	
Catastrophic Coverage			
After your yearly out-of-pocket drug costs reach $____, there is no copayment for prescription drugs. ***OR*** **After your yearly out-of-pocket drug costs reach $____ you pay the greater of:** - **$__ for generic (including brand drugs treated as generic) and $__ for all other drugs, or** - **__% coinsurance.** ***OR*** **After your yearly out-of-pocket drug costs reach $____, you pay the following for prescription drugs:**		**In Network** After your yearly out-of-pocket drug costs reach $___ you pay $0. OR After your yearly out-of-pocket drug costs reach $___ you pay the greater of: ▪ $___ copay for generic (including brand drugs treated as generic) and $___ copay for all other drugs, or ▪ ___% coinsurance. OR After your yearly out-of-pocket drug costs reach $___ you pay the following:	
- *{greater of; lesser of}* $___ [or ____% coinsurance] for *(Tier label)* drugs		- $___ copay [or ____% coinsurance] [whichever costs [more/less]] for *(Tier label)* drugs	
	(2007 Sentences for Enhanced Alternative benefit)		
Deductible			

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
You pay a $___ yearly deductible. *OR* **There is no deductible.** *OR* **You pay a $___ yearly deductible.** *OR* **You pay a $___ deductible on all drugs except Generic drugs. You pay** *{greater of; lesser of}* **$__ [or __%] for Generic drugs until you reach the deductible.**		**In Network** $___ yearly deductible OR $0 deductible OR $___ deductible on all drugs except generic drugs. You pay a $__ copay [or __% coinsurance] [whichever costs [more/less]] for generic drugs until you reach the deductible.	
Initial Coverage			
Before the total yearly drug costs (paid by both you and your plan) reach $___, there is no copayment for prescription drugs. *OR* **Before the total yearly drug costs (paid by both you and your plan) reach $_____, you pay __% of your drug costs.** ***OR*** **Before the total yearly drug costs (paid by both you and your plan) reach $___, you pay the following**		**In Network** $0 copay until total yearly drug costs reach $___. OR __% until total yearly drug costs reach $___. OR You pay the following until total yearly drug costs reach $___.	**General** Total yearly drug costs are the total drug costs paid by both you and the plan.

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
for prescription drugs: *OR* **After you have paid your yearly deductible and before the total yearly drug costs (paid by both you and your plan) reach $___, there is no copayment for prescription drugs.** *OR* **After you have paid your yearly deductible and before the total yearly drug costs (paid by both you and your plan) reach $_____, you pay __% of your drug costs.** *OR* **After you have paid your yearly deductible and before the total yearly drug costs (paid by both you and your plan) reach $___, you pay the following for prescription drugs:** ***OR*** **After you have paid your yearly deductible, there is no copayment for prescription drugs.** *OR* **After you have paid your yearly deductible, you pay __% of your drug costs.** *OR*		*OR* After you pay your yearly deductible, you pay a $0 copay until total yearly drug costs reach $___. *OR* After you pay your yearly deductible, you pay ___% until total yearly drug costs reach $___. OR After you pay your yearly deductible, you pay the following until total yearly drug costs reach $___: OR After you pay your yearly deductible, you pay a $0 copay. OR After you pay your yearly deductible, you pay ___%. OR After you pay your yearly deductible, you	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
After you have paid your yearly deductible, you pay the following for prescription drugs: ***OR*** **There is no copayment for prescription drugs.** *OR* **You pay __% of your drug costs.** *OR* **You pay the following for prescription drugs:**		pay the following: OR $0 copay OR ___% OR You pay the following:	
In-Network Retail Pharmacy			
- *{greater of; lesser of}* $___ [or ____% coinsurance] for a one month (x day) supply of *(Tier label)* drugs **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a three month (x day) supply of *(Tier label)* drugs** **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a x day supply of *(Tier label)* drugs**		▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a x-day supply of *(Tier label)* drugs	
- *{greater of; lesser of}* $___ [or ____% coinsurance] for a one month (x day) supply of *(Tier label)* drugs you get at a preferred pharmacy **- *{greater of; lesser of}* $___ [or**		▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a preferred pharmacy ▪ $___ copay [or ____% coinsurance]	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** <u>Plan Comparison Report</u>: For the Top Benefit Categories, these sentences automatically display.** *** <u>Plan Detail Report</u>: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** <u>Plan Comparison Report</u>: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** <u>Plan Detail Report</u>: These sentences display along with the "Default Sentences"**
____% coinsurance] for a three month (x day) supply of *(Tier label)* drugs you get at a preferred pharmacy **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a x day supply of *(Tier label)* drugs you get at a preferred pharmacy**		[whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a preferred pharmacy ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a x-day supply of *(Tier label)* drugs from a preferred pharmacy	
- *{greater of; lesser of}* $___ [or ____% coinsurance] for a one month (x day) supply of *(Tier label)* drugs you get at a non-preferred pharmacy **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a three month (x day) supply of *(Tier label)* drugs you get at a non-preferred pharmacy** **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a x day supply of *(Tier label)* drugs you get at a non-preferred pharmacy**		▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a non-preferred pharmacy ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a non-preferred pharmacy ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a x-day supply of *(Tier label)* drugs from a non-preferred pharmacy	
Mail Order			
- *{greater of; lesser of}* $___ [or ____% coinsurance] for a one month (x day) supply of *(Tier label)* drugs **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a three month (x day) supply of *(Tier***		▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier*	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** <u>Plan Comparison Report</u>: For the Top Benefit Categories, these sentences automatically display.** *** <u>Plan Detail Report</u>: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** <u>Plan Comparison Report</u>: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** <u>Plan Detail Report</u>: These sentences display along with the "Default Sentences"**
***label)* drugs** **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a x day supply of *(Tier label)* drugs**		*label)* drugs ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a x-day supply of *(Tier label)* drugs	
- *{greater of; lesser of}* $___ [or ____% coinsurance] for a one month (x day) supply of *(Tier label)* drugs you get through a preferred mail order. **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a three month (x day) supply of *(Tier label)* drugs you get through a preferred mail order** **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a x day supply of *(Tier label)* drugs you get through a preferred mail order**		▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a preferred mail order pharmacy. ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a preferred mail order pharmacy. ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a x-day supply of *(Tier label)* drugs from a preferred mail order pharmacy.	
- *{greater of; lesser of}* $___ [or ____% coinsurance] for a one month (x day) supply of *(Tier label)* drugs you get through a non-preferred mail order **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a three month (x day) supply of *(Tier label)* drugs you get through a non-preferred mail order** **- *{greater of; lesser of}* $___ [or**		▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a non-preferred mail order pharmacy. ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a non-preferred mail order pharmacy. ▪ $___ copay [or ____% coinsurance]	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
____% coinsurance] for a x day supply of *(Tier label)* drugs you get through a non-preferred mail order		[whichever costs [more/less]] for a x-day supply of *(Tier label)* drugs from a non-preferred mail order pharmacy.	
Coverage After You Reach Your Initial Coverage Limit			
After the total yearly drug costs (paid by both you and your plan) reach $____, you pay 100% of your prescription drug costs up until your yearly out-of-pocket drug costs reach $____. ***OR*** **You pay the following:**		**In Network** After your total yearly drug costs reach $____, you pay 100% until your yearly out-of-pocket drug costs reach $___. OR You pay the following:	**General** Total yearly drug costs are the total drug costs paid by both you and the plan.
In-Network Retail Pharmacy			
- *{greater of; lesser of}* $___ [or ____% coinsurance] for a one month (x day) supply of *(Tier label)* drugs **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a three month (x day) supply of *(Tier label)* drugs** **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a x day supply of *(Tier label)* drugs**		▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a x-day supply of *(Tier label)* drugs	
- *{greater of; lesser of}* $___ [or ____% coinsurance] for a one month (x day) supply of *(Tier*		▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier*	

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***label)* drugs you get at a preferred pharmacy** **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a three month (x day) supply of *(Tier label)* drugs you get at a preferred pharmacy** **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a x day supply of *(Tier label)* drugs you get at a preferred pharmacy**		*label)* drugs from a preferred pharmacy ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a preferred pharmacy ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a x-day supply of *(Tier label)* drugs from a preferred pharmacy	
- *{greater of; lesser of}* $___ [or ____% coinsurance] for a one month (x day) supply of *(Tier label)* drugs you get at a non-preferred pharmacy **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a three month (x day) supply of *(Tier label)* drugs you get at a non-preferred pharmacy** **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a x day supply of *(Tier label)* drugs you get at a non-preferred pharmacy**		▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a non-preferred pharmacy ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a non-preferred pharmacy ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a x-day supply of *(Tier label)* drugs from a non-preferred pharmacy	
Mail Order			
- *{greater of; lesser of}* $___ [or ____% coinsurance] for a one month (x day) supply of *(Tier label)* drugs		▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
- *{greater of; lesser of}* $___ [or ____% coinsurance] for a three month (x day) supply of *(Tier label)* drugs **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a x day supply of *(Tier label)* drugs**		▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a x-day supply of *(Tier label)* drugs	
- *{greater of; lesser of}* $___ [or ____% coinsurance] for a one month (x day) supply of *(Tier label)* drugs you get through a preferred mail order . **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a three month (x day) supply of *(Tier label)* drugs you get through a preferred mail order** **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a x day supply of *(Tier label)* drugs you get through a preferred mail order**		▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a preferred mail order pharmacy. ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a preferred mail order pharmacy. ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a x-day supply of *(Tier label)* drugs from a preferred mail order pharmacy.	
- *{greater of; lesser of}* $___ [or ____% coinsurance] for a one month (x day) supply of *(Tier label)* drugs you get through a non-preferred mail order **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a three**		▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a one-month (x-day) supply of *(Tier label)* drugs from a non-preferred mail order pharmacy. ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
month (x day) supply of *(Tier label)* drugs you get through a non-preferred mail order **- *{greater of; lesser of}* $___ [or ____% coinsurance] for a x day supply of *(Tier label)* drugs you get through a non-preferred mail order**		one-month (x-day) supply of *(Tier label)* drugs from a non-preferred mail order pharmacy. ▪ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for a x-day supply of *(Tier label)* drugs from a non-preferred mail order pharmacy.	
For all other covered drugs and after the total yearly drug costs (paid by both you and your plan) reach $___, you pay 100% of your prescription drug costs up until your yearly out-of-pocket drug costs reach $____.		**In Network** For all other covered drugs, after your total yearly drug costs reach $____, you pay 100% until your yearly out-of-pocket drug costs reach $___.	**General** Total yearly drug costs are the total drug costs paid by both you and the plan.
Catastrophic Coverage			
After your total yearly out-of-pocket drug costs reach $____, there is no copayment for your prescription drugs *OR* **After your total yearly out-of-pocket drug costs reach $____, you pay** **the greater of:** - **$__ for generic (including brand drugs treated as generic) and $__ for all other drugs, or**		**In Network** After your yearly out-of-pocket drug costs reach $___ you pay a $0 copay. OR After your yearly out-of-pocket drug costs reach $___ you pay the greater of: ▪ $___ copay for generic (including brand drugs treated as generic) and $___ copay for all other drugs, or ▪ ___% coinsurance.	

Benefit Category and SB Sentences	Plan Type (*Sentences are for ALL plan types, unless noted.)*	Default Sentence(s) * Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display. * Plan Detail Report: These sentences display along with the "Full Details Sentences"	Full Details Sentences * Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details" * Plan Detail Report: These sentences display along with the "Default Sentences"
- **__% coinsurance.** *OR* **After your total yearly out-of-pocket drug costs reach $____, you pay the following for your prescription drugs:**		OR After your yearly out-of-pocket drug costs reach $___ you pay the following:	
After your total yearly drug costs (paid by both you and your plan) reach $____, there is no copayment for your prescription drugs *OR* **After your total yearly drug costs (paid by both you and your plan) reach $____, you pay the greater of:** - **$__ for generic (including brand drugs treated as generic) and $__ for all other drugs, or** - **__% coinsurance.** *OR* **After your total yearly drug costs (paid by both you and your plan) reach $____, you pay the following for your prescription drugs:**		**In Network** After your total yearly drug costs reach $___ you pay a $0 copay. OR After your total yearly drug costs reach $___ you pay the greater of: ▪ $___ copay for generic (including brand drugs treated as generic) and $___ copay for all other drugs, or ▪ ___% coinsurance. OR After your total yearly drug costs reach $___ you pay the following:	**General** Total yearly drug costs are the total drug costs paid by both you and the plan.

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** <u>Plan Comparison Report</u>: For the Top Benefit Categories, these sentences automatically display.** *** <u>Plan Detail Report</u>: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** <u>Plan Comparison Report</u>: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** <u>Plan Detail Report</u>: These sentences display along with the "Default Sentences"**
- ***{greater of; lesser of}* $___ [or ____% coinsurance] for *(Tier label)* drugs.**		○ $___ copay [or ____% coinsurance] [whichever costs [more/less]] for *(Tier label)* drugs.	
	2007 Sentences for all types:		
General Information			
You may incur a cost in addition to the copay if you select a higher cost drug when a lesser cost drug is available.	***Sentence for Actuarially Equivalent, Basic and Enhanced Alternative ONLY*** *Change for 2007* *Sentence will NOT be generatd for Exclusive Full Dual Eligible SNPs.* *Sentence will NOT be generated for Exclusive Partial Dual Eligible SNPs*		**In Network** You may have to pay more than your copay if you choose to use a higher cost drug when a lower cost drug is available.
In some cases, the plan requires you to first try one drug to treat your medical condition before they will cover another drug for that condition.	***New for 2007***		**General** The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.
Certain prescription drugs will have maximum quantity limits.			**General** Some drugs have quantity limits.

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
Your provider must get prior authorization from <*Plan Name*> for certain prescription drugs.			**In Network** Your provider must get prior authorization from <*Plan Name*> for certain drugs.
Some of the drugs covered by this plan do not count toward your out-of-pocket expenses. You are covered up to $___ for these drugs.	***Sentence for Enhanced Alternative ONLY*** *New for 2007* *Sentence will NOT be generatd for Exclusive Full Dual Eligible SNPs.* *Sentence will NOT be generated for Exclusive Partial Dual Eligible SNPs.*	**In Network** Some covered drugs don't count toward your out-of-pocket drug costs. You are covered up to $___ for these drugs.	
Covered Part D drugs are available at out-of-network pharmacies in special circumstances including illness while traveling outside of the plan's service area where there is no network pharmacy. You may also incur an additional cost for drugs received at an out-of-network pharmacy.	***New for 2007***		**Out-of-Network** Covered drugs are available in special circumstances, including illness while traveling outside of the plan's service area where there is no network pharmacy. You may pay more for drugs you get at an out-of-network pharmacy.
Please contact the plan for details.	***New for 2007***	<sentence not used>	

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29. Dental			
In general, you pay 100% for preventive dental services. ***OR*** **In general, you pay 100% for preventive dental services.** **See optional benefits section below.**	***Change for 2007***	**In-Network** Preventive Dental Benefits: In general, you pay 100% for preventive dental benefits (such as cleaning).	**In-Network** Preventive Dental Benefits: This plan offers more preventive dental coverage as an optional benefit. See the Optional Benefits section below.
You pay $___to $___ [or ___%to ___% of the cost] for each Medicare-covered dental benefit.	*New for 2007*	**In-Network** Preventive Dental Benefits: $___ to $___ copay [or ___%to ___% of the cost] for Medicare-covered dental benefits.	
There is no copayment for the following preventive dental services: **- oral exams** **- cleanings** **- fluoride treatments** **- dental x-rays** *OR* **- oral exams up to __ visit(s)** **- cleanings up to __ visit(s)** **- fluoride treatments up to __ visit(s)** **- dental x-rays up to __ visit(s)** *OR* **- oral exams up to __ visit(s) every *(Specified period)*** **- cleanings up to __ visit(s) every**		**In-Network** Preventive Dental Benefits: $0 copay for *In combination with any of the following:* ▪ oral exams [,and] ▪ cleanings[,and] ▪ fluoride [,and] ▪ dental x-rays OR ▪ up to __ oral exam(s) [,and] ▪ up to ___ cleaning(s)] [,and] ▪ up to ___ fluoride treatment(s)] [,and] ▪ up to __ dental x-ray (s).	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** <u>Plan Comparison Report</u>: For the Top Benefit Categories, these sentences automatically display.** *** <u>Plan Detail Report</u>: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** <u>Plan Comparison Report</u>: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** <u>Plan Detail Report</u>: These sentences display along with the "Default Sentences"**
(Specified period) **- fluoride treatments up to __ visit(s) every *(Specified period)*** **- dental x-rays up to __ visit(s) every *(Specified period)***		OR ▪ up to __ oral exam(s) every (specified period) [,and] ▪ up to ___ cleaning(s) every (specified period) [,and] ▪ up to ___ fluoride treatment(s) every (specified period) [,and] ▪ up to __ dental x-ray (s) every (specified period).	
You pay the following for preventive dental services: **- $___ [or ___% of the cost] for an office visit that includes the following services:** **- oral exams** **- cleanings** **- fluoride treatments** **- dental x-rays** *OR* **- oral exams up to __ visit(s)** **- cleanings up to __ visit(s)** **- fluoride treatments up to __ visit(s)** **- dental x-rays up to __ visit(s)** *OR* **- oral exams up to __ visit(s) every (*Specified period*)** **- cleanings up to __ visit(s) every (*Specified period*)**		**In-Network** <u>Preventive Dental Benefits :</u> *The following sentence:* $___ copay [or __ % of the cost] for an office visit that includes: *1. In combination with any of the following:* ▪ oral exams [,and] ▪ cleanings[,and] ▪ fluoride [,and] ▪ dental x-rays OR ▪ up to __ oral exam(s) [,and] ▪ up to ___ cleaning(s)] [,and] ▪ up to ___ fluoride treatment(s)] [,and] ▪ up to __ dental x-ray (s).	

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- fluoride treatments up to __ visit(s) every (*Specified period*) **- dental x-rays up to __ visit(s) every (*Specified period*)** *OR* **- $__ 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** *OR* **- $__ 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)** *OR* **- $__ to $__ [*or* __% to __% of the cost] for each oral exam up to**		OR ▪ up to __ oral exam(s) every (specified period) [,and] ▪ up to ___ cleaning(s) every (specified period) [,and] ▪ up to ___ fluoride treatment(s) every (specified period) [,and] ▪ up to __ dental x-ray (s) every (specified period). 2. AND/OR *Any combination of the following:* $__ to $__ copay [or __% to __% of the cost] for oral exams $__ to $__ copay [or __% to __% of the cost] for cleanings $__ to $__ copay [or __% to __% of the cost] for fluoride treatments $__ to $__ copay [or __% to __% of the cost] for dental x-rays *OR* $__ to $__ copay [or __% to __% of the cost] for up to ___ oral exam(s) *OR* $__ to $__ copay [or __% to __% of the cost] for up to ___ cleaning(s) *OR* $__ to $__ copay [or __% to __% of the	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
__ visit(s) every *(Specified period)* - $__ to $__ [*or* __% to __% of the cost] for each cleaning up to __ visit(s) every *(Specified period)* - $__ to $__ [*or* __% to __% of the cost] for each fluoride treatment up to __ visit(s) every *(Specified period)* - $__ to $__ [*or* __% to __% of the cost] for dental x-rays up to __ visit(s) every *(Specified period)*		cost] for up to fluoride treatment(s) *OR* $__ to $__ copay [or __% to __% of the cost] for up to ___ dental x-ray (s) *OR* $__ to $__ copay [*or* __% to __% of the cost] for up to ___ oral exam(s) every *(Specified period)* $__ to $__ copay [*or* __% to __% of the cost] for up to ___ cleaning(s) every *(Specified period)* $__ to $__ copay [*or* __% to __% of the cost] for up to ___ fluoride treatment(s) every *(Specified period)* $__ to $__ copay [*or* __% to __% of the cost] for up to ___ dental x-ray (s) every *(Specified period)*	
You pay $__ to $__ [or __% to __% of the cost] for out of network preventive dental services.	*Sentence for PPOs only* *Change for 2007*	**Out of Network** Preventive Dental Benefits: $__ to $__ copay [or __% to __% of the cost] for dental benefits.	
You are covered up to $___ for preventive dental services every *(Specified period)*. *OR* **You are covered up to $___ for preventive dental services.**		**In-Network** Preventive Dental Benefits: $___ limit for dental benefits every *(Specified period)*. *OR* $___ limit for dental benefits.	
You are covered up to $___ for in-network and out-of-network	*Sentence for PPOs only*	**In Network (and) Out of Network** Preventive Dental Benefits :	

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preventive dental services every *(Specified period).* *OR* **You are covered up to $___ for in-network and out-of-network preventive dental services.**	*New for 2007*	$___ limit for dental benefits every *(Specified period)*. This limit applies to both in-network and out-of-network benefits. *OR* $___ limit for dental benefits. This limit applies to both in-network and out-of-network benefits.	
Additional comprehensive dental benefits are available. Contact plan for details.	***Change for 2007***		**In-Network** Comprehensive Dental Benefits: Plan offers additional comprehensive dental benefits.
Additional in-network and out-of-network comprehensive dental benefits are available. Contact plan for details.	*Sentence for PPOs only* *New for 2007*		**General** Comprehensive Dental Benefits: Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits.
You are covered up to $___ for comprehensive dental services every *(Specified period).* *OR* **You are covered up to $___ for comprehensive dental services.**		**In-Network** Comprehensive Dental Benefits : $___ limit for dental benefits every *(Specified period)*. *OR* $___ limit for dental benefits.	
You are covered up to $___ for in-network and out-of-network comprehensive dental services every *(Specified period).* *OR* **You are covered up to $___ for in-network and out-of-network comprehensive dental services.**	*Sentence for PPOs only* *New for 2007*	**In Network (and) Out of Network** Comprehensive Dental Benefits : $___ limit for dental benefits every *(Specified period)*. This limit applies to both in-network and out-of-network benefits. *OR* $___ limit for dental benefits. This limit applies to both in-network and out-of-	

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		network benefits.	
You are covered up to $___ for non-Medicare dental services every *(Specified period)*. *OR* **You are covered up to $___ for non-Medicare dental services.**		**In-Network** Other Dental Benefits : $___ limit for non-Medicare dental benefits every *(Specified period)*. *OR* $___ limit for non-Medicare dental benefits.	
You are covered up to $___ for in-network and out-of-network non-Medicare dental services every *(Specified period)*. *OR* **You are covered up to $___ for in-network and out-of-network non-Medicare dental services.**	*Sentence for PPOs only* *New for 2007*	**In Network (and) Out of Network** Other Dental Benefits : $___ limit for dental benefits every *(Specified period)*. This limit applies to both in-network and out-of-network benefits. *OR* $___ limit for dental benefits. This limit applies to both in-network and out-of-network benefits.	
Authorization rules may apply for services. Contact plan for details.			**General** Authorization rules may apply.
30. Hearing			
In general, you pay 100% for routine hearing exams and hearing aids.		**In-Network** In general, you pay 100% for routine hearing exams and hearing aids.	
You pay 100% for hearing aids.		**In-Network** You pay 100% for hearing aids.	
There is no copayment for the following services: **- Medicare-covered hearing exams (diagnostic hearing**		**In-Network** $0 copay for diagnostic hearing exams *In combination with any of the following:*	

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exams) **- routine hearing tests** **- fittings-evaluations for a hearing aid** *OR* **- routine hearing tests up to __ visit(s)** **- fittings-evaluations for a hearing aid up to __ visit(s)** *OR* **- routine hearing tests up to __ visit(s) every *(Specified period)*** **- fittings-evaluations for a hearing aid up to __ visit(s) every *(Specified period)***		▪ routine hearing tests [, and] ▪ fitting evaluations for a hearing aid *OR* ▪ up to ___ routine hearing test(s) [, and] ▪ up to ___ fitting evaluation(s) for a hearing aid *OR* ▪ up to ___ routine hearing test(s) every *(specified period)* ▪ up to ___ fitting evaluation(s) for a hearing aid every *(specified period)*	
There is no copayment for hearing aids. *OR* **There is no copayment for hearing aids up to __ aid(s).** *OR* **There is no copayment for hearing aids up to __ aid(s) every (*Specified period*).**		**In-Network** $0 copay for hearing aids. OR $0 copay for up to __ hearing aid(s). OR $0 copay for up to __ hearing aid(s) every *(specified period)*.	
There is no copayment for the following items: **- hearing aids-inner ear** **- hearing aids-outer ear** **- hearing aids-over the ear**		**In-Network** $0 copay for *In combination with any of the following:* ▪ inner-ear hearing aids [, and]	

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OR **- 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)** *OR* **- hearing aids-inner ear up to __ aid(s) every *(Specified period)*** **- hearing aids-outer ear up to __ aid(s) every *(Specified period)*** **- hearing aids-over the ear up to __ aid(s) every *(Specified period)***		▪ outer-ear hearing aids[, and] ▪ over-the-ear hearing aids *OR* ▪ up to __ inner-ear hearing aid(s) [, and] ▪ up to __ outer-ear hearing aid(s) [, and] ▪ up to ___ over-the-ear hearing aid(s) *OR* ▪ up to __ inner-ear hearing aid(s) every *(specified period)* [, and] ▪ up to __ outer-ear hearing aid(s) every *(specified period)* [, and] ▪ up to ___ over-the-ear hearing aid(s) every *(specified period)*.	
You pay: **- $__ [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** *OR* **- $__ to $__ [or __% to__% of**		**In-Network** $__ copay [or __% of the cost] for diagnostic hearing exams *In combination with any of the following:* $__ to $__ copay [or __% to__% of the cost] for routine hearing tests $__ to $__ copay [or __% to__% of the cost] for hearing aid fitting evaluations *OR* $__ to $__ copay [or __% to__% of the	

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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)** *OR* **- $__ to $__ [or __% to__% of the cost] for each routine hearing test up to __ test(s) every *(Specified period)*** **- $__ to $__ [or __% to__% of the cost] for each fitting-evaluation for a hearing aid up to __ fitting(s)-evalution(s) every *(Specified period)***		cost] for up to ___ routine hearing test(s) $__ to $__ copay [or __% to__% of the cost] for up to ___ hearing aid fitting evaluation(s) ***OR*** $__ to $__ copay [or __% to__% of the cost] for up to ___ routine hearing test(s) every *(Specified period)* $__ to $__ copay [or __% to__% of the cost] for up to ___ hearing aid fitting evaluation(s) every *(Specified period)*	
(You pay:) **- $__ to $__ [or __% to __% of the cost] for out of network hearing exams.**	***Sentence for PPOs only***	**Out of Network** $__ to $__ copay [or __% to __% of the cost] for hearing exams.	
- $__ 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** *OR*		**In-Network** $__ to $___ copay [or __% of the cost] *Any combination of the following:* ▪ inner-ear hearing aids [, and] ▪ outer-ear hearing aids[, and] ▪ over-the-ear hearing aids *OR*	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** <u>Plan Comparison Report</u>: For the Top Benefit Categories, these sentences automatically display.** *** <u>Plan Detail Report</u>: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** <u>Plan Comparison Report</u>: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** <u>Plan Detail Report</u>: These sentences display along with the "Default Sentences"**
- $__ 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)** *OR* **- $__ to $__ [or __% of the cost] for each hearing aid up to __ aid(s) every *(Specified period)*** **- $__ [or __% of the cost] for each hearing aid-inner ear up to __ aid(s) every *(Specified period)*** **- $__ [or __% of the cost] for each hearing aid-outer ear up to __ aid(s) every *(Specified period)*** **- $__ [or __% of the cost] for each hearing aid-over the ear up to __ aid(s) every *(Specified period)***		▪ up to __ inner-ear hearing aid(s) [, and] ▪ up to __ outer-ear hearing aid(s) [, and] ▪ up to ___ over-the-ear hearing aid(s) *OR* ▪ up to __ inner-ear hearing aid(s) every *(specified period)* [, and] ▪ up to __ outer-ear hearing aid(s) every *(specified period)* [, and] ▪ up to ___ over-the-ear hearing aid(s) every *(specified period)*.	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
(You pay:) **- $__ to $__ [or __% to __% of the cost] for out of network hearing aids.**	***Sentence for PPOs only***	**Out of Network** $__ to $__ copay [or __% to __% of the cost] for hearing aids.	
You are covered up to $___ for routine hearing tests every *(Specified period)*. *OR* **You are covered up to $___ for routine hearing tests.**		**In-Network** $___ limit for routine hearing tests every ***(Specified period)***. *OR* $___ limit for routine hearing tests.	
You are covered up to $___ for hearing aids every *(Specified period)*. *OR* **You are covered up to $___ for hearing aids.**		**In-Network** $___ limit for hearing aids every ***(Specified period)***. *OR* $___ limit for hearing aids.	
You are covered up to $___ for routine hearing tests and hearing aids every *(Specified period)*. *OR* **You are covered up to $___ for routine hearing tests and hearing aids.**		**In-Network** $___ limit for routine hearing tests and hearing aids every ***(Specified period)***. *OR* $___ limit for routine hearing tests and hearing aids.	
Authorization rules may apply for services. Contact plan for details.			**General** Authorization rules may apply.
31. Vision			

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
You pay 100% for non-Medicare-covered eye exams and glasses.		**In-Network** You pay 100% for non-Medicare-covered eye exams and glasses.	
There is no copayment for the following services: **- Medicare-covered eye exams (diagnosis and treatment for diseases and conditions of the eye)** **- routine eye exams** *OR* **- routine eye exams up to __ visit(s)** *OR* **- routine eye exams up to __ visit(s) every *(Specified period)***		**In-Network** $0 copay for diagnosis and treatment for diseases and conditions of the eye and for *In combination with one of the following:* routine eye exams. OR up to ___ routine eye exam(s). OR up to ___ routine eye exam(s) every *(specified period)*.	
There is no copayment for the following items: **- Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery)** **- Glasses** **- Contacts** **- Lenses** **- Frames** *OR*		**In-Network** $0 copay for ▪ one pair of eyeglasses or contact lenses after each cataract surgery, [, and] *In combination with one of the following:* ▪ glasses [, and] ▪ contacts[, and] ▪ lenses[, and] ▪ frames OR	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
- 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)** *OR* **- Glasses, limited to __ pair(s) of glasses every *(Specified period)*** **- Contacts, limited to __ pair(s) of contacts every *(Specified period)*** **- Lenses, limited to __ pair(s) of lenses every *(Specified period)*** **- Frames, limited to __ frame(s) every *(Specified period)***		▪ up to __ pair(s) of glasses[, and] ▪ up to __ pair(s) of contacts[, and] ▪ up to __ pair(s) of lenses[, and] ▪ up to __ frame(s) *OR* ▪ up to __ pair(s) of glasses every *(specified period)* [, and] ▪ up to __ pair(s) of contacts every *(specified period)* [, and] ▪ up to __ pair(s) of lenses every *(specified period)* [, and] ▪ up to __ frame(s) every *(specified period)*	
You pay: **- $__ [or __% of the cost] for Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery)** **$__ to $__ [or __% to __% of the cost] for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye).**		**In-Network** $__ copay [or __% of the cost] for one pair of eyeglasses or contact lenses after each cataract surgery. $__ to $__ copay [or __% to __% of the cost] for exams to diagnose and treat diseases and conditions of the eye. $__ to $__ copay [or __% to __% of the cost] for *In combination with any of the following:*	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
- $__ to $__ [or __% to __% of the cost] for each routine eye exam *OR* **- $__ to $__ [or __% to __% of the cost] for each routine eye exam, limited to ___ exams** *OR* **- $__ to $__ [or __% to __% of the cost] for each routine eye exam, limited to ___ exam(s) every (*Specified period)***		routine eye exams *OR* up to ___ routine eye exams. *OR* up to ___ routine eye exam(s) every *(specified period)*.	
- $__ to $__ [or __% to __% of the cost] for out of network eye exams	***Sentence for PPOs only***	**Out of Network** $__ to $__ copay [or __% to __% of the cost] for eye exams.	
- $ ___ [or __% of the cost] for glasses **- $ ___ [or __% of the cost] for contacts** **- $ ___ [or __% of the cost] for lenses** **- $ ___ [or __% of the cost] for frames** *OR* **- $ ___ [or __% of the cost] for glasses, limited to ___ pair(s) of glasses** **- $ ___ [or __% of the cost] for contacts, limited to ___ pair(s) of**		**In-Network** $ ___ copay [or __% of the cost] for *In combination with one of the following:* ▪ glasses [, and] ▪ contacts[, and] ▪ lenses[, and] ▪ frames OR ▪ up to __ pair(s) of glasses[, and] ▪ up to __ pair(s) of contacts[, and] ▪ up to __ pair(s) of lenses[, and] ▪ up to __ frame(s)	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
contacts **- $ ___ [or __% of the cost] for lenses, limited to ___ pair(s) of lenses** **- $ ___ [or __% of the cost] for frames, limited to ___ frame(s)** *OR* **- $ ___ [or __% of the cost] for glasses, limited to ___ pair(s) of glasses every (*Specified period)*** **- $ ___ [or __% of the cost] for contacts, limited to ___ pair(s) of contacts every (*Specified period)*** **- $ ___ [or __% of the cost] for lenses, limited to ___ pair(s) of lenses every (*Specified period)*** **- $ ___ [or __% of the cost] for frames, limited to ___ frame(s)** every (*Specified period)*		*OR* ▪ up to __ pair(s) of glasses every *(specified period)* [, and] ▪ up to __ pair(s) of contacts every *(specified period)* [, and] ▪ up to __ pair(s) of lenses every *(specified period)* [, and] ▪ up to __ frame(s) every *(specified period)*	
- $__ to $__ [or __% to __% of the cost] for out of network eye wear	***Sentence for PPOs only***	**Out of Network** $__ to $__ copay [or __% to __% of the cost] for eye wear.	
You are covered up to $___ for eye exams every *(Specified period).* *OR* **You are covered up to $___ for eye exams.**		**In-Network** $___ limit for eye exams every *(specified period).* OR $___ limit for eye exams.	
You are covered up to $___ for eye wear every *(Specified period).*		**In-Network** $___ limit for eye wear every *(specified*	

Benefit Category and SB Sentences	Plan Type (*Sentences are for ALL plan types, unless noted.)*	Default Sentence(s) * Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display. * Plan Detail Report: These sentences display along with the "Full Details Sentences"	Full Details Sentences * Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details" * Plan Detail Report: These sentences display along with the "Default Sentences"
OR **You are covered for $___ for eye wear.**		*period).* OR $___ limit for eye wear.	
You are covered up to $___ for eye exams and eye wear every *(Specified period).* *OR* **You are covered up to $____ for eye exams and eye wear.**		**In-Network** $___ limit for eye exams and eye wear every *(specified period)*. OR $___ limit for eye exams and eye wear.	
Additional vision benefits are available.			**In-Network** Plan offers additional vision benefits. Contact plan for details.
Authorization rules may apply for services. Contact plan for details.			**General** Authorization rules may apply.
32. 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 plan for further details.			**In-Network** When you get Medicare Part B, you can get a one-time physical within the first 6 months of your new Part B coverage. The coverage does not include lab tests.
You pay $__ [or __% of the cost] for Medicare covered services.		**In-Network** $__ [or __%] for Medicare-covered benefits	
You pay 100% for routine physical exams.		**In-Network** You pay 100% for routine exams.	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
OR **There is no copayment for routine physical exams.** *OR* **You pay $___ [or ___% of the cost] for each exam.**		OR $0 copay for routine exams. OR $ ___ copay [or ___% of the cost] for routine exams.	
You pay $__ to $__ [or __% to __% of the cost] for each out of network routine physical exam.	***Sentence for PPOs only***	**Out-of-Network** $__ to $__ copay [or __% to __% of the cost] for routine exams.	
You are covered for an unlimited number of exams. *OR* **You are covered up to ___ exam(s).** *OR* **You are covered up to ___ exam(s) every (*Specified period*).**			**In-Network** No limit on the number of covered exams. OR Limited to ___ exam(s) OR Limited to __ exam(s) every *(specified period)*.
Authorization rules may apply for services. Contact plan for details.			**General** Authorization rules may apply.
Health/Wellness Education			

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
CATEGORY WILL NOT APPEAR IN SB REPORT *OR* **You are covered for the following:** **- Written health education materials, including Newsletter** **- Nutritional Training** **- Nutritional benefit** **- Smoking Cessation** **- Alternative Medicine Program** **- Health Club Membership/ Fitness Classes** **- Nursing Hotline** **- Other Wellness Services**		**In-Network** This plan does not cover health/wellness education benefits. OR This plan covers health/wellness education benefits.	**In-Network** The plan covers the following health/wellness education benefits: - Written health education materials, including Newsletters - Nutritional Training - Nutritional benefit - Smoking Cessation - Alternative Medicine Program - Health Club Membership/ Fitness Classes - Nursing Hotline - Other Wellness Benefits
Copayments may apply. Contact plan for details.		**In-Network** Copays may apply for these benefits.	
Authorization rules may apply for services. Contact plan for details.			**General** Authorization rules may apply.
Transportation (Routine)			
CATEGORY WILL NOT APPEAR IN SB REPORT *OR* **There is no copayment for each (one-way trip/round trip) to (Plan-approved location/Any**		**In-Network** This plan does not cover routine transportation. OR $0 copay for each [one-way/round] trip to	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
location). *OR* **There is no copayment for each (one-way trip/round trip) up to ___ trip(s) to (Plan-approved location/Any location).** *OR* **There is no copayment for each (one-way trip/round trip) up to ___trip(s) to (Plan-approved location/Any location) every (*Specified period*).** *OR* **You pay $___ [or ___% of the cost] for each (one-way trip/round trip) to (Plan-approved location/Any location).** *OR* **You pay $___ [or ___ % of the cost] for each (one-way trip/round trip) up to____ trip(s) to (Plan-approved location/Any location).** *OR* **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).***		[plan-approved/any] location. OR $0 copay for up to __ [one-way/round] trip(s) to [plan-approved/any] location. OR $0 copay for up to __ [one-way/round] trip(s) to [plan-approved/any] location every *(specified period)*. OR $___ copay [or ___ % of the cost] for each [one-way/round] trip to [plan-approved/any] location. OR $___ copay [or ___ % of the cost] for up to __ [one-way/round] trip(s) to [plan-approved/any] location. OR $___ copay [or ___ % of the cost] for up to __ [one-way/round] trip(s) to [plan-approved/any] location every *(specified period)*.	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
You pay $__ to $__ [or __% to __% of the cost] for out of network transportation services.	Sentence for PPOs only	**Out-of-Network** $__ to $__ copay [or __% to __% of the cost] for transportation.	
Authorization rules may apply for services. Contact plan for details.			**General** Authorization rules may apply.
Acupuncture			
CATEGORY WILL NOT APPEAR IN SB REPORT *OR* **There is no copayment for each acupuncture visit.** *OR* **There is no copayment for each acupuncture visit up to ____ visit(s).** *OR* **There is no copayment for each acupuncture visit up to ___ visit(s) every *(Specified period)*.** *OR* **You pay $__ [or __% of the cost] for each visit.** *OR* **You pay $__ [or __% of the cost] for each visit up to ____ visit(s).** *OR* **You pay $___ [or ___% of the cost] for each visit up to visit(s) every (*Specified period*).**		**In-Network** This plan does not cover Acupuncture. OR $0 copay OR $0 copay for *In combination with any of the following:* up to ___ visit(s). ***OR*** up to to ___ visit(s) every *(specified period)*. OR $__ copay [or __% of the cost] ***In combination with any of the following:*** per visit *OR* per visit up to ____ visit(s). *OR* per visit up to ___visit(s) every (*Specified period*).	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Default Sentence(s)** *** Plan Comparison Report: For the Top Benefit Categories, these sentences automatically display.** *** Plan Detail Report: These sentences display along with the "Full Details Sentences"**	**Full Details Sentences** *** Plan Comparison Report: For the Top Benefit Categories, these sentences only display if the user clicks to "Show all details"** *** Plan Detail Report: These sentences display along with the "Default Sentences"**
You pay $__ to $__ [or __% to __% of the cost] for each out of network acupuncture visit.	Sentence for PPOs only	**Out-of-Network** $__ to $__ copay [or __% to __% of the cost] for acupuncture visits.	
Authorization rules may apply for services. Contact plan for details.			**General** Authorization rules may apply.
Point-of-service [Note to Reviewers – This section appears in the SB, but would be removed from the MPPF. We have moved all sentences in this section into their appropriate category (for example, POS sentences for Inpatient Hospital can be found in the OON section of Inpatient Hospital Care above)]			

Optional Benefits

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Detailed Report Sentence(s)**	**More Details Sentences**
Premium			
You pay $__ each month, in addition to your monthly plan premium of $ <*Plan must reflect actual 2007 plan premium amount sentence as it appears in the HPMS Summary of Benefits report.*> and the Medicare Part B premium, for these optional benefits.	*Change for 2007*	**General** $___ monthly premium, in addition to our $___ monthly plan premium and the $__ monthly Medicare Part B premium.	
Chiropractic			
There is no copayment for: **- routine visits** *OR* **- routine visits up to ___ visit(s) every *(Specified period)*** *OR* **- routine visits up to ___ visit(s)**		**In-Network** $0 copay for *In combination with one of the following* routine visits. *OR* up to ___ routine visit(s) every *(Specified period).OR* up to ___ routine visit(s).	
You pay: **- $__ to $__ [or __% to __% of the cost] for each routine visit up to ___ visit(s) every *(Specified period)*** *OR* **- $__ to $__ [or __% to __% of the cost] for each routine visit up to ___ visit(s)**		**In-Network** $___ to $___ copay [or __% to %___ of the cost] for *In combination with one of the following* up to ___ routine visits(s) every *(Specified period) OR* up to ___ routine visit(s) *OR* each routine visit.	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Detailed Report Sentence(s)**	**More Details Sentences**
OR **- $__ to $__ [or __% to __% of the cost] for each routine visit**			
Podiatry			
There is no copayment for: **- routine visits** *OR* **- routine visits up to ___ visit(s) every *(Specified period)*** *OR* **- routine visits up to ___ visits**		**In-Network** $0 copay for *In combination with one of the following* routine visits. *OR* up to ___ routine visit(s) every *(Specified period).OR* up to ___ routine visit(s).	
You pay: **- $__ to $__ [or __% to __% of the cost] for each routine visit up to ___ visit(s) every *(Specified period)*** *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**		**In-Network** $___ to $___ copay [or __% to %___ of the cost] for *In combination with one of the following* up to ___ routine visits(s) every *(Specified period) OR* up to ___ routine visit(s) *OR* each routine visit.	
Prescription Drugs – Section 1876 Cost Plans			
	Sentences for 1876 Cost Plans ONLY		

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Detailed Report Sentence(s)**	**More Details Sentences**
You pay a deductible of $___.		**In-Network** $___ deductible	
For prescription drugs, you pay for each prescription or refill: **- $__ to $___ [or__% to __% of the cost] for (Group 1 label) drugs up to a ___-day supply** ***(Repeat for Groups 2-5)*** **- $___ [or ___% of the cost] for mail order (Group 1 label) drugs up to a -day supply** ***(Repeat for Groups 2-5)***		**In-Network** For each prescription or refill: ▪ $__ to $___ copay [or__% to __% of the cost] for (Group 1 label) drugs up to a ___-day supply *(Repeat for Groups 2-5)* ▪ $___ copay [or ___% of the cost] for mail order pharmacy (Group 1 label) drugs up to a ___-day supply *(Repeat for Groups 2-5)*	
There is no individual limit on ***(Group 1 label)*** **drugs.** ***(Repeat for Groups 2-5)*** ***OR*** **There is a $__ limit (*Specified period*) for *(Group 1 label)* drugs.** ***(Repeat for Groups 2-5)*** ***OR*** **There is a $___ limit for *(Group 1 label)* drugs. Ask *(Medicare Advantage Org. Marketing Name)* about the time period for this limit.** **(Repeat for Groups 2-5)**		**In-Network** No individual limit for *(Group 1 label)* drugs. *(Repeat for Groups 2-5)* *OR* $__ individual limit (*Specified period*) for *(Group 1 label)* drugs. *(Repeat for Groups 2-5)* *OR* $___ individual limit for *(Group 1 label)* drugs. Ask *(Medicare Advantage Org. Marketing Name)* about the time period for this limit. (Repeat for Groups 2-5)	
**There is a $___ limit (*Specified*		**In-Network**	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Detailed Report Sentence(s)**	**More Details Sentences**
***period*) for combined (*selected Groups 1-5 labels*) prescription drugs.** *OR* **There is a $___ limit for combined (*selected Groups 1-5 labels*) prescription drugs. Ask *(Medicare Advantage Org. Marketing Name)* about the time period for this limit.**		$___ combined limit (*Specified period*) for (*selected Groups 1-5 labels*) drugs. *OR* $___ combined limit for (*selected Groups 1-5 labels*) drugs. Ask *(Medicare Advantage Org. Marketing Name)* about the time period for this limit.	
There is no limit on *[selected unlimited Group(s) label]* drugs after the combined limit on [*groups included in combined max*] is reached.		**In-Network** No limit on *[selected unlimited Group(s) label]* drugs once you reach the combined limit on [*groups included in combined max*].	
There is an overall limit of $_____ [*Specified period*] for [*Groups 1-5 labels*] prescription drugs. This overall maximum limit applies even if you have not yet reached the separate limits (if applicable) for [list drug types] drugs. ***OR*** **There is an overall limit of $_____ for [*Groups 1-5 labels*] prescription drugs. This overall maximum limit applies even if you have not yet reached the separate limits (if applicable) for [*Groups 1-5 labels*] drugs. Ask *(Medicare Advantage Org.***		**In-Network** $____ overall limit [*Specified period*] for [*Groups 1-5 labels*] drugs. Limit applies even if you haven't reached the individual limits (if applicable) for [list drug types] drugs. *OR* $___ overall limit for [*Groups 1-5 labels*] drugs. Limit applies even if you haven't reached the individual limits (if applicable) for [*Groups 1-5 labels*] drugs. Ask *(Medicare Advantage Org. Marketing Name)* about the time period for this limit.	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Detailed Report Sentence(s)**	**More Details Sentences**
Marketing Name) **about the time period for this limit.** ***OR*** **There is an overall limit of $_____ [*Specified period*] for [*Groups 1-5 labels*] prescription drugs.**		*OR* $____ overall limit [*Specified period*] for [*Groups 1-5 labels*] drugs.	
Any used amounts cannot be carried forward to the next period. *OR* **Any unused amounts can be carried forward to the next period.**			**In-Network** You cannot count used amounts in the next period. OR You can count unused amounts in the next period.
Drugs that are covered by Original Medicare do not count toward your prescription drug limit. **Plans can calculate the part you pay in different ways.** ***AND*** **The copayment does apply toward the plan prescription limit.** ***OR*** **The copayment does not apply toward the plan prescription limit.** ***AND*** **Please ask *(Medicare Advantage Org. Marketing Name)* about how we determine drug costs that count towards these limits.**			**In-Network** Drugs covered by Original Medicare don't count toward your drug limit. *AND* Copays apply toward the drug limit. *OR* Copays do <u>not</u> apply toward the drug limit. *AND* Contact the plan for information on how it figures out which drug costs count towards the limits.
You must use [designated retail		**General**	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Detailed Report Sentence(s)**	**More Details Sentences**
pharmacies/managed care-owned pharmacies/ mail order] to get your prescription drugs. *OR* **You may use [designated retail pharmacies/managed care-owned pharmacies/ mail order] and other ways to get your prescription drugs. Ask *(Medicare Advantage Org. Marketing Name)* for details.**		You must use [designated retail pharmacies/managed care-owned pharmacies/ mail order] to get your drugs. *OR* You may use [designated retail pharmacies/managed care-owned pharmacies/ mail order] or other ways to get your drugs.	
Ask *(Medicare Advantage Org. Marketing Name)* for details on where you can get your prescription drugs.			**In-Network** Call the plan for information on where you can get your drugs.
Authorization may be required for prescription drugs.			**General** Authorization rules may apply.
When you want higher cost drugs even though lower cost drugs are available, ask *(Medicare Advantage Org. Marketing Name)* for details on costs and what is covered.			**In-Network** If you want to use higher cost drugs even though lower cost drugs are available, first contact the plan to find out costs and what is covered.
Dental			
There is no copayment for the following: **- oral exams** **- cleanings** **- fluoride treatments** **- dental x-rays** *OR* **- oral exams up to __ visit(s)**		**In-Network** Preventive Dental Benefits: $0 copay for *In combination with:* ▪ oral exams [,and] ▪ cleanings[,and] ▪ fluoride [,and] ▪ dental x-rays	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Detailed Report Sentence(s)**	**More Details Sentences**
- cleanings up to __ visit(s) **- fluoride treatments up to __ visit(s)** **- dental x-rays up to __ visit(s)** *OR* **- oral exams up to __ visit(s) every *(Specified period)*** **- cleanings up to __ visit(s) every *(Specified period)*** **- fluoride treatments up to __ visit(s) every *(Specified period)*** **- dental x-rays up to __ visit(s) every *(Specified period)***		OR ▪ up to __ oral exam(s) [,and] ▪ up to ___ cleaning(s)] [,and] ▪ up to ___ fluoride treatment(s)] [,and] ▪ up to __ dental x-ray (s). OR ▪ up to __ oral exam(s) every (specified period) [,and] ▪ up to ___ cleaning(s) every (specified period) [,and] ▪ up to ___ fluoride treatment(s) every (specified period) [,and] ▪ up to __ dental x-ray (s) every (specified period).	
You pay: **- $___ [or ___% of the cost] for an Office Visit that includes the following services:** **- oral exams** **- cleanings** **- fluoride treatments** **- dental x-rays** *OR* **- oral exams up to __ visit(s)** **- cleanings up to __ visit(s)** **- fluoride treatments up to __ visit(s)** **- dental x-rays up to __ visit(s)** *OR*		**In-Network** Preventive Dental Benefits: *The following sentence:* $___ copay [or __ % of the cost] for an office visit that includes: *1. In combination with any of the following:* ▪ oral exams [,and] ▪ cleanings[,and] ▪ fluoride [,and] ▪ dental x-rays	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Detailed Report Sentence(s)**	**More Details Sentences**
- oral exams up to __ visit(s) every (*Specified period*) **- cleanings up to __ visit(s) every (*Specified period*)** **- fluoride treatments up to __ visit(s) every (*Specified period*)** **- dental x-rays up to __ visit(s) every (*Specified period*)** *OR* **- $__ 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** *OR* **- $__ 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)** *OR* **- $__ to $__ [*or* __% to __% of**		OR ▪ up to __ oral exam(s) [,and] ▪ up to ___ cleaning(s)] [,and] ▪ up to ___ fluoride treatment(s)] [,and] ▪ up to __ dental x-ray (s). OR ▪ up to __ oral exam(s) every (specified period) [,and] ▪ up to ___ cleaning(s) every (specified period) [,and] ▪ up to ___ fluoride treatment(s) every (specified period) [,and] ▪ up to __ dental x-ray (s) every (specified period). 2. AND/OR *Any combination of the following:* $__ to $__ copay [or __% to __% of the cost] for oral exams $__ to $__ copay [or __% to __% of the cost] for cleanings $__ to $__ copay [or __% to __% of the cost] for fluoride treatments $__ to $__ copay [or __% to __% of the cost] for dental x-rays *OR* $__ to $__ copay [or __% to __%	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Detailed Report Sentence(s)**	**More Details Sentences**
the cost] for each oral exam up to __ visit(s) every *(Specified period)* **- $__ to $__ [*or* __% to __% of the cost] for each cleaning up to __ visit(s) every *(Specified period)*** **- $__ to $__ [*or* __% to __% of the cost] for each fluoride treatment up to __ visit(s) every *(Specified period)*** **- $__ to $__ [*or* __% to __% of the cost] for dental x-rays up to __ visit(s) every *(Specified period)***		of the cost] for up to ___ oral exam(s) $__ to $__ copay [or __% to __% of the cost] for up to ___ cleaning(s) $__ to $__ copay [or __% to __% of the cost] for up to fluoride treatment(s) $__ to $__ copay [or __% to __% of the cost] for up to ___ dental x-ray visit(s) *OR* $__ to $__ copay [*or* __% to __% of the cost] for up to ___ oral exam(s) every *(Specified period)* $__ to $__ copay [*or* __% to __% of the cost] for up to ___ cleaning(s) every *(Specified period)* $__ to $__ copay [*or* __% to __% of the cost] for up to ___ fluoride treatment(s) every *(Specified period)* $__ to $__ copay [*or* __% to __% of the cost] for up to ___ dental x-ray visit(s) every *(Specified period)*	
Additional comprehensive dental benefits are available. Contact plan for details.	*Change for 2007*		**General** Comprehensive Dental Benefits: Plan offers additional comprehensive dental benefits. Contact plan for details.
You are covered up to $___ for		**In-Network**	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Detailed Report Sentence(s)**	**More Details Sentences**
Preventive dental services every *(Specified period).* *OR* **You are covered up to $___ for Preventive dental services.**		Preventive Dental Benefits: $___ limit for dental benefits every *(Specified period).* *OR* $___ limit for dental benefits.	
You are covered up to $___ for Comprehensive dental services every *(Specified period).* *OR* **You are covered up to $___ for Comprehensive dental services.**		**In-Network** Comprehensive Dental Benefits: $___ limit for dental benefits every *(Specified period).* *OR* $___ limit for dental benefits.	
You are covered up to $___ for dental services every *(Specified period).* *OR* **You are covered up to $___ for dental services.**		**In-Network** $___ limit for dental benefits every *(Specified period).* *OR* $___ limit for dental benefits.	
Hearing			
There is no copayment for the following services: **- routine hearing tests** **- fittings-evaluations for a hearing aid** *OR* **- routine hearing tests up to __ visit(s)** **- fittings-evaluations for a hearing aid up to __ visit(s)** *OR* **- routine hearing tests up to __ visit(s) every *(Specified period)*** **- fittings-evaluations for a**		**In-Network** $0 copay for *In combination with any of the following*: ▪ routine hearing tests [, and] ▪ fitting evaluations for a hearing aid *OR* ▪ up to ___ routine hearing test(s) [, and] ▪ up to ___ fitting evaluation(s) for a hearing aid	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Detailed Report Sentence(s)**	**More Details Sentences**
hearing aid up to __ visit(s) every *(Specified period)*		*OR* ▪ up to ___ routine hearing test(s) every *(specified period)* ▪ up to ___ fitting evaluation(s) for a hearing aid every *(specified period)*	
There is no copayment for hearing aids. *OR* **There is no copayment for hearing aids up to __ aid(s).** *OR* **There is no copayment for hearing aids up to __ aid(s) every (*Specified period*).**		**In-Network** $0 copay for *In combination with any of the following:* hearing aids. *OR* up to __ hearing aid(s). *OR* up to __ hearing aid(s) every *(specified period)*.	
There is no copayment for the following items: **- hearing aids-inner ear** **- hearing aids-outer ear** **- hearing aids-over the ear** *OR* **- 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)** *OR* **- hearing aids-inner ear up to __ aid(s) every *(Specified period)***		**In-Network** $0 copay for *In combination with any of the following:* ▪ routine hearing tests [, and] ▪ fitting evaluations for a hearing aid *OR* ▪ up to ___ routine hearing test(s) [, and] ▪ up to ___ fitting evaluation(s) for a hearing aid	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Detailed Report Sentence(s)**	**More Details Sentences**
- hearing aids-outer ear up to __ aid(s) every *(Specified period)* **- hearing aids-over the ear up to __ aid(s) every *(Specified period)***		*OR* ▪ up to ___ routine hearing test(s) every *(specified period)* ▪ up to ___ fitting evaluation(s) for a hearing aid every *(specified period)*	
You pay: **- $__ 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** *OR* **- $__ 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)** *OR* **- $__ to $__ [or __% to__% of the cost] for each routine hearing test up to __ test(s) every *(Specified period)*** **- $__ to $__ [or __% to__% of the cost] for each fitting-evaluation for a hearing aid up to __ fitting(s)-evalution(s) every *(Specified period)***		**In-Network** *A combination of any of the following:* $__ to $__ copay [or __% to__% of the cost] for routine hearing tests $__ to $__ copay [or __% to__% of the cost] for hearing aid fitting evaluations *OR* $__ to $__ copay [or __% to__% of the cost] for up to ___ routine hearing test(s) $__ to $__ copay [or __% to__% of the cost] for up to ___ hearing aid fitting evaluation(s) ***OR*** ***OR*** $__ to $__ copay [or __% to__% of the cost] for up to ___ routine hearing test(s) every *(Specified period)* $__ to $__ copay [or __% to__% of the cost] for up to ___ hearing aid fitting evaluation(s) every	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Detailed Report Sentence(s)**	**More Details Sentences**
- $__ 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** *OR* **- $__ 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)** *OR* **- $__ to $__ [or __% of the cost] for each hearing aid up to __ aid(s) every *(Specified period)*** **- $__ [or __% of the cost] for each hearing aid-inner ear up to __ aid(s) every *(Specified period)*** **- $__ [or __% of the cost] for each hearing aid-outer ear up to __ aid(s) every *(Specified period)*** **- $__ [or __% of the cost] for**		*(Specified period)* *AND/OR* *The following sentence* $__ to $___ copay [or __% of the cost] *In combination with any of the following:* per hearing aid per inner-ear hearing aid per outer-ear hearing aid per over-the-ear hearing aid *OR* for up to ___ hearing aid(s) for up to ___ inner-ear hearing aid(s) for up to ___ outer-ear hearing aid(s) for up to ___ over-the-ear hearing aid(s) ***OR*** for up to ___ hearing aid(s) every *(Specified period)* for up to ___ inner-ear hearing aid(s) every *(Specified period)* for up to ___ outer-ear hearing aid(s) every *(Specified period)* for up to ___ over-the-ear hearing aids) every *(Specified period)*	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Detailed Report Sentence(s)**	**More Details Sentences**
each hearing aid-over the ear] up to __ aid(s) every *(Specified period)*			
You are covered up to $___for routine hearing tests every *(Specified period)*. *OR* **You are covered up to $___ for routine hearing tests.**		**In-Network** $___ limit for routine hearing tests every ***(Specified period)***. *OR* $___ limit for routine hearing tests.	
You are covered up to $___ for hearing aids every *(Specified period)*. *OR* **You are covered up to $___ for hearing aids.**		**In-Network** $___ limit for hearing aids every ***(Specified period)***. *OR* $___ limit for hearing aids.	
You are covered up to $___ for routine hearing tests and hearing aids every *(Specified period)*. *OR* **You are covered up to $___ for routine hearing tests and hearing aids.**		**In-Network** $___ limit for routine hearing tests and hearing aids every ***(Specified period)***. *OR* $___ limit for routine hearing tests and hearing aids.	
Vision			
There is no copayment for the following services: **- routine eye exams** *OR* **- routine eye exams up to __ visit(s)** *OR* **- routine eye exams up to __ visit(s) every *(Specified period)***		**In-Network** $0 copay for *In combination with one of the following:* routine eye exams. OR up to ___ routine eye exam(s). OR up to ___ routine eye exam(s) every *(specified period)*.	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Detailed Report Sentence(s)**	**More Details Sentences**
There is no copayment for the following items: **- Glasses** **- Contacts** **- Lenses** **- Frames** *OR* **- 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)** *OR* **- Glasses, limited to __ pair(s) of glasses every *(Specified period)*** **- Contacts, limited to __ pair(s) of contacts every *(Specified period)*** **- Lenses, limited to __ pair(s) of lenses every *(Specified period)*** **- Frames, limited to __ frame(s) every *(Specified period)***		**In-Network** $0 copay for ▪ one pair of eyeglasses or contact lenses after each cataract surgery, [, and] *In combination with one of the following:* ▪ glasses [, and] ▪ contacts[, and] ▪ lenses[, and] ▪ frames OR ▪ up to __ pair(s) of glasses[, and] ▪ up to __ pair(s) of contacts[, and] ▪ up to __ pair(s) of lenses[, and] ▪ up to __ frame(s) *OR* ▪ up to __ pair(s) of glasses every *(specified period)* [, and] ▪ up to __ pair(s) of contacts every *(specified period)* [, and] ▪ up to __ pair(s) of lenses every *(specified period)* [,	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Detailed Report Sentence(s)**	**More Details Sentences**
		and] ▪ up to __ frame(s) every *(specified period)*	
You pay: **- $__ to __ [or __% to __% of the cost] for each routine eye exam** *OR* **- $__ to __ [or __% to __% of the cost] for each routine eye exam, limited to ___ exams** *OR* **- $__ to __ [or __% to __% of the cost] for each routine eye exam, limited to ___ exam(s) every (*Specified period)*** **- $ ___ [or __% of the cost] for glasses** **- $ ___ [or __% of the cost] for contacts** **- $ ___ [or __% of the cost] for lenses** **- $ ___ [or __% of the cost] for frames** *OR* **- $ ___ [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**		**In-Network** $__ to $__ copay [or __% to __% of the cost] for *In combination with any of the following:* routine eye exams *OR* up to ___ routine eye exams. *OR* up to ___ routine eye exam(s) every *(specified period)*. *AND/OR The following sentence:* $ ___ copay [or __% of the cost] for *In combination with any of the following:* ▪ glasses [, and] ▪ contacts[, and] ▪ lenses[, and] ▪ frames OR ▪ up to __ pair(s) of glasses[, and] ▪ up to __ pair(s) of contacts[, and] ▪ up to __ pair(s) of lenses[, and] ▪ up to __ frame(s)	

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Detailed Report Sentence(s)**	**More Details Sentences**
lenses, limited to ___ pair(s) of lenses **- $ ___ [or __% of the cost] for frames, limited to ___ frame(s)** *OR* **- $ ___ [or __% of the cost] for glasses, limited to ___ pair(s) of glasses every (*Specified period)*** **- $ ___ [or __% of the cost] for contacts, limited to ___ pair(s) of contacts every (*Specified period)*** **- $ ___ [or __% of the cost] for lenses, limited to ___ pair(s) of lenses every (*Specified period)*** **- $ ___ [or __% of the cost] for frames, limited to ___ frame(s) every (*Specified period)***		*OR* ▪ up to __ pair(s) of glasses every *(specified period)* [, and] ▪ up to __ pair(s) of contacts every *(specified period)* [, and] ▪ up to __ pair(s) of lenses every *(specified period)* [, and] ▪ up to __ frame(s) every *(specified period)*	
You are covered up to $___ for eye exams every *(Specified period).* *OR* **You are covered up to $___ for eye exams.**		**In-Network** $___ limit for eye exams every *(specified period)*. OR $___ limit for eye exams.	
You are covered up to $___ for eye wear every *(Specified period).* *OR* **You are covered for $___ for eye wear.**		**In-Network** $___ limit for eye wear every *(specified period)*. OR $___ limit for eye wear.	
You are covered up to $___ for eye exams and eye wear every *(Specified period).* *OR* **You are covered up to $____ for**		**In-Network** $___ limit for eye exams and eye wear every *(specified period)*. OR $___ limit for eye exams and eye	

Benefit Category and SB Sentences	Plan Type (*Sentences are for ALL plan types, unless noted.)*	Detailed Report Sentence(s)	More Details Sentences
eye exams and eye wear.		wear.	
Additional vision benefits are available.			**General** Plan offers additional vision benefits.
Transportation (Routine)			
There is no copayment for each (one-way trip/round trip) to (Plan-approved location/Any location). *OR* **There is no copayment for each (one-way trip/round trip) up to ___ trip(s) to (Plan-approved location/Any location).** *OR* **There is no copayment for each (one-way trip/round trip) up to ___trip(s) to (Plan-approved location/Any location) every (*Specified period*).** *OR* **You pay $___ [or ___% of the cost] for each (one-way trip/round trip) to (Plan-approved location/Any location).** *OR* **You pay $___ [or ___ % of the cost] for each (one-way trip/round trip) up to____ trip(s) to (Plan-approved location/Any location).** *OR* **You pay $___ [or ___% of the**		**In-Network** $0 copay for each [one-way/round] trip to [plan-approved/any] location. OR $0 copay for up to __ [one-way/round] trip(s) to [plan-approved/any] location. OR $0 copay for up to __ [one-way/round] trip(s) to [plan-approved/any] location every *(specified period)*. OR $___ copay [or ___ % of the cost] for each [one-way/round] trip to [plan-approved/any] location. OR $___ copay [or ___ % of the cost] for up to __ [one-way/round] trip(s) to [plan-approved/any] location. OR $___ copay [or ___ % of the cost]	

Benefit Category and SB Sentences	Plan Type (*Sentences are for ALL plan types, unless noted.)*	Detailed Report Sentence(s)	More Details Sentences
cost] for each (one-way trip/round trip) up to __trip(s) to (Plan-approved location/Any location) every *(Specified period).*		for up to __ [one-way/round] trip(s) to [plan-approved/any] location every	
Point-of-service			
Point of Service is available for the following benefits: *(Selected categories from pick list).*		**Out-of-Network** Point-of-service coverage is available for the following benefits: *(Selected categories from pick list).*	
A referral may be necessary for the following Point of Service benefits: *(Selected categories from pick list).*			**Out-of-Network** You may need a referral for the following Point-of-service benefits: *(Selected categories from pick list).*
There is no copayment for Inpatient Hospital services received at a non-network hospital.		**Out-of-Network** $0 copay for inpatient hospital benefits.	
You pay $___ [or __% of the cost] for each stay at a non-network hospital.		**Out-of-Network** $___ copay [or __% of the cost] per hospital stay.	
You pay $___ [or ___% of the cost] for each day at a non-network hospital.		**Out-of-Network** $___ copay [or __% of the cost] per hospital day.	
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')*		**Out-of-Network** $___ copay [or ___% of the cost] per day for days __-__ in a hospital.	**Out-of-Network** For longer hospital stays: Days __-__: $___ copay [or ___% of the cost] per day Days __-__: $___ copay [or ___% of the cost] per day.

Benefit Category and SB Sentences	**Plan Type** (*Sentences are for ALL plan types, unless noted.)*	**Detailed Report Sentence(s)**	**More Details Sentences**
at a non-network hospital.			
There is no copayment for services at a non-network Inpatient Psychiatric Hospital.		**Out-of-Network** $0 copay for Inpatient Psychiatric Hospital benefits.	
You pay $___ [or __% of the cost] for each stay at a non-network Inpatient Psychiatric Hospital.		**Out-of-Network** $___ copay [or __% of the cost] per Inpatient Psychiatric Hospital stay.	
You pay $___ [or ___% of the cost] each day at a non-network Inpatient Psychiatric Hospital.		**Out-of-Network** $___ copay [or __% of the cost] per Inpatient Psychiatric Hospital day.	
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.**		**Out-of-Network** $___ copay [or ___% of the cost] per day for days __-__ in an Inpatient Psychiatric Hospital.	**Out-of-Network** For longer Inpatient Psychiatric Hospital stays: Days __-__: $___ copay [or ___% of the cost] per day Days __-__: $___ copay [or ___% of the cost] per day.
Authorization rules may apply for services. Contact plan for details.	*New for 2007*		**General** Authorization rules may apply.