Attachment B: Original Medicare Sentences
2007 MPPF Benefit Sentences
Draft Date: April 27, 2006

Original Medicare Sentences

PBP Benefit Category	SB Sentence	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 the Medicare Part B premium of $88.50 each month.	$___ monthly Medicare Part B premium. $___ yearly deductible	If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.
2. Doctor and Hospital Choice (For more information, see Emergency-#15 and Urgently Needed Care-#16.)	**You may go to any doctor, specialist or hospital that accepts Medicare.**	You may go to any doctor, specialist or hospital that accepts Medicare.	
Inpatient Care			
3. Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	You pay for each benefit period (3): Days 1 - 60: an initial deductible of $952 Days 61 - 90: $238 each day Days 91 - 150: $476 each lifetime reserve day (4) Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. (4)	For each benefit period: Days 1 - 60: $952 deductible Days 61 - 90: $238 per day Days 91 - 150: $476 per lifetime reserve day	Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If

PBP Benefit Category	SB Sentence	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 go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.
4. Inpatient Mental Health Care	You pay the same deductible and copayments as inpatient hospital care (above) except Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.	Same deductible and copay as inpatient hospital care (#3 above). 190 day limit in a Psychiatric Hospital.	
5. Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	You pay for each benefit period (3), following at least a 3-day covered hospital stay: Days 1 - 20: $0 for each day Days 21 - 100: $119 for each day There is a limit of 100 days for each benefit period. (3)	For each benefit period after at least a 3-day covered hospital stay: Days 1 - 20: $0 per day Days 21 - 100: $119 per day	100 day limit per benefit period. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.
6. Home Health Care (includes medically necessary intermittent skilled nursing care, home	There is no copayment for all covered home health visits.	$0 copay.	

PBP Benefit Category	SB Sentence	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"
health aide services, and rehabilitation services, etc.)			
7. Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must receive care from a Medicare-certified hospice.	You pay part of the cost for outpatient drugs and inpatient respite care.	You must get care from a Medicare-certified hospice.
Outpatient Care			
8. Doctor Office Visits	You pay 20% of Medicare approved amounts. (1)(2)	20% coinsurance	
9. Chiropractic Services	You pay 20% of Medicare approved amounts.(1)(2) You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers. You pay 100% for routine care.	20% coinsurance You pay 100% for routine care.	You pay 20% coinsurance for manual manipulation of the spine to correct subluxation if you get it from a chiropractor or other qualified provider.
10. Podiatry Services	You pay 20% of the Medicare-approved amounts. (1)(2)	20% coinsurance You pay 100% for routine care.	You pay 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.

PBP Benefit Category	SB Sentence	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 are covered for medically necessary foot care, including care for medical conditions affecting the lower limbs. You pay 100% for routine care.		
11. Outpatient Mental Health Care	You pay 50% of Medicare-approved amounts with the exception of certain situations and services for which you pay 20% of approved charges. (1)(2)	50% coinsurance for most outpatient mental health services.	
12. Outpatient Substance Abuse Care	You pay 20% of Medicare-approved amounts. (1)(2)	20% coinsurance	
13. Outpatient Services/Surgery	You pay 20% of Medicare-approved amounts for the doctor. (1)(2) You pay 20% of outpatient facility charges. (1)(2)	20% coinsurance for the doctor 20% of outpatient facility charges	
14. Ambulance Services (medically necessary ambulance services)	You pay 20% of Medicare-approved amounts or applicable fee schedule charge. (1)(2)	20% coinsurance	

PBP Benefit Category	SB Sentence	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"
15. Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	You pay 20% of the facility charge or applicable Copayment for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. (1)(2) You pay 20% of doctor charges. (1)(2) NOT covered outside the U.S. except under limited circumstances.	20% coinsurance for the doctor 20% of facility charge, or a set copay per emergency room visit	For more information, call 1-800-MEDICARE (1-800-633-4227). You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit Not covered outside the U.S. except under limited circumstances.
16. Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	You pay 20% of Medicare-approved amounts or applicable Copayment. (1)(2) NOT covered outside the U.S. except under limited circumstances.	20% coinsurance, or a set copay	For more information, call 1-800-MEDICARE (1-800-633-4227). Not covered outside the U.S. except under limited circumstances.
17. Outpatient Rehabilitation Services (Occupational, Physical, Speech, and Language Therapy)	***You pay 20% of Medicare-approved amounts. (1)(2)***	20% coinsurance	
Outpatient Medical Services and Supplies			

PBP Benefit Category	SB Sentence	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"
18. Durable Medical Equipment (Wheelchairs, oxygen, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)	20% coinsurance	
19. Prosthetic Devices (Braces, artificial limbs and eyes, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)	20% coinsurance	
20. Diabetes Self-Monitoring Training and Supplies (Glucose monitors, test strips, lancets, screening tests, self-management training, etc.)	You pay 20% of Medicare-approved amounts. (1)(2)	20% coinsurance	
21. Diagnostic Tests, X-Rays, and Lab Services	You pay 20% of Medicare-approved amounts, except for approved lab services. (1)(2) ***There is no copayment for Medicare-approved lab services.***	20% coinsurance for diagnostic tests and x-rays $0 copay for Medicare-covered lab services	**Lab Services:** Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare **does not** cover most routine screening tests, like checking your cholesterol.
Preventive Services			
22. Bone Mass	You pay 20% of Medicare-	20% coinsurance	

PBP Benefit Category	SB Sentence	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"
Measurement (for people with Medicare who are at risk)	approved amounts. (1)(2)		
23. Colorectal Screening Exams (for people with Medicare age 50 and older)	You pay 20% of Medicare-approved amounts. (1)(2)	20% coinsurance	
24. Immunizations/Vaccines Flu and Pneumonia shots for all people with Medicare. Hepatitis B for people with Medicare who are at risk.	There is no copayment for the Pneumonia and Flu vaccines. You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine. (1)(2) You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.	$0 copay for Flu and Pneumonia vaccines 20% coinsurance for Hepatitis B vaccine	You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.
25. Mammograms (Annual Screening) (for women with Medicare age 40 and older)	You pay 20% of Medicare-approved amounts. (2) No referral necessary for Medicare-covered screenings.	20% coinsurance	No referral needed
26. Pap Smears and Pelvic Exams (for women with Medicare)	There is no copayment for a Pap Smear once every 2 years, annually for beneficiaries at	$0 copay for Pap smears. 20% coinsurance for Pelvic Exams	Pap smears covered once every 2 years. Covered once a year for people at high risk.

PBP Benefit Category	SB Sentence	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"
	high risk. (2) You pay 20% of Medicare-approved amounts for Pelvic Exams. (2)		
27. Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	There is no copayment for approved lab services and a copayment of 20% of Medicare-approved amounts for other related services. (1)(2)	20% coinsurance for the digital rectal exam. $0 for the PSA test; 20% coinsurance for other related services.	For more information, call 1-800-MEDICARE (1-800-633-4227).
28. Prescription Drugs	You pay 100% for most prescription drugs.	Most drugs not covered.	
29. Dental Services	In general, you pay 100% for preventive dental services.	Preventive dental services (such as cleaning) not covered.	
30. Hearing Services	You pay 100% for routine hearing exams and hearing aids. You pay 20% of Medicare-approved amounts for diagnostic hearing exams. (1)(2)	Routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	
31. Vision Services	You are covered for one pair of eyeglasses or contact lenses after each cataract surgery.	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.	Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.

PBP Benefit Category	SB Sentence	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)(2) For people with Medicare who are at risk, you are covered for annual glaucoma screenings. (1) (2) You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye. (1)(2) You pay 100% for routine eye exams and glasses.	You pay 100% for routine eye exams and glasses.	Annual glaucoma screenings covered for people at risk.
32. Physical Exams	If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physicial 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. You pay 20% of the Medicare-approved amount. (1)(2)	20% coinsurance	When you get Medicare Part B, you can get a one time physical exam within the first 6 months of your new Part B coverage. The coverage does not include lab tests.
Health/Wellness Education	You pay 100%.	You pay 100%.	

PBP Benefit Category	SB Sentence	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"
Transportation (Routine)	You pay 100%.	You pay 100%.	
Acupuncture	***You pay 100%.***	You pay 100%.	