

Summary of Benefits Template for Cost Plans for Contract Year 2003

[Please see *(Cost Contractor's Name)*'s •Evidence of Coverage• for a complete listing of benefits.]

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
<p>Premium</p>	<p>You pay the Medicare Part B premium of \$54.00 each month.</p> <p>(This is the 2002 amount and may change January 1, 2003.)</p>	<ul style="list-style-type: none"> • You pay \$___ each month. • You pay one initial deductible of \$_____ for plan services. • You pay one initial deductible of \$_____ for certain services • There is a maximum out-of-pocket limit for plan services. • You also continue to pay the Medicare Part B premium of \$54.00 each month. <p>(This is the 2002 amount and may change January 1, 2003.)</p> <p>Please note that <i>(Cost Plan Marketing Name)</i> is reducing your monthly Part B premium by \$_____. <i>(This may be a rounded number.)</i> Please contact <i>(Cost Plan Marketing Name)</i> for details.</p>
<p>Doctor and Hospital Choice (For more information, see Emergency- #15 and Urgently Needed Care -#16.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p><i>(Choose all that apply.)</i></p> <p><u>In most cases:</u></p> <ul style="list-style-type: none"> • You must go to network doctors, specialists, and hospitals. <p>You need a referral to go to network hospitals and certain doctors, including specialists.</p> <ul style="list-style-type: none"> • You need a referral to go to network specialists for certain services. • You need a referral to go to network hospitals.

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
		<ul style="list-style-type: none"> • A separate doctor office visit copayment may apply for certain services. • You do NOT need a referral to go to network doctors, specialists, and hospitals. • A Visitor/Travel program is available. Ask <i>(Cost Plan Marketing Name)</i> for details.
Inpatient Care		
<p>Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p>	<p>You pay for each benefit period: Days 1-60: an initial deductible of \$812</p> <p>Days 61- 90: \$203 each day</p> <p>Day 91- 150: \$406 each lifetime reserve day</p> <p>[These are 2002 amounts and may change January 1, 2003.]</p> <p>Please call 1-800-Medicare (1-800-633-4227) for information on lifetime reserve days. (4)</p>	<ul style="list-style-type: none"> • You pay a deductible of \$ ____ . • There is no copayment for Inpatient Hospital services in a network hospital. ••••You pay \$____ [or ____% of the cost] for each Medicare-covered stay in a network hospital. • You pay \$ ____ [or ____ % of the cost] each day for day(s) ____ - ____ for a Medicare-covered stay in a network hospital • You pay \$ ____ [or ____ % of the cost] for each non-Medicare-covered stay in a network hospital. • You pay \$ ____ [or ____ % of the cost] each day for day(s) ____ - ____ for each stay in a non-Medicare covered stay in a network hospital. • You pay \$ ____ [or ____ % of the cost] each day for additional day(s) ____ - ____ in a network hospital.

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
		<ul style="list-style-type: none"> • You are covered for 90 days each benefit period. (3) • You are covered for unlimited days each benefit period. (3) • You are covered for <i>(90+number of additional days)</i> days each benefit period. (3) <p>There is a \$ ___ maximum out of pocket limit every <i>(Specified period)</i></p> <p>There is a \$ ___ maximum out of pocket limit.</p>
<p>Inpatient Mental Health Care</p>	<p>You pay the same deductible and copayments as inpatient hospital care (above) except there is a 190-day lifetime limit in a psychiatric hospital.</p>	<ul style="list-style-type: none"> • You pay a deductible of \$ ___. • There is no copayment for services in a network hospital. • You pay \$ __ [or __% of the cost] for each Medicare-covered stay in a network hospital. • You pay \$ __ [__% of the cost] each day for days ___ - ___ for a Medicare-covered stay in a network hospital. • You pay \$ __ [or __% of the cost] for each stay in a network hospital. • You pay \$ __ [or __% of the cost] for each non-Medicare-covered stay in a network hospital. • You pay \$ __ [or __% of the cost] each day for days ___ - ___ for a stay in a network hospital. • There is no copayment for additional days in a network hospital • You pay \$ __ [or __% of the cost] each day for additional days ___ - ___ in a network hospital.

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
		<ul style="list-style-type: none"> • The maximum out of pocket limit is covered under Inpatient Hospital Care • There is a \$ __ maximum out of pocket limit every <i>(Specified period)</i>. • There is a \$ __ maximum out of pocket limit. • Contact plan for details about benefits beyond 190 days. • There is a 190-day lifetime limit in a psychiatric hospital.
<p>Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)</p>	<p>You pay for each benefit period, following at least a 3-day covered hospital stay:</p> <p>Days 1-20: \$0 for each day</p> <p>Days 21- 100: \$101.50 for each day</p> <p>There is a limit of 100 days for each benefit period. [These are 2002 amounts and may change January 1, 2003.]</p>	<ul style="list-style-type: none"> • You pay a deductible of \$ __. • There is no copayment for services in a Skilled Nursing Facility. • You pay \$ __ [or __ % of the cost] for each Medicare-covered stay in a Skilled Nursing Facility. • You pay \$ __ [or __ % of the cost] each day for days __ - __ for a non-Medicare-covered stay in a Skilled Nursing Facility. • You pay \$ __ [or __ % of the cost] for each stay in a Skilled Nursing Facility. • You pay \$ __ [or __ % of the cost] each day for days __ - __ in a Skilled Nursing Facility. • You pay \$ __ [or __ % of the cost] for each non-Medicare-covered stay in a Skilled Nursing Facility. • You pay \$ __ [or __ % of the cost] for each day for days __ - __ for a non-Medicare-covered stay in a Skilled Nursing Facility. • There is no copayment for additional days in a Skilled Nursing Facility. • You pay \$ __ [or __ % of the cost] each day for additional days in a Skilled Nursing Facility. • You pay \$ __ [or __ % of the cost] each day for additional days - in a Skilled Nursing

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		Facility. <ul style="list-style-type: none"> • You are covered for 100 days each benefit period. (3) • You are covered for unlimited days each benefit period. (3) • You are covered for <i>(100+ number of additional days)</i> days each benefit period. (3) • 3-day prior hospital stay is required. • <i>(1 or 2, whichever is applicable)</i>-day prior hospital stay is required. • No hospital stay is required. • There is a \$__ maximum out of pocket limit every <i>(Specified period)</i>.
<p>Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	There is no copayment for all covered home health visits.	<ul style="list-style-type: none"> • There is no copayment for Medicare covered home health visits. • There is no copayment for: <ul style="list-style-type: none"> -Custodial Care -Respite Care -Homemaker Services <p><i>You pay \$__ to \$__ [or __% to __% of the cost] for Medicare-covered home health visits.</i></p> <ul style="list-style-type: none"> • You pay \$__ to \$__ [<i>or</i> __% to __% of the cost] for Custodial care. • You pay \$__ to \$__ [<i>or</i> __% to __% of the cost] for Respite care. • You pay \$__ to \$__ [<i>or</i> __% to __% of the cost] for Homemaker services.
<p>Hospice</p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>And</p> <p>You must receive care from any Medicare-certified</p>	<p>You must receive care from a Medicare-certified hospice.</p>

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
	hospice.	
Doctor Office Visits	You pay 20% of Medicare approved amounts.	<ul style="list-style-type: none"> • There is no copayment for each primary care doctor office visit for Medicare-covered services. • You pay \$__ to \$__ [<i>or</i> __% to __% of the cost] for each primary care doctor office visit for Medicare-covered services. • There is no copayment for each specialist visit for Medicare-covered services. • You pay \$__ to \$__ [<i>or</i> __% to __% of the cost] for each specialist visit for Medicare-covered services. • See 32- Routine Physical Exams for more information.
Chiropractic Services	<p>You pay 20% of Medicare-approved amounts.</p> <p>You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers.</p> <p>You Pay 100% for routine care</p>	<ul style="list-style-type: none"> • There is no copayment for Medicare-covered chiropractic services (manual manipulation of the spine to correct subluxation). • You pay \$__ to \$__ [<i>or</i> __% to __% of the cost] for each Medicare covered visit (manual manipulation of the spine to correct subluxation). • There is no copayment for: <ul style="list-style-type: none"> -Medicare covered visits (manual manipulation of the spine to correct subluxation). -Routine visits up to __ visit(s) every (<i>Specified period</i>). You pay \$__ to \$__ [__% to __% of the cost] for each routine visit. You pay \$__ to \$__ [__% to __% of the cost] for each routine visit up to __ visit(s) every (<i>Specified period</i>)
Podiatry Services	<p>You pay 20% of the Medicare approved amounts.</p> <p>You are covered for medically necessary foot care,</p>	<p>There is no copayment for Medicare-covered podiatry services (medically necessary foot care)</p> <ul style="list-style-type: none"> • There is no copayment for:

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
	<p>including care for medical conditions affecting lower limbs.</p> <p>You pay 100% for routine care.</p>	<p>-Medicare-covered visits (medically necessary foot care)</p> <p>-routine visits up to ___ visit(s) every (<i>Specified period</i>).</p> <ul style="list-style-type: none"> • You pay: - \$ ___ to \$ ___ [or ___% to ___% of the cost] for each Medicare-covered visit (medically necessary foot care). - \$ ___ to \$ ___ [or ___% to ___% of the cost] for each routine visit up to visit(s) every (<i>Specified period</i>).
<p>Outpatient Mental Health Care</p>	<p>You pay 50% of Medicare- approved amounts with the exception of certain situations and services for which you pay 20% of approved charges.</p>	<ul style="list-style-type: none"> • There is no copayment for each Medicare covered visit for Mental Health services. • For Medicare covered Mental Health services, you pay \$ ___ [or ___% of the cost] for individual therapy visits ___ to ___. • For Medicare covered Mental Health services, you pay \$ ___ [or ___% of the cost] for group therapy visits ___ to ___. • For Medicare covered Mental Health services, you pay \$ ___ [or ___% of the cost] for individual/ group therapy visits ___ to ___. • There is no copayment for each Medicare covered visit for Mental Health Services with a Psychiatrist. • For Medicare covered Mental Health services with a psychiatrist, you pay \$ ___ [or ___% of the cost] for individual therapy visits ___ to ___. • For Medicare covered Mental Health services with a psychiatrist, you pay \$ ___ [or ___% of the cost] for group therapy visits ___ to ___. • For Medicare covered Mental Health services with a psychiatrist, you pay \$ ___ [or ___% of the cost] for individual/ group therapy visits ___ to ___.
<p>Outpatient Substance Abuse Care</p>	<p>You pay 20% of Medicare- approved amounts.</p>	<ul style="list-style-type: none"> • There is no copayment for each Medicare covered visit. • For Medicare covered services you pay \$ ___ [or ___% of the cost] for individual visits ___ to ___. • For Medicare covered services you pay \$ ___ [or ___% of the cost] for group visits ___ to ___. • For Medicare covered services you pay \$ ___ [or ___% of the cost] for individual/ group therapy visits ___ to ___.

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
		of the cost] for individual/group visits ___ to ___.
Outpatient Surgery	<p>You pay 20% of Medicare approved amounts for the doctor.</p> <p>You pay 20% of outpatient facility charges.</p>	<ul style="list-style-type: none"> • There is no copayment for a Medicare covered visit to an ambulatory surgical center. • You pay \$__ to \$__ [<i>or</i> __% to __% of the cost] for each Medicare-covered visit to an ambulatory surgical center. • There is no copayment for a Medicare covered visit to an outpatient hospital facility. • You pay \$__ to \$__ [<i>or</i> __% to __% of the cost] for each Medicare-covered visit to an outpatient hospital facility.
Ambulance Services (medically necessary ambulance services)	You pay 20% of Medicare approved amounts or applicable fee schedule charge.	<ul style="list-style-type: none"> • There is no copayment for Medicare-covered ambulance services. • You pay \$__ [<i>or</i> __% of the cost] for Medicare-covered ambulance services; (you do NOT pay this amount if you are admitted to the hospital. <i>If applicable</i>)
Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	<p>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.</p> <p>You pay 20% of doctor charges.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<ul style="list-style-type: none"> • There is no copayment for each Medicare-covered emergency room visit. • You pay \$__ to \$__ [<i>or</i> __% to __% of the cost] for each Medicare-covered emergency room visit. • You do not pay this amount if you are admitted to the hospital within [<i>insert number of days or hours, whichever is applicable</i>] for the same condition. • You do not pay this amount if you are immediately admitted to the hospital. <p><i>(One of the following must be included)</i></p> <ul style="list-style-type: none"> • NOT covered outside the U.S. except under limited circumstances. <p>OR</p> <ul style="list-style-type: none"> • Worldwide coverage.

Benefit	Original Medicare	(Cost Plan Name)
<p>Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>You pay 20% of Medicare approved amounts or applicable Copayment.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<ul style="list-style-type: none"> • There is no copayment for each Medicare-covered urgently needed care visit. • You pay \$__ to \$__ [or __% to __% of the cost] for Medicare-covered urgently needed care. • You do not pay this amount if you are admitted to the hospital within ___ day(s) [or ___ hour(s)] for the same condition. • You do not pay this amount if you are immediately admitted to the hospital. <p><i>(One of the following must be included)</i></p> <ul style="list-style-type: none"> • NOT covered outside the U.S. except under limited circumstances. <p>OR</p> <ul style="list-style-type: none"> • Worldwide coverage.
<p>Outpatient Rehabilitation Services</p> <ul style="list-style-type: none"> • Occupational Therapy • Physical Therapy • Speech and Language Therapy 	<p>You pay 20% of Medicare approved amounts.</p>	<ul style="list-style-type: none"> • There is no copayment for each Medicare-covered occupational therapy visit. • You pay \$__ to \$__ [or __% to __% of the cost] for each Medicare-covered Occupational Therapy visit. • There is no copayment for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit. <ul style="list-style-type: none"> • You pay \$__ to \$__ [or __% to __% of the cost] for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit.
<p>Outpatient Medical Services and Supplies</p>		
<p>Durable Medical Equipment (includes wheelchairs, oxygen, etc.)</p>	<p>You pay 20% of Medicare approved amounts.</p>	<ul style="list-style-type: none"> • There is no copayment for Medicare-covered items. • You pay \$__ to \$__ [or __% to __% of the cost] for each Medicare-covered item.
<p>Prosthetic Devices (includes pacemakers, braces, artificial limbs and eyes, etc.)</p>	<p>You pay 20% of Medicare approved amounts.</p>	<ul style="list-style-type: none"> • There is no copayment for Medicare-covered items. • You pay \$__ to \$__ [or __% to __% of the cost] for each Medicare-covered item.

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
etc.)		
Diabetes Self-Monitoring Training and Supplies (includes coverage for glucose monitors, test strips, lancets, and self-management training)	You pay 20% of Medicare approved amounts.	<ul style="list-style-type: none"> • There is no copayment for Diabetes self-monitoring training. • You pay \$__ to \$___ [<i>or</i> __% to __% of the cost] for Medicare-covered Diabetes self-monitoring training. • There is no copayment for Diabetes supplies. You pay \$__ to \$___ [<i>or</i> __% to __% of the cost] for each Medicare-covered Diabetes supply item
Diagnostic Tests, X-Rays, and Lab Services	<p>You pay 20% of Medicare approved amounts, except for approved lab services.</p> <p>There is no copayment for Medicare-approved lab services.</p>	<ul style="list-style-type: none"> • There is no copayment for the following Medicare-covered services: <ul style="list-style-type: none"> -Clinical/Diagnostic Lab Services -X-Ray visits. -Radiation therapy • You pay \$__ to \$___ [<i>or</i> __% to __% of the cost] for each Medicare-covered clinical/diagnostic lab service. • You pay \$__ to \$___ [<i>or</i> __% to __% of the cost] for each Medicare-covered radiation therapy service. • You pay \$__ to \$___ [<i>or</i> __% to __% of the cost] for each Medicare-covered X-ray visit.
Preventive Services		
Bone Mass Measurement (for people with Medicare who are at risk)	You pay 20% of Medicare approved amounts.	<p>There is no copayment for Medicare covered Bone Mass Measurements.</p> <ul style="list-style-type: none"> • <i>You pay \$___ [<i>or</i> ___% of the cost]</i> for each Medicare-covered Bone Mass Measurement.

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
<p>Mammograms (Annual Screening) (for women with Medicare age 40 and older)</p>	<p>You pay 20% of Medicare approved amounts.</p>	<p>There is no copayment for:</p> <ul style="list-style-type: none"> -Medicare-covered Screening Mammograms -Additional Screening Mammograms up to ___ Mammogram(s) every <i>(Specified period)</i>. <p>• You pay:</p> <ul style="list-style-type: none"> -\$_ [or ___% of the cost] for each Medicare-covered Screening Mammogram. -\$_ [or ___% of the cost] for each additional Screening Mammogram up to ___ Mammogram(s) every <i>(Specified Period)</i>. <p>• You are covered for an unlimited number of Screening Mammograms.</p>
<p>Pap Smears and Pelvic Exams (for women with Medicare)</p>	<p>There is no copayment for a Pap Smear once every 2 years, annually for beneficiaries at high risk.</p> <p>You pay 20% of Medicare approved amounts for Pelvic Exam.</p>	<ul style="list-style-type: none"> • There is no copayment for: -Medicare-covered Pap Smears and Pelvic Exams -Additional Pap Smears and Pelvic Exams up to ___ Pap Smear(s) and Pelvic Exam(s) every <i>(Specified Period)</i>. -Additional Pelvic Exams up to ___ Pelvic Exam(s) every <i>(Specified Period)</i>. -Additional <p>• You pay</p> <ul style="list-style-type: none"> -\$_ [or ___% of the cost] for each Medicare-covered Pap Smear. -\$_ [or ___% of the cost] for each Medicare-covered Pelvic Exam.-\$_ [or ___% of the cost] for each additional Pap Smear up to ___ Pap Smear(s) every <i>(Specified period)</i>. -\$_ [or ___% of the cost] for each additional Pelvic Exam up to ___ exam(s) every <i>(Specified period)</i>. <ul style="list-style-type: none"> • You are covered for an unlimited number of Pap Smears. • You are covered for an unlimited number of Pelvic Exams. • You are covered for unlimited number of Pap Smears and Pelvic Exams

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
<p>Prostate Cancer Screening Exams (for men with Medicare age 50 and older)</p>	<p>There is no copayment for approved lab services and a copayment of 20% of Medicare- approved amounts for other related services.</p>	<ul style="list-style-type: none"> • There is no copayment for: <ul style="list-style-type: none"> -Medicare covered Prostate Cancer Screening exams -Additional Screening exams up to ___ exam(s) every (<i>Specified Period</i>). • You pay: <ul style="list-style-type: none"> -\$___ [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 (<i>Specified Period</i>). • You are covered for an unlimited number of Screening exams.
Additional Benefits (What Original Medicare Does NOT Cover)		
<p>Outpatient Prescription Drugs (Drugs that are covered by Original Medicare do NOT count toward your plan prescription drug limit.)</p>	<p>You pay 100% for most prescription drugs.</p>	<ul style="list-style-type: none"> • You pay 100% for non-Medicare prescription drugs. • You pay a deductible of \$_____. • For prescription drugs on plan approved list (Formulary), you pay for each prescription or refill: <ul style="list-style-type: none"> \$__ to \$__ [or __% to __% of the cost] for Formulary Generic drugs up to a ___ day supply. \$__ to \$__ [or __% to __% of the cost] for Formulary Preferred Brand name drugs up to a ___ day supply. \$__ to \$__ [or __% to __% of the cost] for Formulary Brand name drugs up to a ___ day supply. \$___ [or ___% of the cost] for mail order Formulary Generic drugs up to a ___ day supply.

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
		<p>\$__ [or __% of the cost] for mail order Formulary Preferred Brand name drugs up to a __ day supply.</p> <p>\$__ [or __% of the cost] for mail order Formulary Brand name drugs up to a __ day supply.</p> <ul style="list-style-type: none"> • Ask <i>(Cost Plan Marketing Name)</i> for our formulary. • There is no individual limit on Formulary Generic drugs. • There is no individual limit on Formulary Preferred Brand drugs • There is no individual limit on Formulary Brand drugs. • There is a \$__ limit every <i>[Specified period]</i> for Formulary Generic drugs. • There is a \$__ limit every <i>[Specified period]</i> for Formulary Preferred Brand drugs. • There is a \$__ limit every <i>[Specified period]</i> for Formulary Brand drugs. • There is a \$__ limit for Formulary Generic Drugs. Ask <i>(Cost Plan Marketing Name)</i> about the time period for this limit. • There is a \$__ limit for Formulary Preferred Brand drugs. Ask <i>(Cost Plan Marketing Name)</i> about the time period for this limit. • There is a \$__ limit for Formulary Brand drugs. Ask <i>(Cost Plan Marketing Name)</i> about the time period for this limit. • You are NOT covered for prescription drugs that are NOT on a plan approved list (formulary). • You may be covered for non-formulary drugs when medically necessary. Ask <i>(Cost Plan Marketing Name)</i> for details. <p>• For prescription drugs that are NOT on a plan approved list (Formulary), you pay for each prescription or refill:</p> <p>\$__ to \$__ [or __% to __% of the cost] for Non-Formulary Generic drugs up to a __ day supply.</p>

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
		<p>\$__ to \$__ [<i>or</i> __% to __% of the cost] for Non-Formulary Brand name drugs up to a __ day supply.</p> <p>\$__ [<i>or</i> __% of the cost] for mail order Non-Formulary Generic drugs up to a __ day supply.</p> <p>\$__ [<i>or</i> __% of the cost] for mail order Non-Formulary Brand name drugs up to a __ day supply.</p> <p>For prescription drugs, you pay for each prescription or refill:</p> <p>\$__ to __ [<i>or</i> __% to __% of the cost] for Generic drugs up to a __-day supply.</p> <p>\$__ to __ [<i>or</i> __% to __% of the cost] for Brand drugs up to a __-day supply.</p> <p>\$__ to __ [<i>or</i> __% to __% of the cost] for mail order Brand drugs up to a __-day supply.</p> <p>\$__ to __ [<i>or</i> __% to __% of the cost] for mail order Generic drugs up to a __-day supply.</p> <ul style="list-style-type: none"> • There is no individual limit on Non-Formulary Generic drugs. • There is no individual limit on Non-Formulary Brand drugs. • There is a \$__ limit every (<i>Specified period</i>) for Non-Formulary Generic drugs. • There is a \$__ limit every (<i>Specified period</i>) for Non-Formulary Brand drugs. • There is a \$__ limit for Non-Formulary Generic drugs. Ask (<i>Cost Plan Marketing Name</i>) about the time period for this limit. • There is a \$__ limit for Non-Formulary Brand drugs. Ask (<i>Cost Plan Marketing Name</i>) about the time period for this limit. • There is no individual limit on Generic drugs. • There is no individual limit on Brand drugs. • There is a \$__ limit (<i>Specified period</i>) for Generic drugs.

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
		<ul style="list-style-type: none"> • There is a \$___ limit (<i>Specified period</i>) for Brand drugs. • There is a \$___ limit for Generic drugs. Ask (<i>Cost Plan Marketing Name</i>) about the time period for this limit. • There is a \$___ limit for Brand drugs. Ask (<i>Cost Plan Marketing Name</i>) about the time period for this limit. • There is a \$___ limit (<i>Specified period</i>) for combined (<i>specified drug types</i>: Formulary Brand, Formulary Generic, Non-Formulary Brand, Non-Formulary Generic) prescription drugs. • There is a \$___ limit (<i>Specified period</i>) for combined (<i>specified drug types</i>: Formulary Brand, Formulary Preferred Brand, Formulary Generic, Non-Formulary Brand, Non-Formulary Generic) prescription drugs. Ask (<i>Cost Plan Marketing Name</i>) about the time period for this limit. • There is a \$___ limit (<i>Specified period</i>) for combined (<i>specified drug types</i>: Brand, Generic) prescription drugs. Ask (<i>Cost Plan Marketing Name</i>) about the time period for this limit. • There is a \$___ limit (<i>Specified period</i>) for combined (<i>specified drug types</i>: Brand, Generic) prescription drugs. • There is no limit on [Formulary and/or Non-Formulary] Generic drugs after the combined limit on [<i>list drug types included in combined max</i>] is reached. • There is no limit on Generic drugs after the combined limit on Generic and Brand is reached. • There is an overall limit of \$___ every [<i>Specified period</i>] for [<i>list drug types</i>] prescription drugs. This overall maximum limit applies even if have not yet reached the separate limits (if applicable) for [<i>list drug types</i>] drugs. Ask (<i>Cost Plan Marketing Name</i>) about the time period for this limit. • There is an overall limit of \$___ every [<i>Specified period</i>] for Generic and Brand prescription drugs. This overall maximum limit applies even if have not yet reached the separate limits (if applicable) for [<i>list drug types</i>] drugs. Ask (<i>Cost Plan Marketing</i>

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
		<p><i>Name)</i> about the time period for this limit.</p> <ul style="list-style-type: none"> • Any unused amounts cannot be carried forward to 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. • The copayment does apply toward the plan prescription limit. • The copayment does not apply toward the plan prescription limit. • Please ask <i>(Cost Plan Marketing Name)</i> about how we determine drug costs that count towards these limits. • You must use [designated retail pharmacies/HMO-owned pharmacies/mail order] to get your prescription drugs. • You may use [designated retail pharmacies/HMO-owned pharmacies/mail order] and other ways to get your prescription drugs. Ask <i>(Cost Plan Marketing Name)</i> for more details. • Ask <i>(Cost Plan Marketing Name)</i> for details on where you can get your prescription drugs. • Authorization may be required for Formulary Drugs. • Authorization may be required for Non-Formulary Drugs. • Authorization may be required for prescription drugs. • When you want brand name drugs even though generic drugs are available, ask <i>(Cost Plan Marketing Name)</i> for details on costs and what is covered.
Dental Services	In general, you pay 100% for dental services.	<ul style="list-style-type: none"> • In general, you pay 100% for dental services. • There is no copayment for the following: <ul style="list-style-type: none"> -oral exams up to ___ visits every <i>(Specified period)</i> -cleanings up to ___ visits every <i>(Specified period)</i> -fluoride treatments up to ___ visits every <i>(Specified period)</i>

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
		<p><i>period)</i> -dental x-rays up to ____ visits every (<i>Specified period</i>)</p> <ul style="list-style-type: none"> • You pay: - \$ ____ [or ____% of the cost] for an Office Visit that includes the following services: <ul style="list-style-type: none"> • Oral Exams • Cleaning • Fluoride Treatment • Dental X-Rays • You pay: - \$ ____ to \$ ____ [or ____% to ____% of the cost] for each oral exam up to ____ visit(s) every (<i>Specified period</i>) - \$ ____ to \$ ____ [or ____% to ____% of the cost] for each cleaning up to ____ visit(s) every (<i>Specified period</i>) - \$ ____ to \$ ____ [or ____% to ____% of the cost] for each fluoride exam up to ____ visit(s) every (<i>Specified period</i>) - \$ ____ to \$ ____ [or ____% to ____% of the cost] for dental x-rays up to ____ visit(s) every (<i>Specified period</i>) • You are covered up to \$ ____ for Preventative dental services every (<i>Specified period</i>). • You are covered up to \$ ____ for Comprehensive dental services every (<i>Specified period</i>). • You are covered up to \$ ____ for dental services every (<i>Specified period</i>). • Additional benefits are available.
<p>Hearing Services</p>	<p>You pay 100% for routine hearing exams and hearing aids.</p> <p>You pay 20% of Medicare-approved amounts for diagnostic hearing exams.</p>	<p>In general, you pay 100% for routine hearing exams and hearing aids.</p> <ul style="list-style-type: none"> • There is no copayment for the following services: - Medicare-covered hearing exams (diagnostic hearing exams) - routine hearing tests up to ____ visit(s) every (<i>Specified period</i>) - fittings-evaluations for a hearing aid up to ____ visit(s) every (<i>Specified period</i>)

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
		<ul style="list-style-type: none"> • There is no copayment for hearing aids up to ___ aid(s) every <i>(Specified period)</i>. • There is no copayment for the following items <ul style="list-style-type: none"> -hearing aids-inner ear -hear aids-outer ear -hearing aids-over the ear • You pay \$__ [<i>or</i> __% of the cost] for a Medicare-covered hearing exam. (diagnostic hearing exams) • You pay \$__ to \$__ [<i>or</i> __% to __% of the cost] for each routine hearing test up to __ visit(s) each <i>(Specified period)</i>. • You pay \$__ to \$__ [<i>or</i> __% to __% of the cost] for each fitting-evaluation for hearing aid up to __ visit(s) each <i>(Specified period)</i>. • You pay \$__ to \$__ [<i>or</i> __% to __% of the cost] for each hearing aid-outer ear up to __ aid(s) each <i>(Specified period)</i>. • You pay \$__ to \$__ [<i>or</i> __% to __% of the cost] for each pair of hearing aids-outer ear up to __ aid(s) each <i>(Specified period)</i>. • You pay \$__ to \$__ [<i>or</i> __% to __% of the cost] for each pair of hearing aids-over the ear up to __ aid(s) each <i>(Specified period)</i>. • You are covered up to \$___ for routine hearing tests every <i>(Specified period)</i>
Vision Services	<p>You are covered for one pair of eyeglasses or contact lenses after each cataract surgery.</p> <p>For people with Medicare who are at risk, you are</p>	<ul style="list-style-type: none"> • You pay 100% for non-Medicare- covered eye exams and glasses. • There is no copayment for the following services:

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
	<p>covered for annual glaucoma screenings.</p> <p>You pay 20% of Medicare approved amounts for diagnosis and treatment for diseases and conditions of the eye.</p> <p>You pay 100% for routine eye exams and glasses.</p>	<p>Medicare-covered eye exams (diagnosis and treatment for disease and conditions of the eye)</p> <ul style="list-style-type: none"> • - routine eye exams up to ___ visits(s) every <i>(Specified period)</i>. • There is no coayment for the following items: <ul style="list-style-type: none"> - Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery) • Glasses Contacts Lenses Frames • Glasses, limited to ___ pair(s) of glasses every <i>(Specified period)</i> Contacts, limited to ___ pair(s) of contacts every <i>(Specified period)</i> Lenses, limited to ___ pair(s) of lenses every <i>(Specified period)</i> Frames, limited to ___ frames every <i>(Specified period)</i> • You pay \$___ [or ___% of the cost] for Medicare-covered eye wear • (one pair of eyeglasses or contact lenses after each cataract surgery) <p>\$___ to \$___ [___% to ___% of the cost] for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye).</p> <ul style="list-style-type: none"> • \$___ to ___ [or ___% to ___% of the cost] for each routine eye exam, limited to ___ exam(s) every <i>(Specified period)</i> • \$___ [or ___% of the cost] for glasses, limited to ___ pair(s) of glasses every <i>(Specified period)</i> • \$___ [or ___% of the cost] for contacts, limited to ___ pair(s) of contacts every <i>(Specified period)</i> • \$___ [or ___% of the cost] for lenses, limited to ___ pair(s) of lenses every <i>(Specified period)</i> • \$___ [or ___% of the cost] for frames, limited to

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
		<p>pair(s) of frames every (Specified period)</p> <ul style="list-style-type: none"> • You are covered up to \$__ for eye exams every (Specified period). • You are covered up to \$__ for eyewear every (Specified period). • You are covered up to \$__ for eye exams and eye wear every (Specified period). • Additional benefits are available.
Routine Physical Exams	You pay 100% for routine physical exams.	<ul style="list-style-type: none"> • You pay 100% for routine physical exams. • There is no copayment for routine physical exams. • You pay \$__ [or __% of the cost] for each exam. • You are covered for an unlimited number of exams. • You are covered up to __ exams every (Specified period).
Acupuncture	You pay 100%.	<ul style="list-style-type: none"> • There is no copayment for each acupuncture visit up to __ visit(s) every (Specified period). • You pay \$__ [or __% of the cost] for each visit. • You pay \$__ [or % of the cost] for each visit up to __ visit(s) every (Specified period). <p>(If no Benefits do not add category)</p>
Health/Wellness Education	You pay 100%.	<p>You are covered for the following:</p> <ul style="list-style-type: none"> • - Health Ed classes - Newsletter - Nutritional Training - Smoking Cessation - Congestive Heart Program - Alternative Medicine Program - Health Club Membership/ Fitness Classes

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
		<ul style="list-style-type: none"> - Nursing Hotline - Disease management - Other Wellness Services
Transportation (Routine)	In general, you pay 100%	<ul style="list-style-type: none"> • There is no copayment for each (one-way trip/roundtrip) up to ___ trip(s) to (Plan-approved location/Any location) every (Specified period). • You pay \$__ [or __% of the cost] for each (one-way trip/roundtrip) up to ___ trip(s) to (Plan-approved location/Any location) every (Specified period)
Optional Supplemental Benefits		
Premium	You pay the Medicare Part B premium of \$54.00 each month. (This is the 2002 amount and may change January 1, 2003.)	You pay \$__ each month, in addition to your monthly plan premium of \$__ and the Medicare Part B premium, for these optional benefits.
Chiropractic Services	You pay 20% of Medicare-approved amounts. 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	There is no copayment for: -routine visits -routine visits up to ___ visit(s) every (<i>Specified period</i>) -routine visits up to ___ visit(s) You pay: -\$__ to \$__ [or __% to __% of the cost] for each routine visit up to ___ visit(s) every (<i>Specified Period</i>) -\$__ to \$__ [or __% to __% of the cost] for each routine visit up to ___ visit(s) -\$__ to \$__ [or __% to __% of the cost] for each routine visit

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
Podiatry Services	In general, you pay 100%.	<p>There is no copayment for:</p> <ul style="list-style-type: none"> -routine visits -routine visits up to ___ visit(s) every (<i>Specified Period</i>) -routine visits up to ___ visit(s) <p>You pay:</p> <ul style="list-style-type: none"> -\$ ___ to \$ ___ [or ___% to ___% of the cost] for each routine visit up to ___ visit(s) every (<i>Specified Period</i>) -\$ ___ to \$ ___ [or ___% to ___% of the cost] for each routine visit up to ___ visit(s) -\$ ___ to \$ ___ [or ___% to ___% of the cost] for each routine visit
Outpatient Prescription Drugs	You pay 100% for most prescription drugs.	<p>Your pay a deductible of \$___.</p> <p>For prescription drugs on plan approved list (Formulary), you pay for each prescription or refill:</p> <ul style="list-style-type: none"> -\$ ___ to \$ ___ [or ___% to ___% of the cost] for Formulary Generic drugs up to a ___-day supply -\$ ___ to \$ ___ [or ___% to ___% of the cost] for Formulary Preferred Brand drugs up to a ___-day supply -\$ ___ to \$ ___ [or ___% to ___% of the cost] for Formulary Brand drugs up to a ___-day supply <ul style="list-style-type: none"> -\$ ___ [or ___% of the cost] for mail order Formulary Generic drugs up to a ___-day supply -\$ ___ [or ___% of the cost] for mail order Formulary Preferred Brand drugs up to a ___-day supply -\$ ___ [or ___% of the cost] for mail order Formulary Brand drugs up to a ___-day supply <p>-Ask (<i>Cost Plan Marketing Name</i>) for a copy of our Formulary.</p> <p>-There is no individual limit on Formulary Generic drugs.</p>

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
		<p>-There is no individual limit on Formulary Preferred Brand drugs.</p> <p>-There is no individual limit on Formulary Brand drugs.</p> <p>-There is a \$ ___ limit (<i>Specified period</i>) for Formulary Generic drugs.</p> <p>- There is a \$ ___ limit (<i>Specified period</i>) for Formulary Preferred Brand drugs.</p> <p>- There is a \$ ___ limit (<i>Specified period</i>)</p> <p>-There is a \$ ___ limit for Formulary Generic Drugs. Ask (<i>Cost Plan Marketing Name</i>) about the time period for this limit.</p> <p>-There is a \$ ___ limit for Formulary Preferred Brand drugs. Ask (<i>Cost Plan Marketing Name</i>) about the time period for this limit.</p> <p>-There is a \$ ___ limit for Formulary Brand drugs. Ask (<i>Cost Plan Marketing Name</i>) about the time period for this limit.</p> <p>-You are NOT covered for prescription drugs that are NOT on a plan-approved list (formulary).</p> <p>-You may be covered for non-formulary drugs when medically necessary. Ask (<i>Cost Plan Marketing Name</i>) for details.</p> <p>For prescription drugs that are NOT on a plan approved list (Formulary), you pay for each prescription or refill:</p> <p>\$__ to \$__ [<i>or</i> __% to __% of the cost] for Non-Formulary Generic drugs up to a ___ day supply.</p> <p>\$__ to \$__ [<i>or</i> __% to __% of the cost] for Non-Formulary Brand name drugs up to a ___ day supply.</p> <p>\$__ [<i>or</i> __% of the cost] for mail order Non-Formulary Generic drugs up to a ___ day supply.</p> <p>\$__ [<i>or</i> __% of the cost] for mail order Non-Formulary Brand name drugs up to a ___ day supply.</p>

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
		<ul style="list-style-type: none"> • There is no individual limit on Non-Formulary Generic drugs. • There is no individual limit on Non-Formulary Brand drugs. • There is a \$____ limit every (<i>Specified period</i>) for Non-Formulary Generic drugs. • There is a \$____ limit every (<i>Specified period</i>) for Non-Formulary Brand drugs. • There is a \$____ limit for Non-Formulary Generic drugs. Ask (<i>Cost Plan Marketing Name</i>) about the time period for this limit. • There is a \$____ limit for Non-Formulary Brand drugs. Ask (<i>Cost Plan Marketing Name</i>) about the time period for this limit. • There is a \$____ limit every (<i>Specified period</i>) for combined (<i>specified drug types</i>: Brand, Generic) prescription drugs. Ask (<i>Cost Plan Marketing Name</i>) about the time period for this limit. • There is no limit on [Formulary and/or Non-Formulary] Generic drugs after the combined limit on [<i>list drug types included in combined max</i>] is reached. • There is no limit on Generic drugs after the combined limit on Generic and Brand is reached. • There is an overall limit of \$____ [<i>Specified period</i>] for [<i>list drug types</i>] prescription drugs. This overall maximum limit applies even if you have not reached the separate limits (<i>if applicable</i>) for [<i>list drug types</i>] drugs. • There is an overall limit of \$____ [<i>Specified period</i>] for [<i>list drug types</i>] prescription drugs. This overall maximum limit applies even if you have not reached the separate limits (<i>if applicable</i>) for [<i>list drug types</i>] drugs. Ask (<i>Cost Plan Marketing Name</i>) about the time period for this limit. • There is an overall limit of \$____ [<i>Specified period</i>] for Generic and Brand prescription drugs. This overall maximum limit applies even if you have not reached the separate limits (<i>if applicable</i>) for [<i>list drug types</i>] drugs. • There is an overall limit of \$____ for Generic and Brand prescription drugs. This overall maximum limit applies even if you have not yet reached the separate limits (<i>if applicable</i>) for [<i>list of drug types</i>] drugs. Ask

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
		<p><i>(Cost Plan Marketing Name)</i> about the time period for this limit.</p> <ul style="list-style-type: none"> • Any unused amounts cannot be carried forward to 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. • The copayment does apply toward the plan prescription limit. • The copayment does not apply toward the plan prescription limit. • Please ask <i>(Cost Plan Marketing Name)</i> about how we determine drug costs that count towards these limits. • You must use [<i>designated retail pharmacies/HMO-owned pharmacies/mail order</i>] to get your prescription drugs. • You may use [<i>designated retail pharmacies/HMO-owned pharmacies/mail order</i>] to get your prescription drugs. Ask <i>(Cost Plan Marketing Name)</i> for details. • Ask <i>(Cost Plan Marketing Name)</i> for details on where you can get your prescription drugs. • Authorization may be required for Formulary Drugs. • Authorization may be required for Non-Formulary Drugs. • Authorization may be required for prescription drugs. • When you want brand name drugs even though generic drugs are available, ask <i>(Cost Plan Marketing Name)</i> for details on costs and what is covered.
Dental Services	In general, you pay 100% for dental services.	There is no copayment for the following:

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
		<p>-oral exams -cleanings -fluoride treatments -dental x-rays</p> <p>-oral exams up to ___ visit(s) -cleanings up to ___ visit(s) -fluoride treatments up to ___ visit(s) -dental x-rays up to ___ visit(S)</p> <p>-oral exams up to ___ visit(s) every <i>(Specified period)</i> -cleanings up to ___ visit(s) every <i>(Specified period)</i> -fluoride treatments up to ___ visit(s) every <i>(Specified period)</i> -dental x-rays up to ___ visit(s) every <i>(Specified period)</i></p> <p>You Pay:</p> <p>\$ ___ [or ___% of the cost] for an Office Visit that includes the following services:</p> <p>-oral exams -cleanings -fluoride treatments -dental x-rays</p> <p>-oral exams up to ___ visit(s) -cleanings up to ___ visit(s) -fluoride treatments up to ___ visit(s) -dental x-rays up to ___ visit(S)</p> <p>-oral exams up to ___ visit(s) every <i>(Specified period)</i> -cleanings up to ___ visit(s) every <i>(Specified period)</i> -fluoride treatments up to ___ visit(s) every <i>(Specified period)</i> -dental x-rays up to ___ visit(s) every <i>(Specified period)</i></p>

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
		<p>- \$ ___ to ___ [or ___ % to ___ % of the cost] for each oral exam</p> <p>- \$ ___ to ___ [or ___ % to ___ % of the cost] for each cleaning</p> <p>- \$ ___ to ___ [or ___ % to ___ % of the cost] for each fluoride treatment</p> <p>- \$ ___ to ___ [or ___ % to ___ % of the cost] for dental x-rays</p> <p>- \$ ___ to ___ [or ___ % to ___ % of the cost] for each oral exam up to ___ visit(s)</p> <p>- \$ ___ to ___ [or ___ % to ___ % of the cost] for each cleaning up to ___ visit(s)</p> <p>- \$ ___ to ___ - \$ ___ to ___ [or ___ % to ___ % of the cost] for each oral exam up to ___ visit(s)</p> <p>- \$ ___ to ___ [or ___ % to ___ % of the cost] for each cleaning up to ___ visit(s) every <i>(Specified period)</i></p> <p>- \$ ___ to ___ [or ___ % to ___ % of the cost] for each fluoride treatment up to ___ visit(s) every <i>(Specified period)</i></p> <p>- \$ ___ to ___ [or ___ % to ___ % of the cost] for dental x-rays up to ___ visit(s) every <i>(Specified period)</i></p> <p>- \$ ___ to ___ [or ___ % to ___ % of the cost] for dental x-rays up to ___ visit(s) <i>(Specified period)</i></p> <p>You are covered up to \$ ___ for Preventive dental services.</p> <p>You are covered up to \$ ___ for Comprehensive dental services every <i>(Specified period)</i>.</p> <p>You are covered up to \$ ___ for Comprehensive dental services</p> <p>You are covered up to \$ ___ for dental services every <i>(Specified period)</i>.</p> <p>You are covered up to \$ ___ for dental services.</p> <p>Additional benefits are available.</p>

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
Hearing Services	<p>You pay 100% for routine hearing exams and hearing aids.</p> <p>You pay 20% of Medicare-approved amounts for diagnostic hearing exams.</p>	<p>There is no copayment for the following services:</p> <ul style="list-style-type: none"> -routine hearing tests -fittings-evaluations for a hearing aid -routine hearing tests up to ___ visit(s) -fittings-evaluations for a hearing aid up to ___ visit(s) -routine hearing tests up to ___ visit(s) every (<i>Specified period</i>) -fittings-evaluations for a hearing aid up to ___ visit(s) every (<i>Specified period</i>) <p>There is no copayment for hearing aids.</p> <p>There is no copayment for hearing aids up to ___ aid(s)</p> <p>There is no copayment for hearing aids up to ___ aid(s)</p> <p>There is no copayment for the following items</p> <ul style="list-style-type: none"> -hearing aids-inner ear -hearing aids-outer ear -hearing aids-over the ear -hearing aids-inner ear up to ___ aid(s) -hearing aids-outer ear up to ___ aid(s) -hearing aids-over the ear to ___ aid(s) hearing aids-inner ear up to ___ aid(s) every (<i>Specified period</i>) -hearing aids-outer ear up to ___ aid(s) every (<i>Specified period</i>) -hearing aids-over the ear to ___ aid(s) every (<i>Specified period</i>) <p>You pay</p>

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
		<p>- \$ ___ to \$ ___ [or ___% to ___% of the cost] for each routine hearing test</p> <p>- \$ ___ to \$ ___ [or ___% to ___% of the cost] for each fitting –evaluation for a hearing aid</p> <p>- \$ ___ to \$ ___ [or ___% to ___% of the cost] for each routine hearing test up to ___ test(s)</p> <p>- \$ ___ to \$ ___ [or ___% to ___% of the cost] for each fitting –evaluation for a hearing aid up to ___ fittings(s)-evaluations(s)</p> <p>- \$ ___ to \$ ___ [or ___% to ___% of the cost] for each routine hearing test up to ___ test(s) every (<i>Specified Period</i>)</p> <p>- \$ ___ to \$ ___ [or ___% to ___% of the cost] for each fitting –evaluation for a hearing aid up to ___ fittings(s)-evaluations(s) every (<i>Specified period</i>)</p> <p>- \$ ___ to \$ ___ [or ___% to ___% of the cost] for each hearing aid</p> <p>- \$ ___ to \$ ___ [or ___% to ___% of the cost] for each hearing aid-inner ear</p> <p>- \$ ___ to \$ ___ [or ___% to ___% of the cost] for each hearing aid-over the ear</p> <p>- \$ ___ to \$ ___ [or ___% to ___% of the cost] for each hearing aid up to ___ aid(s)</p> <p>- \$ ___ to \$ ___ [or ___% to ___% of the cost] for each hearing aid-inner ear up to ___ aid(s)</p> <p>- \$ ___ to \$ ___ [or ___% to ___% of the cost] for each hearing aid-over the ear up to ___ aid(s)</p> <p>- \$ ___ to \$ ___ [or ___% to ___% of the cost] for each hearing aid up to ___ aid(s) every (<i>Specified period</i>)</p> <p>- \$ ___ to \$ ___ [or ___% to ___% of the cost] for each hearing aid-inner ear up to ___ aid(s) every (<i>Specified period</i>)</p> <p>- \$ ___ to \$ ___ [or ___% to ___% of the cost] for each hearing aid-over the ear up to ___ aid(s) every (<i>Specified period</i>)</p> <p>You are covered up to \$ ___ for routine hearing tests every</p>

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
		<p><i>(Specified period).</i></p> <p>You are covered up to \$__ for routine hearing tests.</p> <p>You are covered up to \$__ for hearing aids every <i>(Specified period).</i></p> <p>You are covered up to \$__ for hearing aids</p> <p>You are covered up to \$__ for routine hearing tests and hearing aids every <i>(Specified period).</i></p> <p>You are covered up to \$__ for routine hearing tests and hearing aids.</p>
<p>Vision Services</p>	<p>You are covered for one pair of eyeglasses or contact lenses after each cataract surgery.</p> <p>For people with Medicare who are at risk, you are covered for annual glaucoma screenings.</p> <p>You pay 20% of Medicare approved amounts for diagnosis and treatment for diseases and conditions of the eye.</p> <p>You pay 100% for routine eye exams and glasses.</p>	<p>There is no copayment for the following services:</p> <ul style="list-style-type: none"> -routine eye exams -routine eye exams up to __ visit(s) routine eye exams up to __ visit(s) every <i>(Specified period)</i> <p>There is no coapymnt for the following items:</p> <ul style="list-style-type: none"> -Glasses -Contacts -Lenses -Frames <p>Glasses, limited to __ pair(s) of glasses</p> <p>Contacts, limited to __ pair(s) of contacts</p> <p>Lenses, limited to __ pair(s) of lenses</p>

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
		<p>Frames, limited to ___ frame(s) Glasses, limited to ___ pair(s) of glasses</p> <p>Contacts, limited to ___ pair(s) of contacts every (<i>Specified period</i>)</p> <p>Lenses, limited to ___ pair(s) of lenses every (<i>Specified period</i>)</p> <p>Frames, limited to ___ frame(s) every (<i>Specified period</i>)</p> <p>You pay:</p> <p>-\$ ___ to ___ [or ___ % to ___ % of the cost] for each routine eye exam</p> <p>-\$ ___ to ___ [or ___ % to ___ % of the cost] for each routine eye exam, limited to ___ exam(s)</p> <p>-\$ ___ to ___ [or ___ % to ___ % of the cost] for each routine eye exam, limited to ___ exam(s) every (<i>Specified Period</i>)</p> <p>-\$ ___ to ___ [or ___ % to ___ % of the cost] for glasses</p> <p>-\$ ___ to ___ [or ___ % to ___ % of the cost] for contacts</p> <p>-\$ ___ to ___ [or ___ % to ___ % of the cost] for lenses</p> <p>-\$ ___ to ___ [or ___ % to ___ % of the cost] for frames</p> <p>-\$ ___ to ___ [or ___ % to ___ % of the cost] for glasses, limited to ___ pair(s) of glasses</p> <p>-\$ ___ to ___ [or ___ % to ___ % of the cost] for contacts, limited to ___ pair(s) of contacts</p> <p>-\$ ___ to ___ [or ___ % to ___ % of the cost] for lenses, limited to ___ pairs(s) of lenses</p> <p>-\$ ___ to ___ [or ___ % to ___ % of the cost] for frames, limited to ___ pair(s) of frames</p> <p>-You are covered up to \$ ___ for eye exams every (<i>Specified period</i>)</p> <p>-You are covered up to \$ ___ for eye exams</p> <p>-You are covered up to \$ ___ for eye wear every (<i>Specified period</i>)</p> <p>-You are covered for \$ ___ for eye wear</p> <p>-You are covered up to \$ ___ for eye exams every (<i>Specified period</i>).</p>

Benefit	Original Medicare	<i>(Cost Plan Name)</i>
		<p>- You are covered up to \$___ for eye exams and eye wear.</p> <p>-Additional benefits are available</p>
<p>Transportation</p>	<p>In general, you pay 100%</p>	<p>-There is no copayment for each (one-way trip/roundtrip) to (Plan approved location/Any location).</p> <p>-There is no copayment for each (one-way trip/round trip) up to ___ trip(s) to (Plan-approved location/ Any location).</p> <p>-There is no copayment for each (one-way trip/round trip up to ___ trip(s) to (Plan-approved location/Any location) every (<i>Specified period</i>).</p> <p>-You pay \$___[or ___% of the cost] for each (one-way trip/round trip) to (Plan-approved location/Any location).</p> <p>-You pay \$___[or ___% of the cost] for each (one-way trip/round trip) up to ___trip(s) to (Plan-approved location/Any location).</p> <p>-You pay \$___[or ___% of the cost] for each (one-way trip/round trip) up to ___trip(s) to (Plan-approved location/Any location).</p>