

SECTION D – PLAN DEDUCTIBLE (COMBINED) – BASE 1 SCREEN

PBP 2008 Data Entry System - Plan Deductible (Combined) - Base 1

File

Is there a Combined (In-Network and Out-of-Network) Deductible amount?
 Yes
 No

Do you charge the Medicare-defined Part B Deductible amount?
 Yes
 No

Indicate Combined (In-Network and Out-of-Network) Deductible Amount:

Select all of the In-Network Medicare-covered Service Categories to which the Combined Deductible applies:

- #1a Inpatient Hospital Acute
- #1b Inpatient Psych Hospital
- #2 Skilled Nursing Facility (SNF)
- #3 Comprehensive Outpatient Rehabilitation Facility (CORF)
- #5 Partial Hospitalization
- #6 Home Health Services
- #7a Primary Care Physician

Select the benefits that apply to the Combined Deductible:

- In-Network Medicare-covered benefits
- In-Network Non-Medicare covered benefits
- Out-of-Network Medicare-covered benefits
- Out-of-Network Non-Medicare covered benefits

Does the Combined Deductible apply to all In-Network Non-Medicare-covered plan services?
 Yes
 No

Does the Combined Deductible apply to all In-Network Medicare-covered plan services?
 Yes
 No

Select all of the In-Network Non-Medicare-covered Service Categories to which the Combined Deductible applies:

- #10b Transportation
- #13b Acupuncture
- #13c Other 1
- #13d Other 2
- #13e Other 3
- #14a Health Ed/Wellness
- #16a Preventive Dental
- #16b Comprehensive Dental
- #17a Eye Exams
- #17b Eye Wear
- #18a Hearing Exams
- #18b Hearing Aids

SECTION D – PLAN DEDUCTIBLE (COMBINED) – BASE 2 SCREEN

File

Does the Combined Deductible apply to all Out-Of-Network Medicare-covered plan services?
 Yes
 No

Does the Combined Deductible apply to all Out-Of-Network Non-Medicare-covered plan services?
 Yes
 No

Select all of the Out-of-Network Medicare-covered Service Categories to which the Combined Deductible applies:

- #1a Inpatient Hospital Acute
- #1b Inpatient Psych Hospital
- #2 Skilled Nursing Facility (SNF)
- #3 Comprehensive Outpatient Rehabilitation Facility (CORF)
- #4b Urgently Needed Care
- #5 Partial Hospitalization
- #6 Home Health Services
- #7a Primary Care Physician
- #7b Chiropractic Services
- #7c Occupational Therapy
- #7d Physician Specialist excl Psychiatric
- #7e Mental Health - Non-Physician
- #7f Podiatry Services
- #7g Other Health Care Professional
- #7h Psychiatric
- #7i PT and SP Services
- #8a Outpatient Clin/Diag/Ther Rad Lab
- #8b Outpatient X-Rays
- #9a Outpatient Hospital
- #9b ASC Services
- #9c Outpatient Substance Abuse
- #9d Cardiac Rehabilitation Services

Select all of the Out-of-Network Non-Medicare-covered Service Categories to which the Combined Deductible applies:

- #10b Transportation
- #13b Acupuncture
- #13c Other 1
- #13d Other 2
- #13e Other 3
- #14a Health Ed/Wellness
- #16a Preventive Dental
- #16b Comprehensive Dental
- #17a Eye Exams
- #17b Eye Wear
- #18a Hearing Exams
- #18b Hearing Aids

SECTION D – PLAN DEDUCTIBLE (IN-NETWORK) SCREEN

PBP 2008 Data Entry System - Plan Deductible (In-Network)

File

Is there an In-Network Plan Deductible?
 Yes
 No

Do you charge the Medicare-defined Part B Deductible amount?
 Yes
 No

Indicate In-Network Plan Deductible Amount:

Select all of the In-Network Medicare-covered Service Categories to which the In-Network Plan Deductible applies:

- #1 a Inpatient Hospital Acute
- #1 b Inpatient Psych Hospital
- #2 Skilled Nursing Facility (SNF)
- #3 Comprehensive Outpatient Rehabilitation Facility (CORF)
- #5 Partial Hospitalization
- #6 Home Health Services

Select the benefits that apply to the In-Network Deductible:
 In-Network Medicare-covered benefits
 In-Network Non-Medicare covered benefits

Does the In-Network Deductible apply to all In-Network Non-Medicare-covered plan services?
 Yes
 No

Does the In-Network Deductible apply to all In-Network Medicare-covered plan services?
 Yes
 No

Select all of the In-Network Non-Medicare-covered Service Categories to which the In-Network Deductible applies:

- #10 b Transportation
- #13 b Acupuncture
- #13 c Other 1
- #13 d Other 2
- #13 e Other 3
- #14 a Health Ed/Wellness
- #16 a Preventive Dental
- #16 b Comprehensive Dental
- #17 a Eye Exams
- #17 b Eye Wear
- #18 a Hearing Exams
- #18 b Hearing Aids

SECTION D – PLAN DEDUCTIBLE (OUT-OF-NETWORK) SCREEN

File

Is there an Out-of-Network (DON) Plan Deductible?
 Yes
 No

Do you charge the Medicare-defined Part B Deductible amount?
 Yes
 No

Indicate Out-of-Network Plan Deductible Amount:

Select the benefits that apply to the Out-of-Network Deductible:
 Out-of-Network Medicare-covered benefits
 Out-of-Network Non-Medicare covered benefits

Does the Out-of-Network Deductible apply to all Out-of Network Medicare-covered plan services?
 Yes
 No

Select all of the Out-of-Network Medicare-covered Service Categories to which the Out-of-Network Plan Deductible applies:

- #1a Inpatient Hospital Acute
- #1b Inpatient Psych Hospital
- #2 Skilled Nursing Facility (SNF)
- #3 Comprehensive Outpatient Rehabilitation Facility (CORF)
- #4b Urgently Needed Care
- #5 Partial Hospitalization

Does the Out-of-Network Deductible apply to all Out-of Network Non-Medicare-covered plan services?
 Yes
 No

Select all of the Out-of-Network Non-Medicare-covered Service Categories to which the Out-of-Network Deductible applies:

- #10b Transportation
- #13b Acupuncture
- #13c Other 1
- #13d Other 2
- #13e Other 3
- #14a Health Ed/Wellness
- #16a Preventive Dental
- #16b Comprehensive Dental
- #17a Eye Exams
- #17b Eye Wear
- #18a Hearing Exams
- #18b Hearing Aids

SECTION D – MAX ENROLLEE COST LIMIT (COMBINED) – BASE 1 SCREEN

PBP 2008 Data Entry System - Max Enrollee Cost Limit (Combined) - Base 1

File

Is there a Combined (In-Network and Out-of-Network) Maximum Enrollee Out-of-Pocket Cost?
 Yes
 No

Indicate Combined (In-Network and Out-of-Network) Maximum Enrollee Out-of-Pocket Cost Amount:

Select the benefits that apply to the Combined Maximum Enrollee Out-of-Pocket cost:
 In-Network Medicare-covered benefits
 In-Network Non-Medicare covered benefits
 Out-of-Network Medicare-covered benefits
 Out-of-Network Non-Medicare covered benefits

Note: For Regional PPOs, all Medicare Part A/B services must be included in the Maximum Enrollee Out-of-Pocket Cost.

Does the Combined Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?
 Yes
 No

Select all of the In-Network Medicare-covered Service Categories to which the Combined Maximum Enrollee Out-of-Pocket Cost applies:
#1a Inpatient Hospital Acute
#1b Inpatient Psych Hospital
#2 Skilled Nursing Facility (SNF)
#3 Comprehensive Outpatient Rehabilitation Facility (CORF)
#5 Partial Hospitalization

Does the Combined Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Non-Medicare-covered plan services?
 Yes
 No

Select all of the In-Network Non-Medicare-covered Service Categories to which the Combined Maximum Enrollee Out-of-Pocket Cost applies:
#10b Transportation
#13b Acupuncture
#13c Other 1
#13d Other 2
#13e Other 3
#14a Health Ed/Wellness
#16a Preventive Dental
#16b Comprehensive Dental
#17a Eye Exams
#17b Eye Wear
#18a Hearing Exams
#18b Hearing Aids

SECTION D – MAX ENROLLEE COST LIMIT (COMBINED) – BASE 2 SCREEN

File

Does the Combined Maximum Enrollee Out-of-Pocket Cost apply to all Out-of-Network Medicare-covered plan services?

Yes
 No

Does the Combined Maximum Enrollee Out-of-Pocket Cost apply to all Out-of-Network Non-Medicare-covered plan services?

Yes
 No

Select all of the Out-of-Network Medicare-covered Service Categories to which the Combined Maximum Enrollee Out-of-Pocket Cost applies:

- #1a Inpatient Hospital Acute
- #1b Inpatient Psych Hospital
- #2 Skilled Nursing Facility (SNF)
- #3 Comprehensive Outpatient Rehabilitation Facility (CORF)
- #4b Urgently Needed Care
- #5 Partial Hospitalization
- #6 Home Health Services
- #7a Primary Care Physician
- #7b Chiropractic Services
- #7c Occupational Therapy
- #7d Physician Specialist excl Psychiatric
- #7e Mental Health - Non-Physician

Select all of the Out-of-Network Non-Medicare-covered Service Categories to which the Combined Maximum Enrollee Out-of-Pocket Cost applies:

- #10b Transportation
- #13b Acupuncture
- #13c Other 1
- #13d Other 2
- #13e Other 3
- #14a Health Ed/Wellness
- #16a Preventive Dental
- #16b Comprehensive Dental
- #17a Eye Exams
- #17b Eye Wear
- #18a Hearing Exams
- #18b Hearing Aids

SECTION D – MAX ENROLLEE COST LIMIT (IN-NETWORK) SCREEN

File

Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?
 Yes
 No

Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:

Note: For Regional PPOs, all Medicare Part A/B services must be included in the Maximum Enrollee Out-of-Pocket Cost.

Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:
 In-Network Medicare-covered benefits
 In-Network Non-Medicare covered benefits

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?
 Yes
 No

Select all of the In-Network Medicare-covered Service Categories to which the In-Network Maximum Enrollee Out-of-Pocket Cost applies:

- #1a Inpatient Hospital Acute
- #1b Inpatient Psych Hospital
- #2 Skilled Nursing Facility (SNF)
- #3 Comprehensive Outpatient Rehabilitation Facility (CORF)
- #5 Partial Hospitalization
- #6 Home Health Services
- #7a Primary Care Physician

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Non-Medicare-covered plan services?
 Yes
 No

Select all of the In-Network Non-Medicare-covered Service Categories to which the In-Network Maximum Enrollee Out-of-Pocket Cost applies:

- #10b Transportation
- #13b Acupuncture
- #13c Other 1
- #13d Other 2
- #13e Other 3
- #14a Health Ed/Wellness
- #16a Preventive Dental
- #16b Comprehensive Dental
- #17a Eye Exams
- #17b Eye Wear
- #18a Hearing Exams

SECTION D – MAX ENROLLEE COST LIMIT (OUT-OF-NETWORK) SCREEN

PBP 2008 Data Entry System - Max Enrollee Cost Limit (OON)

File

Is there an Out-of-Network Maximum Enrollee Out-of-Pocket Cost?
 Yes
 No

Indicate the Out-of-Network Maximum Enrollee Out-of-Pocket Cost Amount:

Select the benefits that apply to the Out-of-Network Maximum Enrollee Out-of-Pocket cost:
 Out-of-Network Medicare-covered benefits
 Out-of-Network Non-Medicare covered benefits

Note: For Regional PPOs, all Medicare Part A/B services must be included in the Maximum Enrollee Out-of-Pocket Cost.

Does the Out-of-Network Maximum Enrollee Out-of-Pocket Cost apply to all Out-of-Network Medicare-covered plan services?
 Yes
 No

Select all of the Out-of-Network Medicare-covered Service Categories to which the Out-of-Network Maximum Enrollee Out-of-Pocket Cost applies:

- #1a Inpatient Hospital Acute
- #1b Inpatient Psych Hospital
- #2 Skilled Nursing Facility (SNF)
- #3 Comprehensive Outpatient Rehabilitation Facility (CORF)
- #4b Urgently Needed Care
- #5 Partial Hospitalization
- #6 Home Health Services

Does the Out-of-Network Maximum Enrollee Out-of-Pocket Cost apply to all Out-of-Network Non-Medicare-covered plan services?
 Yes
 No

Select all of the Out-of-Network Non-Medicare-covered Service Categories to which the Out-of-Network Maximum Enrollee Out-of-Pocket Cost applies:

- #10b Transportation
- #13b Acupuncture
- #13c Other 1
- #13d Other 2
- #13e Other 3
- #14a Health Ed/Wellness
- #16a Preventive Dental
- #16b Comprehensive Dental
- #17a Eye Exams
- #17b Eye Wear
- #18a Hearing Exams
- #18b Hearing Aids

SECTION D – MAX PLAN BENEFIT COVERAGE SCREEN

PBP 2008 Data Entry System - (repaint)Max Plan Benefit Coverage

File

The Maximum Plan Benefit Coverage refers to non-Medicare covered benefits.

Is there a Maximum Plan Benefit Coverage Amount?
 Yes
 No

Indicate Maximum Plan Benefit Coverage Amount:

Select Maximum Plan Benefit Coverage Amount Periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

Select the benefits that apply to the Maximum Plan Benefit Coverage Amount:
 In-Network Non-Medicare-covered benefits
 Out-of-Network Non-Medicare covered benefits

Does the Maximum Plan Benefit Coverage amount apply to all In-Network Non-Medicare-covered plan services?
 Yes
 No

Select all of the In-Network Non-Medicare-covered Service Categories to which the Maximum Plan Benefit Coverage Amount applies:
#10b Transportation
#13b Acupuncture
#13c Other 1
#13d Other 2
#13e Other 3

Does the Maximum Plan Benefit Coverage amount apply to all Out-of-Network Non-Medicare-covered plan services?
 Yes
 No

Select all of the Out-of-Network Non-Medicare-covered Service Categories to which the Maximum Plan Benefit Coverage Amount applies:
#10b Transportation
#13b Acupuncture
#13c Other 1
#13d Other 2
#13e Other 3
#14a Health Ed/Wellness
#16a Preventive Dental

SECTION D –PLAN PREMIUM/ REBATE REDUCTION SCREEN

PBP 2008 Data Entry System - Plan Premium/Rebate Reduction

File

Indicate Plan Premium Amount (Part A/B):

Indicate Plan Premium Amount (B Only):

Are you using any of your plan's MA rebates to reduce the Part B Premium?
 Yes
 No

Indicate the Part B Premium reduction amount:

SECTION D – PFFS BALANCE BILLING SCREEN

File

Do you permit balance billing?
 Yes
 No

Balance Billing is a percentage of plan payment rate provider may collect.

What category of providers do you permit to balance bill?

- #1a Inpatient Hospital Acute
- #1b Inpatient Psych Hospital
- #2 Skilled Nursing Facility (SNF)
- #3 Comprehensive Outpatient Rehabilitation Facility (CORF)
- #4a Emergency Care
- #4b Urgently Needed Care
- #5 Partial Hospitalization
- #6 Home Health Services
- #7a Primary Care Physician
- #7b Chiropractic Services
- #7c Occupational Therapy
- #7d Physician Specialist excl Psychiatric
- #7e Mental Health - Non-Physician
- #7f Podiatry Services
- #7g Other Health Care Professional
- #7h Psychiatric
- #7i PT and SP Services
- #8a Outpatient Clin/Diag/Ther Rad Lab
- #8b Outpatient X-Rays
- #9a Outpatient Hospital
- #9b ASC Services
- #9c Outpatient Substance Abuse
- #9d Cardiac Rehabilitation Services
- #10a Ambulance
- #10b Transportation
- #11a DME
- #11b Prosthetics/Medical Supplies

Enter Minimum percentage for balance billing:

Enter Maximum percentage for balance billing:

SECTION D –MSA ANNUAL DEDUCTIBLE/DEPOSIT SCREEN

PBP 2008 Data Entry System - (repaint)MSA Annual Deductible/Deposit

File

Indicate Annual MSA Deductible amount:

Indicate the Annual amount CMS will deposit into the Enrollee MSA:

Does permitted balance billing count toward the plan Deductible?
 Yes
 No

Is permitted balance billing paid by the plan after the Deductible is met?
 Yes
 No

Does permitted balance billing count toward the Out-of-Pocket Maximum after the Deductible is met?
 Yes
 No

Is permitted balance billing paid by the plan after the Out-of-Pocket Maximum is met?
 Yes
 No

SECTION D – MSA DEMO PLANS SCREEN

PBP 2008 Data Entry System - (repaint)MSA Demo plans ONLY

File

Do you offer Medicare covered preventive services before the Deductible is met at reduced cost sharing?

Yes
 No

Do the Medicare covered preventive services offered before the Deductible is met have the same cost shares that are described in Section B for the Medicare covered services offered after the Deductible is met?

Yes
 No, describe

Indicate the Medicare covered preventive services offered before the Deductible is met:

- Bone Mass Measurement
- Cardiovascular Screenings
- Colorectal Cancer Screenings
- Diabetes Screenings
- Immunizations
- Glaucoma Tests
- Screening Mammograms
- Pap Test and Pelvic Exam
- Physical Exam
- Prostate Cancer Screening
- Smoking Cessation

Notes (Describe Cost Sharing Differences):

Import Text

SECTION D – NOTES SCREEN

The screenshot shows a software window titled "PBP 2008 Data Entry System - Notes". The window has a standard Windows-style title bar with minimize, maximize, and close buttons. Below the title bar is a menu bar with the word "File". The main content area is divided into two identical sections. Each section begins with the text "Notes (Optional):" followed by a large, empty rectangular text input field. At the bottom right corner of each text input field is a button labeled "Import Text".