

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

PBP 2010 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 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 Medicare-covered plan services?
 Yes
 No

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

Does the Combined Deductible 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 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

PBP 2010 Data Entry System - Plan Deductible (Combined) - Base 2

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 Services
- #7d Physician Specialist excl Psychiatric
- #7e Mental Health Specialty Services
- #7f Podiatry Services
- #7g Other Health Care Professional
- #7h Psychiatric
- #7i PT and SP Services
- #8a: Diagnostic Procedures/Test/Lab Benefits
- #8b: Diagnostic/Therapeutic Radiological Services
- #9a Outpatient Hospital Services
- #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 2010 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 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 Medicare-covered plan services?
 Yes
 No

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

Does the In-Network Deductible 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 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 (RPPO DIFFERENTIAL DEDUCTIBLE) – BASE 1

PBP 2010 Data Entry System - (repaint)Plan Deductible (RPPO-Differential Deductible)-Base 1

File

Do you have differential service category-level deductibles in addition to your In-Network Plan-level Deductible?

Yes
 No

Select all of the Service Categories to which the differential deductibles apply:

- 1a: Inpatient Hospital Services Including Acute
- 1b: Inpatient Hospital Psychiatric Services
- 2: Skilled Nursing Facility (SNF)
- 3: Comprehensive Outpatient Rehabilitation Facility (CORF)
- 4a: Emergency Care
- 4b: Urgently Needed Services
- 5: Partial Hospitalization
- 6: Home Health Services
- 7a: Primary Care Physician Services
- 7b: Chiropractic Services
- 7c: Occupational Therapy Services
- 7d: Physician Specialist Services
- 7e: Mental Health Specialty Services - Non-Psychiatric
- 7f: Podiatry Services
- 7g: Other Health Care Professional Services
- 7h: Psychiatric Services
- 7i: Physical Therapy and Speech-Language Pathology Services
- 8a: Diagnostic Procedures/Test/Lab Benefits
- 8b: Diagnostic/Therapeutic Radiological Services
- 9a: Outpatient Hospital Services
- 9b: Ambulatory Surgical Center (ASC) Services
- 9c: Outpatient Substance Abuse Services
- 9d: Cardiac Rehabilitation Services

Indicate Differential Deductible Amount for Inpatient Hospital Services including Acute: _____

Indicate Differential Deductible Amount for Partial Hospitalization: _____

Indicate Differential Deductible Amount for Inpatient Hospital Psychiatric Services: _____

Indicate Differential Deductible Amount for Home Health Services: _____

Indicate Differential Deductible Amount for Skilled Nursing Facility (SNF): _____

Indicate Differential Deductible Amount for Primary Care Physician Services: _____

Indicate Differential Deductible Amount for Comprehensive Outpatient Rehabilitation Facility (CORF): _____

Indicate Differential Deductible Amount for Chiropractic Services: _____

Indicate Differential Deductible Amount for Emergency Care: _____

Indicate Differential Deductible Amount for Occupational Therapy Services: _____

Indicate Differential Deductible Amount for Urgently Needed Services: _____

Indicate Differential Deductible Amount for Physician Specialist Services: _____

SECTION D – PLAN DEDUCTIBLE (RPPO DIFFERENTIAL DEDUCTIBLE) – BASE 2

PBP 2010 Data Entry System - (repaint)Plan Deductible (RPPO-Diffirential Deductibles)-Base 2

File

Indicate Differential Deductible Amount for Mental Health Specialty Services - Non-Psychiatric: <input type="text"/>	Indicate Differential Deductible Amount for Inpatient Diagnostic/Therapeutic Radiological Services: <input type="text"/>	Indicate Differential Deductible Amount for Transportation Services: <input type="text"/>	Indicate Differential Deductible Amount for Acupuncture: <input type="text"/>
Indicate Differential Deductible Amount for Podiatry Services: <input type="text"/>	Indicate Differential Deductible Amount for Outpatient Hospital Services: <input type="text"/>	Indicate Differential Deductible Amount for DME: <input type="text"/>	Indicate Differential Deductible Amount for OTC: <input type="text"/>
Indicate Differential Deductible Amount for Other Health Care Professional Services: <input type="text"/>	Indicate Differential Deductible Amount for Ambulatory Surgical Center (ASC) Services: <input type="text"/>	Indicate Differential Deductible Amount for Prosthetics/Medical Supplies: <input type="text"/>	Indicate Differential Deductible Amount for Meal Benefit: <input type="text"/>
Indicate Differential Deductible Amount for Psychiatric Services: <input type="text"/>	Indicate Differential Deductible Amount for Outpatient Substance Abuse Services: <input type="text"/>	Indicate Differential Deductible Amount for Diabetes Monitoring Supplies: <input type="text"/>	Indicate Differential Deductible Amount for Other 3: <input type="text"/>
Indicate Differential Deductible Amount for Physical Therapy and Speech-Language Pathology Services: <input type="text"/>	<input type="text"/>	Indicate Differential Deductible Amount for End-Stage Renal Disease: <input type="text"/>	Indicate Differential Deductible Amount for Health Education/Wellness Programs: <input type="text"/>
Indicate Differential Deductible Amount for Diagnostic Procedures/Test/Lab Benefits: <input type="text"/>	Indicate Differential Deductible Amount for Cardiac Rehabilitation Services: <input type="text"/>	Indicate Differential Deductible Amount for Outpatient Blood: <input type="text"/>	Indicate Differential Deductible Amount for Immunizations: <input type="text"/>
	Indicate Differential Deductible Amount for Ambulance Services: <input type="text"/>		

SECTION D – PLAN DEDUCTIBLE (RPPO DIFFERENTIAL DEDUCTIBLE) – BASE 3

The screenshot shows a window titled "PBP 2010 Data Entry System - (repaint)Plan Deductible (RPPO-Diffirential Deductibles)-Base 3". The window contains a "File" menu and a grid of 16 input fields, each with a label and a text box:

Indicate Differential Deductible Amount for Routine Physical Exams: <input type="text"/>	Indicate Differential Deductible Amount for Bone Mass Measurement: <input type="text"/>	Indicate Differential Deductible Amount for Preventive Dental: <input type="text"/>	Indicate Differential Deductible Amount for Hearing Aids: <input type="text"/>
Indicate Differential Deductible Amount for Pap Smears and Pelvic Exams Screening: <input type="text"/>	Indicate Differential Deductible Amount for Mammography Screening: <input type="text"/>	Indicate Differential Deductible Amount for Comprehensive Dental: <input type="text"/>	Indicate Differential Deductible Amount for Prescription Drugs: <input type="text"/>
Indicate Differential Deductible Amount for Prostate Cancer Screening: <input type="text"/>	Indicate Differential Deductible Amount for Diabetes Monitoring: <input type="text"/>	Indicate Differential Deductible Amount for Eye Exams: <input type="text"/>	Indicate Differential Deductible Amount for Medicare Part B Rx Drugs: <input type="text"/>
Indicate Differential Deductible Amount for Colorectal Screening: <input type="text"/>	Indicate Differential Deductible Amount for Nutrition Therapy for Diabetes and Renal Disease: <input type="text"/>	Indicate Differential Deductible Amount for Eye Wear: <input type="text"/>	

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

PBP 2010 Data Entry System - Plan Deductible (Out-of-Network)

File

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

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

Indicate Out-of-Network Plan Deductible Amount:

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

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 Non-Medicare-covered plan services?
 Yes
 No

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 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 – PLAN DEDUCTIBLE (NON-NETWORK) SCREEN

PBP 2010 Data Entry System - Plan Deductible (Non-Network)

File

Is there a Plan Deductible?
 Yes
 No

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

Indicate Plan Deductible Amount:

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

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

Select all of the Medicare-covered Service Categories to which the Plan 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

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

Select all of the Non-Medicare-covered Service Categories to which the 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 2010 Data Entry System - (repaint)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

CMS' recommended out-of-pocket maximum for Medicare A/B covered services for CY2010 is \$xxxx.

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 that are EXCLUDED from the Combined Maximum Enrollee Out-of-Pocket Cost Amount:

- #1a Inpatient Hospital Acute
- #1b Inpatient Psych Hospital
- #2 Skilled Nursing Facility (SNF)
- #3 Comprehensive Outpatient Rehabilitation Facility (CORF)
- #4a Emergency Care
- #5 Partial Hospitalization
- #6 Home Health Services
- #7a Primary Care Physician
- #7b Chiropractic Services
- #7c Occupational Therapy Services

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 that are EXCLUDED from the Combined Maximum Enrollee Out-of-Pocket Cost Amount:

- #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 (COMBINED) – BASE 2 SCREEN

File

PBP 2010 Data Entry System - (repaint)Max Enrollee Cost Limit (Combined) - Base 2

CMS' recommended out-of-pocket maximum for Medicare A/B covered services for CY2010 is \$xxxx.

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 that are EXCLUDED from the Combined Maximum Enrollee Out-of Pocket Cost Amount:

- #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 Services
- #7d Physician Specialist excl Psychiatric
- #7e Mental Health Specialty Services

Select all of the Out-of-Network Non-Medicare-covered Service Categories that are EXCLUDED from the Combined Maximum Enrollee Out-of Pocket Cost Amount:

- #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

PBP 2010 Data Entry System - (repaint)Max Enrollee Cost Limit (In-Network)

File

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

CMS' recommended out-of-pocket maximum for Medicare A/B covered services for CY2010 is \$xxxx.

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 that are EXCLUDED from the In-Network Maximum Enrollee Out-of-Pocket Cost amount:

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

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 that are EXCLUDED from the In-Network Maximum Enrollee Out-of-Pocket Cost amount:

- #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

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

PBP 2010 Data Entry System - (repaint)Max Enrollee Cost Limit (Out-of-Network)

File

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

CMS' recommended out-of-pocket maximum for Medicare A/B covered services for CY2010 is \$xxxx.

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 that are EXCLUDED from the Out-of-Network Maximum Enrollee Out-of-Pocket Cost amount:

- #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 Services
- #7d Physician Specialist excl Psychiatric

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 that are EXCLUDED from the Out-of-Network Maximum Enrollee Out-of-Pocket Cost amount:

- #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 (NON-NETWORK) SCREEN

PBP 2010 Data Entry System - (repaint)Max Enrollee Cost Limit (Non-Network)

File

Is there a Maximum Enrollee Out-of-Pocket Cost?

Yes

No

CMS' recommended out-of-pocket maximum for Medicare A/B covered services for CY2010 is \$xxxx.

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

Select the benefits that apply to the Maximum Enrollee Out-of-Pocket cost:

Medicare-covered benefits

Non-Medicare covered benefits

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

Yes

No

Select all of the Medicare-covered Service Categories EXCLUDED from the Maximum Enrollee Out-of-Pocket Cost Amount:

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

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

Yes

No

Select all of the Non-Medicare-covered Service Categories EXCLUDED from the Maximum Enrollee Out-of-Pocket Cost Amount:

- #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 PLAN BENEFIT COVERAGE SCREEN

PBP 2010 Data Entry System - 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 – MAX PLAN BENEFIT COVERAGE (NON-NETWORK) SCREEN

PBP 2010 Data Entry System - Max Plan Benefit Coverage (Non-Network)

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

Does the Maximum Plan Benefit Coverage amount apply to all Non-Medicare-covered plan services?

Yes
 No

Select all of the 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

SECTION D – PLAN PREMIUM/ REBATE REDUCTION SCREEN

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

PBP 2010 Data Entry System - PFFS Balance Billing

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 Services
- #7d Physician Specialist excl Psychiatric
- #7e Mental Health Specialty Services
- #7f Podiatry Services
- #7g Other Health Care Professional
- #7h Psychiatric
- #7i PT and SP Services
- #8a: Diagnostic Procedures/Test/Lab Benefits
- #8b: Diagnostic/Therapeutic Radiological Services
- #9a Outpatient Hospital Services
- #9b ASC Services
- #9c Outpatient Substance Abuse
- #9d Cardiac Rehabilitation Services
- #10a Ambulance Services
- #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

File

Indicate Annual MSA Deductible amount:

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

SECTION D – MSA DEMO PLANS SCREEN

PBP 2010 Data Entry System - 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
- Additional Smoking Cessation

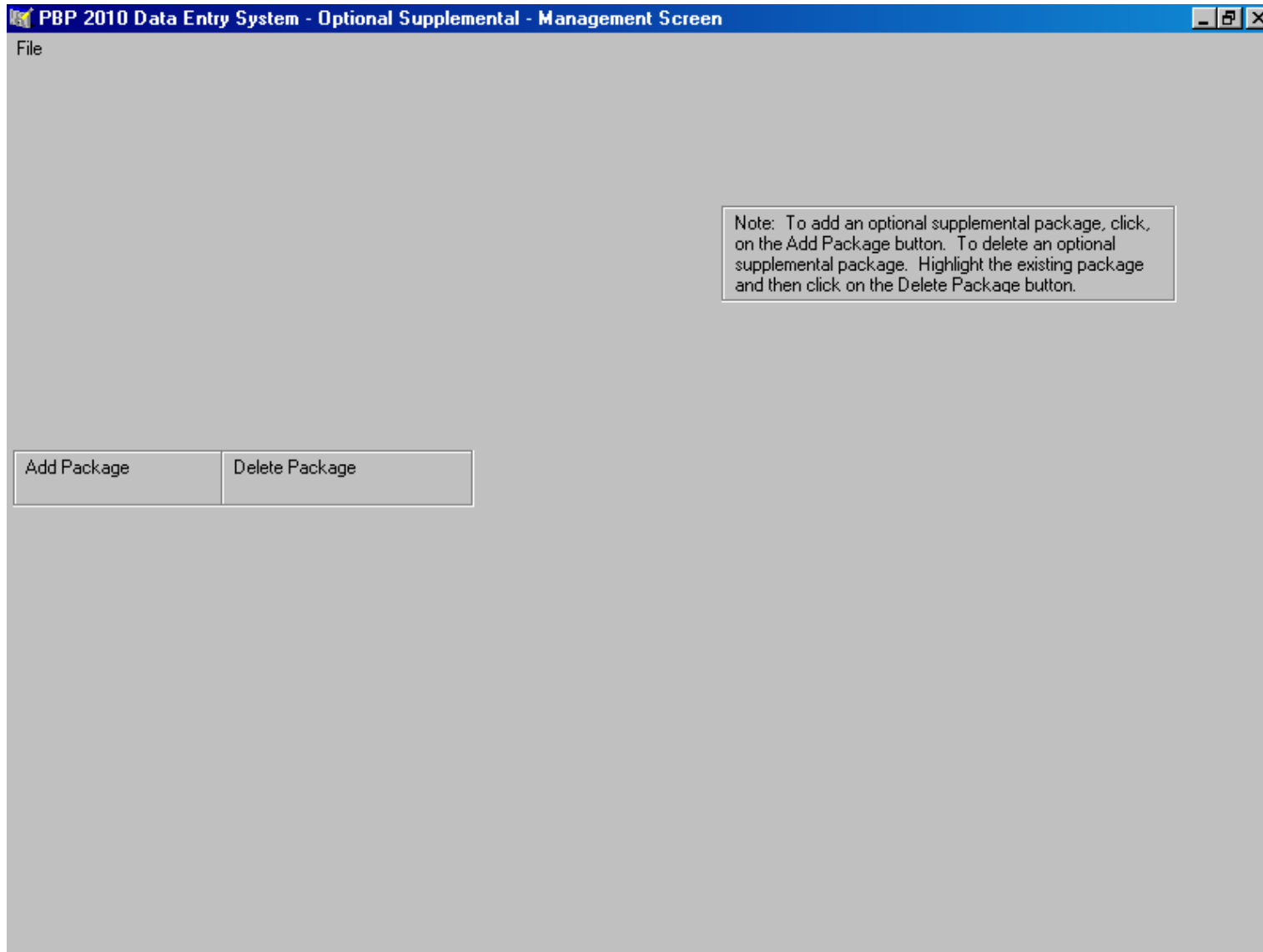
Notes (Describe Cost Sharing Differences):

Import Text

SECTION D – NOTES SCREEN

The screenshot shows a software window titled "PBP 2010 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 input field is a button labeled "Import Text".

SECTION D – OPTIONAL SUPPLEMENTAL PACKAGE MANAGEMENT SCREEN



SECTION D – OPTIONAL SUPPLEMENTAL – LABEL AND PREMIUM SCREEN

File

Optional Supplemental Benefits ID:

Optional Supplemental Package Description:

Indicate Optional Supplemental Premium Amount:

Is there a Maximum Plan Benefit Coverage Amount for this package?
 Yes
 No

Indicate Maximum Plan Benefit Coverage Amount for this package:

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

SECTION D – OPTIONAL SUPPLEMENTAL – SERVICE CATEGORIES SCREEN

PBP 2010 Data Entry System - Optional Supplemental - Service Categories

File

Select the service categories included in this package that have optional supplemental benefits declared in Section B and/or Section C - POS and/or Section C - V/T:

- #1a Inpatient Hospital Acute
- #1b Inpatient Psych Hospital
- #2 Skilled Nursing Facility (SNF)
- #3 Comprehensive Outpatient Rehabilitation Facility (C
- #4a Emergency Care
- #4b Urgently Needed Care
- #5 Partial Hospitalization
- #6 Home Health Services
- #7a Primary Care Physician
- #7b Chiropractic Services
- #7c Occupational Therapy Services
- #7d Physician Specialist excl Psychiatric
- #7e Mental Health Specialty Services
- #7f Podiatry Services
- #7g Other Health Care Professional
- #7h Psychiatric
- #7i PT and SP Services
- #8a: Diagnostic Procedures/Test/Lab Benefits
- #8b: Diagnostic/Therapeutic Radiological Services
- #9a Outpatient Hospital Services
- #9b ASC Services
- #9c Outpatient Substance Abuse
- #9d Cardiac Rehabilitation Services
- #10a Ambulance Services
- #10b Transportation
- #11a DME
- #11b Prosthetics/Medical Supplies
- #11c Diabetes Monitoring Supplies
- #12 End-Stage Renal Disease

Select the other service categories included in this package (i.e., that are NOT declared in Section B and/or Section C - POS and/or Section C - V/T):

- #1a Inpatient Hospital Acute
- #1b Inpatient Psych Hospital
- #2 Skilled Nursing Facility (SNF)
- #3 Comprehensive Outpatient Rehabilitation Facility
- #4a Emergency Care
- #4b Urgently Needed Care
- #5 Partial Hospitalization
- #6 Home Health Services
- #7a Primary Care Physician
- #7b Chiropractic Services*
- #7c Occupational Therapy Services
- #7d Physician Specialist excl Psychiatric
- #7e Mental Health Specialty Services
- #7f Podiatry Services*
- #7g Other Health Care Professional
- #7h Psychiatric
- #7i PT and SP Services
- #8a: Diagnostic Procedures/Test/Lab Benefits
- #8b: Diagnostic/Therapeutic Radiological Services
- #9a Outpatient Hospital Services
- #9b ASC Services
- #9c Outpatient Substance Abuse
- #9d Cardiac Rehabilitation Services
- #10a Ambulance Services
- #10b Transportation*
- #11a DME
- #11b Prosthetics/Medical Supplies
- #11c Diabetes Monitoring Supplies
- #12 End-Stage Renal Disease

The 'other service categories picklist' is intended to capture any step-up benefits and/or non-standard optional benefits that are not available in Section B.

Service categories with an asterisk (*) in the list have additional step-up data entry screens. After highlighting the category, click on either the dropdown box or the right arrow button above to navigate to these screens.

Service categories can be removed from the Optional Supplemental Package by deselecting them from the list. If service categories with an asterisk (*) are deselected, then the associated step-up data entry screens will also be removed.

SECTION D – STEP-UP – 7B – CHIROPRACTIC SERVICES – BASE 1 SCREEN

PBP 2010 Data Entry System - Step Up #7b Chiropractic Services - Base 1

File

DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?
 Yes
 No

Select enhanced benefit:
 Routine Care

Select type of benefit for Routine Care:
 Mandatory
 Optional

Is this benefit unlimited for Routine Care?
 Yes
 No, indicate number

Indicate number of visits for Routine Care:

Select Routine Care periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

Is there a service-specific Maximum Plan Benefit Coverage amount?
 Yes
 No

Indicate Maximum Plan Benefit Coverage amount:

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

Select the Coverage Basis for Maximum Plan Benefit Coverage:
 Published Fee Schedule
 MA Organization Developed Fee Schedule
 MA Organization Developed Cost Structure
 Medicare Fee for Service Charge Structure
 Other, describe

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
 Yes
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

SECTION D – STEP-UP – 7B – CHIROPRACTIC SERVICES – BASE 2 SCREEN

PBP 2010 Data Entry System - Step Up #7b Chiropractic Services - Base 2

File

Is there an enrollee Coinsurance?
 Yes
 No

Indicate Minimum Coinsurance percentage per visit for Medicare Covered Benefits:

Indicate Maximum Coinsurance percentage per visit for Medicare Covered Benefits:

Select the Coinsurance Coverage Basis for Medicare Covered Benefits:
 Published Fee Schedule
 MA Organization Developed Fee Schedule
 MA Organization Developed Cost Structure
 Medicare Fee-for-Service Charge Structure
 Other, describe

Indicate the Minimum Coinsurance percentage per visit for Routine Care:

Indicate the Maximum Coinsurance percentage per visit for Routine Care:

Select the Coinsurance Coverage Basis for Routine Care:
 Published Fee Schedule
 MA Organization Developed Fee Schedule
 MA Organization Developed Cost Structure
 Medicare Fee-for-Service Charge Structure
 Other, describe

SECTION D – STEP-UP – 7B – CHIROPRACTIC SERVICES – BASE 3 SCREEN

PBP 2010 Data Entry System - Step Up #7b Chiropractic Services - Base 3

File

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?
 Yes
 No

Indicate Minimum Copayment amount for Medicare Covered Benefits:

Indicate Maximum Copayment amount for Medicare Covered Benefits:

Indicate Minimum Copayment amount per visit for Routine Care:

Indicate Maximum Copayment amount per visit for Routine Care:

Enrollee must receive Authorization from one or more of the following:
 None
 Primary Care Physician (Internist/Family Practice, General Practice)
 Physician Specialist
 Organization Medical Director/Utilization Management/Utilization Review
 Other, describe

Is a referral required for Chiropractic Services?
 Yes
 No

SECTION D – STEP-UP – 7B – CHIROPRACTIC SERVICES – BASE 4 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - Step Up #7b Chiropractic Services - Base 4". The window has a standard Windows-style title bar with minimize, maximize, and close buttons. Below the title bar is a menu bar with a "File" option. The main content area is divided into several sections: a label "Chiropractic Services Notes" at the top, followed by a label "Notes (Optional):" and a large, empty rectangular text input field. In the bottom right corner of the text area, there is a button labeled "Import Text".

SECTION D – OPTIONAL SUPPLEMENTAL – OUT-OF-NETWORK - 7B – CHIROPRACTIC SERVICES SCREEN

PBP 2010 Data Entry System - (repaint)Optional Supplemental - OON Optional

File

Does this category include Out-of-Network benefits?
 Yes
 No

Is there an OON Copayment?
 Yes
 No

Are the OON cost shares the same as the In-Network cost shares?
 Yes
 No

Enter Minimum Copayment Amount:

Enter Maximum Copayment Amount:

Is there an OON Coinsurance?
 Yes
 No

Enter Minimum Coinsurance Percentage:

Enter Maximum Coinsurance Percentage:

Select the Coinsurance Coverage Basis:
 Published Fee Schedule
 MA Organization Developed Fee Schedule
 MA Organization Developed Cost Structure
 Other, describe

Notes (Optional):

SECTION D – STEP-UP – 7F – PODIATRY SERVICES – BASE 1 SCREEN

PBP 2010 Data Entry System - Step Up #7f Podiatry Services - Base 1

File

DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?
 Yes
 No

Select enhanced benefits:
 Routine Footcare

Select type of benefit for Routine Footcare:
 Mandatory
 Optional

Is this benefit unlimited for Routine Footcare?
 Yes
 No

Indicate number of Routine Footcare visits:

Select the Routine Footcare periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

Is there a service-specific Maximum Plan Benefit Coverage amount?
 Yes
 No

Indicate Maximum Plan Benefit Coverage amount:

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

Select the Coverage Basis for Maximum Plan Benefit Coverage:
 Published Fee Schedule
 MA Organization Developed Fee Schedule
 MA Organization Developed Cost Structure
 Medicare Fee-for-Service Charge Structure
 Other, describe

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
 Yes
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

SECTION D – STEP-UP – 7F – PODIATRY SERVICES – BASE 2 SCREEN

PBP 2010 Data Entry System - Step Up #7f Podiatry Services - Base 2

File

Is there an enrollee Coinsurance? <input type="radio"/> Yes <input type="radio"/> No	Indicate Minimum Coinsurance percentage for Routine Footcare: <input type="text"/>	Is there an enrollee Copayment? <input type="radio"/> Yes <input type="radio"/> No
Indicate Minimum Coinsurance percentage for Medicare Covered Benefits: <input type="text"/>	Indicate Maximum Coinsurance percentage for Routine Footcare: <input type="text"/>	Indicate Minimum Copayment amount per visit for Medicare Covered Benefits: <input type="text"/>
Indicate Maximum Coinsurance percentage for Medicare Covered Benefits: <input type="text"/>	Select the Coinsurance Coverage Basis for Routine Footcare: <input type="radio"/> Published Fee Schedule <input type="radio"/> MA Organization Developed Fee Schedule <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Medicare Fee-for-Service Charge Structure <input type="radio"/> Other, describe	Indicate Maximum Copayment amount per visit for Medicare Covered Benefits: <input type="text"/>
Select the Coinsurance Coverage Basis for Medicare Covered Benefits: <input type="radio"/> Published Fee Schedule <input type="radio"/> MA Organization Developed Fee Schedule <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Medicare Fee-for-Service Charge Structure <input type="radio"/> Other, describe	Is there an enrollee Deductible? <input type="radio"/> Yes <input type="radio"/> No	Indicate Minimum Copayment amount per visit for Routine Footcare: <input type="text"/>
	Indicate Deductible Amount: <input type="text"/>	Indicate Maximum Copayment amount per visit for Routine Footcare: <input type="text"/>

SECTION D – STEP-UP – 7F – PODIATRY SERVICES – BASE 3 SCREEN

File

Enrollee must receive Authorization from one or more of the following:

- None
- Primary Care Physician (Internist/Family Practice, General Practice)
- Physician Specialist
- Organization Medical Director/Utilization Management/Utilization Review
- Other, describe

Is a referral required for Podiatrist Services?

- Yes
- No

Notes (Optional):

Import Text

SECTION D – OPTIONAL SUPPLEMENTAL – OUT-OF-NETWORK - 7F – PODIATRY SERVICES SCREEN

File

Does this category include Out-of-Network benefits?
 Yes
 No

Is there an OON Copayment?
 Yes
 No

Are the OON cost shares the same as the In-Network cost shares?
 Yes
 No

Enter Minimum Copayment Amount:

Enter Maximum Copayment Amount:

Is there an OON Coinsurance?
 Yes
 No

Enter Minimum Coinsurance Percentage:

Enter Maximum Coinsurance Percentage:

Select the Coinsurance Coverage Basis:
 Published Fee Schedule
 MA Organization Developed Fee Schedule
 MA Organization Developed Cost Structure
 Other, describe

Notes (Optional):

SECTION D – STEP-UP – 10B – TRANSPORTATION – BASE 1 SCREEN

PBP 2010 Data Entry System - Step Up #10b Transportation - Base 1

File

DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?
 Yes
 No

Select enhanced benefit:
 Plan-approved Location
 Any Location

Select type of benefit for Plan-approved Location:
 Mandatory
 Optional

Is this benefit unlimited for number of trips for Plan-approved Location?
 Yes
 No

Indicate number of trips for Plan-approved Location:

Select Plan-approved Location Trips periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

Select Type of Transportation for Plan-approved Location:
 One-way
 Round Trip
 Days
 Other, describe

Indicate number of days for Plan-approved Location:

Select Mode of Transportation for Plan-approved Location:
 Taxi
 Bus/Subway
 Van
 Other, describe

Select type of benefit for Any Location:
 Mandatory
 Optional

Is this benefit unlimited for number of trips for Any Location?
 Yes
 No

Indicate number of trips for Any Location:

Select Any Location Trips periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

Select Type of Transportation for Any Location:
 One-way
 Round Trip
 Days
 Other, describe

Indicate number of days for Any Location:

Select Mode of Transportation for Any Location:
 Taxi
 Bus/Subway
 Van
 Other, describe

SECTION D – STEP-UP – 10B – TRANSPORTATION – BASE 2 SCREEN

PBP 2010 Data Entry System - Step Up #10b Transportation - Base 2

File

Is there a service-specific Maximum Plan Benefit Coverage amount?
 Yes
 No

Indicate Maximum Plan Benefit Coverage amount:

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

Select the Coverage Basis for Maximum Plan Benefit Coverage:
 Published Fee Schedule
 MA Organization Developed Fee Schedule
 MA Organization Developed Cost Structure
 Other, describe

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
 Yes
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

Is there an enrollee Coinsurance?
 Yes
 No

Indicate Coinsurance percentage:

Select the Coinsurance Coverage Basis:
 Published Fee Schedule
 MA Organization Developed Fee Schedule
 MA Organization Developed Cost Structure
 Other, describe

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

SECTION D – STEP-UP – 10B – TRANSPORTATION – BASE 3 SCREEN

PBP 2010 Data Entry System - Step Up #10b Transportation - Base 3

File

Is there an enrollee Copayment?
 Yes
 No

Indicate Copayment amount per trip:

Enrollee must receive Authorization from one or more of the following:
 None
 Primary Care Physician (Internist/Family Practice, General Practice)
 Physician Specialist
 Organization Medical Director/Utilization Management/Utilization Review
 Other, describe

Is a referral required for Transportation Services?
 Yes
 No

Notes (Optional):

Import Text

SECTION D – OPTIONAL SUPPLEMENTAL – OUT-OF-NETWORK - 10B – TRANSPORTATION SERVICES SCREEN

PBP 2010 Data Entry System - (repaint)Optional Supplemental - OON Optional

File

Does this category include Out-of-Network benefits? <input type="radio"/> Yes <input type="radio"/> No	Is there an OON Copayment? <input type="radio"/> Yes <input type="radio"/> No
Are the OON cost shares the same as the In-Network cost shares? <input type="radio"/> Yes <input type="radio"/> No	Enter Minimum Copayment Amount: <input type="text"/>
Is there an OON Coinsurance? <input type="radio"/> Yes <input type="radio"/> No	Enter Maximum Copayment Amount: <input type="text"/>
Enter Minimum Coinsurance Percentage: <input type="text"/>	Notes (Optional): <input type="text"/>
Enter Maximum Coinsurance Percentage: <input type="text"/>	
Select the Coinsurance Coverage Basis: <input type="radio"/> Published Fee Schedule <input type="radio"/> MA Organization Developed Fee Schedule <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Other, describe	

SECTION D – STEP-UP – 16A – PREVENTIVE DENTAL – BASE 1 SCREEN

PBP 2010 Data Entry System - Step Up #16a Preventive Dental - Base 1

File

DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?
 Yes
 No

Select enhanced benefits:
 Oral Exams
 Prophylaxis (Cleaning)
 Fluoride Treatment
 Dental X-Rays

Select type of benefit for Oral Exams:
 Mandatory
 Optional

Is this benefit unlimited for Oral Exams?
 Yes
 No, indicate number

Indicate number of visits for Oral Exams:

Select the Oral Exams periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

Select type of benefit for Prophylaxis (Cleaning):
 Mandatory
 Optional

Is this benefit unlimited for Prophylaxis (Cleaning)?
 Yes
 No, indicate number

Indicate number of visits for Prophylaxis (Cleaning):

Select the Prophylaxis (Cleaning) periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

Select type of benefit for Fluoride Treatment:
 Mandatory
 Optional

Is this benefit unlimited for Fluoride Treatment?
 Yes
 No, indicate number

Indicate number of visits for Fluoride Treatment:

Select the Fluoride Treatment periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

SECTION D – STEP-UP – 16A – PREVENTIVE DENTAL – BASE 2 SCREEN

PBP 2010 Data Entry System - Step Up #16a Preventive Dental - Base 2

File

Select type of benefit for Dental X-Rays:

Mandatory

Optional

Is there a service-specific Maximum Plan Benefit Coverage amount?

Yes

No

Indicate Maximum Plan Benefit Coverage amount:

Select the Maximum Plan Benefit Coverage periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, describe

Is this benefit unlimited for Dental X-Rays?

Yes

No, indicate number

Indicate number of visits for Dental X-Rays:

Select the Dental X-Rays periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, describe

Select the Coverage Basis for Maximum Plan Benefit Coverage:

Published Fee Schedule

MA Organization Developed Fee Schedule

MA Organization Developed Cost Structure

Medicare Fee-for-Service Charge Structure

Medicare Fee-for-Service Prospective Payment System

Other, describe

SECTION D – STEP-UP – 16A – PREVENTIVE DENTAL – BASE 3 SCREEN

PBP 2010 Data Entry System - Step Up #16a Preventive Dental - Base 3

File

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
 Yes
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

Is there an enrollee Coinsurance?
 Yes
 No

Is there a combination of services included in a single cost per Office Visit?
 Yes
 No

Select which combination of services are included in a single cost per Office Visit:
 Oral Exams
 Prophylaxis (Cleaning)
 Fluoride Treatment
 Dental X-Rays

Indicate Coinsurance percentage for Office Visit:

Select the Coinsurance Coverage Basis for combination of services included in a single cost per Office Visit:
 Published Fee Schedule
 MA Organization Developed Fee Schedule
 MA Organization Developed Cost Structure
 Medicare Fee-for-Service Charge Structure
 Medicare Fee-for-Service Prospective Payment System
 Other, describe

SECTION D – STEP-UP – 16A – PREVENTIVE DENTAL – BASE 4 SCREEN

PBP 2010 Data Entry System - Step Up #16a Preventive Dental - Base 4

File

Indicate Minimum Coinsurance percentage for Oral Exams:

Indicate Maximum Coinsurance percentage for Oral Exams:

Select the Coinsurance Coverage Basis for Oral Exams:
 Published Fee Schedule
 MA Organization Developed Fee Schedule
 MA Organization Developed Cost Structure
 Medicare Fee-for-Service Charge Structure
 Medicare Fee-for-Service Prospective Payment System
 Other, describe

Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning):

Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning):

Select the Coinsurance Coverage Basis for Prophylaxis (Cleaning):
 Published Fee Schedule
 MA Organization Developed Fee Schedule
 MA Organization Developed Cost Structure
 Medicare Fee-for-Service Charge Structure
 Medicare Fee-for-Service Prospective Payment System
 Other, describe

Indicate Minimum Coinsurance percentage for Fluoride Treatment:

Indicate Maximum Coinsurance percentage for Fluoride Treatment:

Select the Coinsurance Coverage Basis for Fluoride Treatment:
 Published Fee Schedule
 MA Organization Developed Fee Schedule
 MA Organization Developed Cost Structure
 Medicare Fee-for-Service Charge Structure
 Medicare Fee-for-Service Prospective Payment System
 Other, describe

SECTION D – STEP-UP – 16A – PREVENTIVE DENTAL – BASE 5 SCREEN

File

Indicate Minimum Coinsurance percentage for Dental X-Rays:

Indicate Maximum Coinsurance percentage for Dental X-Rays:

Indicate Minimum Coinsurance percentage for Dental X-Rays:

Indicate Maximum Coinsurance percentage for Dental X-Rays:

Indicate Deductible Amount:

Select the Coinsurance Coverage Basis for Dental X-Rays:

- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Medicare Fee-for-Service Prospective Payment System
- Other, describe

SECTION D – STEP-UP – 16A – PREVENTIVE DENTAL – BASE 6 SCREEN

PBP 2010 Data Entry System - Step Up #16a Preventive Dental - Base 6

File

Is there an enrollee Copayment?
 Yes
 No

Is there a combination of services included in a single cost per Office Visit?
 Yes
 No

Select which combination of services are included in a single cost per Office Visit:
 Oral Exams
 Prophylaxis (Cleaning)
 Fluoride Treatment
 Dental X-Rays

Indicate Copayment amount for Office Visit:

Indicate Minimum Copayment amount for Oral Exams:

Indicate Maximum Copayment amount for Oral Exams:

Indicate Minimum Copayment amount for Prophylaxis (Cleaning):

Indicate Maximum Copayment amount for Prophylaxis (Cleaning):

Indicate Minimum Copayment amount for Fluoride Treatment:

Indicate Maximum Copayment amount for Fluoride Treatment:

Indicate Minimum Copayment amount for Dental X-Rays:

Indicate Maximum Copayment amount for Dental X-Rays:

SECTION D – STEP-UP – 16A – PREVENTIVE DENTAL – BASE 7 SCREEN

PBP 2010 Data Entry System - Step Up #16a Preventive Dental - Base 7

File

Enrollee must receive Authorization from one or more of the following:

- None
- Primary Care Physician (Internist/Family Practice, General Practice)
- Physician Specialist
- Organization Medical Director/Utilization Management/Utilization Review
- Other, describe

Is a referral required for Preventive Dental Services?

Yes

No

Notes (Optional):

Import Text

SECTION D – OPTIONAL SUPPLEMENTAL – OUT-OF-NETWORK - 16A – PREVENTIVE DENTAL SERVICES SCREEN

PBP 2010 Data Entry System - (repaint)Optional Supplemental - OON Optional

File

Does this category include Out-of-Network benefits? <input type="radio"/> Yes <input type="radio"/> No	Is there an OON Copayment? <input type="radio"/> Yes <input type="radio"/> No
Are the OON cost shares the same as the In-Network cost shares? <input type="radio"/> Yes <input type="radio"/> No	Enter Minimum Copayment Amount: <input type="text"/>
Is there an OON Coinsurance? <input type="radio"/> Yes <input type="radio"/> No	Enter Maximum Copayment Amount: <input type="text"/>
Enter Minimum Coinsurance Percentage: <input type="text"/>	Notes (Optional): <input type="text"/>
Enter Maximum Coinsurance Percentage: <input type="text"/>	
Select the Coinsurance Coverage Basis: <input type="radio"/> Published Fee Schedule <input type="radio"/> MA Organization Developed Fee Schedule <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Other, describe	

SECTION D – STEP-UP – 16B – COMPREHENSIVE DENTAL – BASE 1 SCREEN

PBP 2010 Data Entry System - Step Up #16b Comp Dental - Base 1

File

DESCRIPTION OF BENEFIT

Even if you do not offer enhanced benefits, you must complete this section for your Medicare Covered Benefits.

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes
 No

Select enhanced benefits:

Emergency Services
 Diagnostic Services
 Restorative Services
 Endodontics/Periodontics/Extractions
 Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Select type of benefit for Emergency Services:

Mandatory
 Optional

Select type of benefit for Diagnostic Services:

Mandatory
 Optional

Is this benefit unlimited for Emergency Services?

Yes
 No, indicate number

Is this benefit unlimited for Diagnostic Services?

Yes
 No, indicate number

Indicate number of visits for Emergency Services:

Indicate number of visits for Diagnostic Services:

Select the Emergency Services periodicity:

Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

Select the Diagnostic Services periodicity:

Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

SECTION D – STEP-UP – 16B – COMPREHENSIVE DENTAL – BASE 2 SCREEN

PBP 2010 Data Entry System - Step Up #16b Comp Dental - Base 2

File

Select type of benefit for Restorative Services: <input type="radio"/> Mandatory <input type="radio"/> Optional	Select type of benefit for Endodontics/Periodontics/Extractions: <input type="radio"/> Mandatory <input type="radio"/> Optional	Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: <input type="radio"/> Mandatory <input type="radio"/> Optional
Is this benefit unlimited for Restorative Services? <input type="radio"/> Yes <input type="radio"/> No, indicate number	Is this benefit unlimited for Endodontics/Periodontics/Extractions? <input type="radio"/> Yes <input type="radio"/> No, indicate number	Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services? <input type="radio"/> Yes <input type="radio"/> No, indicate number
Indicate number of visits for Restorative Services: <input type="text"/>	Indicate number of visits for Endodontics/Periodontics/Extractions: <input type="text"/>	Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: <input type="text"/>
Select the Restorative Services periodicity: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, describe	Select the Endodontics/Periodontics/Extractions periodicity: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, describe	Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Other, describe

SECTION D – STEP-UP – 16B – COMPREHENSIVE DENTAL – BASE 3 SCREEN

PBP 2010 Data Entry System - Step Up #16b Comp Dental - Base 3

File

<p>Is there a service-specific Maximum Plan Benefit Coverage amount?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p>	<p>Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p>
<p>Select the Maximum Plan Benefit Coverage type:</p> <p><input type="radio"/> Covered under Preventive Dental Category 16a</p> <p><input type="radio"/> Plan-specified amount per period</p>	<p>Select the Maximum Enrollee Out-of-Pocket Cost type:</p> <p><input type="radio"/> Covered under Preventive Dental Category 16a</p> <p><input type="radio"/> Plan-specified amount per period</p>
<p>Indicate Maximum Plan Benefit Coverage amount:</p> <input type="text"/>	<p>Indicate Maximum Enrollee Out-of-Pocket Cost amount:</p> <input type="text"/>
<p>Select the Maximum Plan Benefit Coverage periodicity:</p> <p><input type="radio"/> Every three years</p> <p><input type="radio"/> Every two years</p> <p><input type="radio"/> Every year</p> <p><input type="radio"/> Every six months</p> <p><input type="radio"/> Every three months</p> <p><input type="radio"/> Other, describe</p>	<p>Select Maximum Enrollee Out-of-Pocket Cost periodicity:</p> <p><input type="radio"/> Every three years</p> <p><input type="radio"/> Every two years</p> <p><input type="radio"/> Every year</p> <p><input type="radio"/> Every six months</p> <p><input type="radio"/> Every three months</p> <p><input type="radio"/> Other, describe</p>
<p>Select the Coverage Basis for Maximum Plan Benefit Coverage:</p> <p><input type="radio"/> Published Fee Schedule</p> <p><input type="radio"/> MA Organization Developed Fee Schedule</p> <p><input type="radio"/> MA Organization Developed Cost Structure</p> <p><input type="radio"/> Medicare Fee-for-Service Charge Structure</p> <p><input type="radio"/> Other, describe</p>	

SECTION D – STEP-UP – 16B – COMPREHENSIVE DENTAL – BASE 4 SCREEN

File

Is there an enrollee Coinsurance?
 Yes
 No

Indicate the Minimum Coinsurance percentage for Medicare Covered Benefits:

Indicate the Maximum Coinsurance percentage for Medicare Covered Benefits:

Select the Coinsurance Coverage Basis for Medicare Covered Benefits:
 Published Fee Schedule
 MA Organization Developed Fee Schedule
 MA Organization Developed Cost Structure
 Medicare Fee-for-Service Charge Structure
 Other, describe

Indicate Minimum Coinsurance percentage for Emergency Services:

Indicate Maximum Coinsurance percentage for Emergency Services:

Select the Coinsurance Coverage Basis for Emergency Services:
 Published Fee Schedule
 MA Organization Developed Fee Schedule
 MA Organization Developed Cost Structure
 Medicare Fee-for-Service Charge Structure
 Medicare Fee-for-Service Prospective Payment System
 Other, describe

SECTION D – STEP-UP – 16B – COMPREHENSIVE DENTAL – BASE 5 SCREEN

File

Indicate Minimum Coinsurance percentage for Diagnostic Services: <input type="text"/>	Indicate Minimum Coinsurance percentage for Restorative Services: <input type="text"/>
Indicate Maximum Coinsurance percentage for Diagnostic Services: <input type="text"/>	Indicate Maximum Coinsurance percentage for Restorative Services: <input type="text"/>
Select the Coinsurance Coverage Basis for Diagnostic Services: <ul style="list-style-type: none"><input type="radio"/> Published Fee Schedule<input type="radio"/> MA Organization Developed Fee Schedule<input type="radio"/> MA Organization Developed Cost Structure<input type="radio"/> Medicare Fee-for-Service Charge Structure<input type="radio"/> Medicare Fee-for-Service Prospective Payment System<input type="radio"/> Other, describe	Select the Coinsurance Coverage Basis for Restorative Services: <ul style="list-style-type: none"><input type="radio"/> Published Fee Schedule<input type="radio"/> MA Organization Developed Fee Schedule<input type="radio"/> MA Organization Developed Cost Structure<input type="radio"/> Medicare Fee-for-Service Charge Structure<input type="radio"/> Medicare Fee-for-Service Prospective Payment System<input type="radio"/> Other, describe

SECTION D – STEP-UP – 16B – COMPREHENSIVE DENTAL – BASE 6 SCREEN

PBP 2010 Data Entry System - Step Up #16b Comp Dental - Base 6

File

Indicate Minimum Coinsurance percentage for Endodontics/Periodontics/Extractions: <input type="text"/>	Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: <input type="text"/>
Indicate Maximum Coinsurance percentage for Endodontics/Periodontics/Extractions: <input type="text"/>	Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: <input type="text"/>
Select the Coinsurance Coverage Basis for Endodontics/Periodontics/Extractions: <input type="radio"/> Published Fee Schedule <input type="radio"/> MA Organization Developed Fee Schedule <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Medicare Fee-for-Service Charge Structure <input type="radio"/> Medicare Fee-for-Service Prospective Payment System <input type="radio"/> Other, describe	Select the Coinsurance Coverage Basis for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: <input type="radio"/> Published Fee Schedule <input type="radio"/> MA Organization Developed Fee Schedule <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Medicare Fee-for-Service Charge Structure <input type="radio"/> Medicare Fee-for-Service Prospective Payment System <input type="radio"/> Other, describe
Is there an enrollee Deductible? <input type="radio"/> Yes <input type="radio"/> No	
Indicate Deductible Amount: <input type="text"/>	

SECTION D – STEP-UP – 16B – COMPREHENSIVE DENTAL – BASE 7 SCREEN

PBP 2010 Data Entry System - Step Up #16b Comp Dental - Base 7

File

Is there an enrollee Copayment? <input type="radio"/> Yes <input type="radio"/> No	Indicate Minimum Copayment amount for Diagnostic Services: <input type="text"/>	Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: <input type="text"/>
Indicate Minimum Copayment amount for Medicare Covered Benefits: <input type="text"/>	Indicate Maximum Copayment amount for Diagnostic Services: <input type="text"/>	Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: <input type="text"/>
Indicate Maximum Copayment amount for Medicare Covered Benefits: <input type="text"/>	Indicate Minimum Copayment amount for Restorative Services: <input type="text"/>	
Indicate Minimum Copayment amount for Emergency Services: <input type="text"/>	Indicate Maximum Copayment amount for Restorative Services: <input type="text"/>	
Indicate Maximum Copayment amount for Emergency Services: <input type="text"/>	Indicate Minimum Copayment amount for Endodontics/Periodontics/Extractions: <input type="text"/>	
	Indicate Maximum Copayment amount for Endodontics/Periodontics/Extractions: <input type="text"/>	

SECTION D – STEP-UP – 16B – COMPREHENSIVE DENTAL – BASE 8 SCREEN

File

Indicate whether a separate office visit cost share applies for services:

- Yes
- No
- Sometimes, describe

Enrollee must receive Authorization from one or more of the following:

- None
- Primary Care Physician (Internist/Family Practice, General Practice)
- Physician Specialist
- Organization Medical Director/Utilization Management/Utilization Review
- Other, describe

Is a referral required for Comprehensive Dental Services?

- Yes
- No

Notes (Optional):

Import Text

SECTION D – OPTIONAL SUPPLEMENTAL – OUT-OF-NETWORK - 16B – COMPREHENSIVE DENTAL SERVICES SCREEN

PBP 2010 Data Entry System - (repaint)Optional Supplemental - OON Optional

File

Does this category include Out-of-Network benefits? <input type="radio"/> Yes <input type="radio"/> No	Is there an OON Copayment? <input type="radio"/> Yes <input type="radio"/> No
Are the OON cost shares the same as the In-Network cost shares? <input type="radio"/> Yes <input type="radio"/> No	Enter Minimum Copayment Amount: <input type="text"/>
Is there an OON Coinsurance? <input type="radio"/> Yes <input type="radio"/> No	Enter Maximum Copayment Amount: <input type="text"/>
Enter Minimum Coinsurance Percentage: <input type="text"/>	Notes (Optional): <input type="text"/>
Enter Maximum Coinsurance Percentage: <input type="text"/>	
Select the Coinsurance Coverage Basis: <input type="radio"/> Published Fee Schedule <input type="radio"/> MA Organization Developed Fee Schedule <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Other, describe	

SECTION D – STEP-UP – 17A – EYE EXAMS – BASE 1 SCREEN

PBP 2010 Data Entry System - Step Up #17a Eye Exams - Base 1

File

DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?
 Yes
 No

Select enhanced benefit:
 Routine Eye Exams

Select type of benefit for Routine Eye Exams:
 Mandatory
 Optional

Is this benefit unlimited for Routine Eye Exams?
 Yes
 No, indicate number

Indicate number of exams for Routine Eye Exams:

Select the Routine Eye Exams periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

Is there a service-specific Maximum Plan Benefit Coverage amount?
 Yes
 No

Indicate Maximum Plan Benefit Coverage amount:

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

Select the Coverage Basis for Maximum Plan Benefit Coverage:
 Published Fee Schedule
 MA Organization Developed Fee Schedule
 MA Organization Developed Cost Structure
 Medicare Fee-for-Service Charge Structure
 Other, describe

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
 Yes
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select the Maximum Enrollee Out-of-Pocket Cost periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

SECTION D – STEP-UP – 17A – EYE EXAMS – BASE 2 SCREEN

PBP 2010 Data Entry System - Step Up #17a Eye Exams - Base 2

File

Is there an enrollee Coinsurance? <input type="radio"/> Yes <input type="radio"/> No	Indicate Minimum Coinsurance percentage for Routine Eye Exams: <input type="text"/>	Is there an enrollee Copayment? <input type="radio"/> Yes <input type="radio"/> No
Indicate Minimum Coinsurance percentage for Medicare Covered Benefits: <input type="text"/>	Indicate Maximum Coinsurance percentage for Routine Eye Exams: <input type="text"/>	Indicate Minimum Copayment amount for Medicare Covered Benefits: <input type="text"/>
Indicate Maximum Coinsurance percentage for Medicare Covered Benefits: <input type="text"/>	Select the Coverage Basis for Coinsurance for Routine Eye Exams: <input type="radio"/> Published Fee Schedule <input type="radio"/> MA Organization Developed Fee Schedule <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Medicare Fee-for-Service Charge Structure <input type="radio"/> Other, describe	Indicate Maximum Copayment amount for Medicare Covered Benefits: <input type="text"/>
Select the Coverage Basis for Coinsurance for Medicare Covered Benefits: <input type="radio"/> Published Fee Schedule <input type="radio"/> MA Organization Developed Fee Schedule <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Medicare Fee-for-Service Charge Structure <input type="radio"/> Other, describe	Is there an enrollee Deductible? <input type="radio"/> Yes <input type="radio"/> No	Indicate Minimum Copayment amount per Routine Eye Exam: <input type="text"/>
	Indicate Deductible Amount: <input type="text"/>	Indicate Maximum Copayment amount per Routine Eye Exam: <input type="text"/>

SECTION D – STEP-UP – 17A – EYE EXAMS – BASE 3 SCREEN

File

Indicate whether a separate office visit cost share applies for services:

Yes
 No
 Sometimes, describe

Enrollee must receive Authorization from one or more of the following:

None
 Primary Care Physician (Internist/Family Practice, General Practice)
 Physician Specialist
 Organization Medical Director/Utilization Management/Utilization Review
 Other, describe

Is a referral required for Eye Exams?

Yes
 No

Notes (Optional):

Import Text

SECTION D – OPTIONAL SUPPLEMENTAL – OUT-OF-NETWORK - 17A – EYE EXAMS SCREEN

PBP 2010 Data Entry System - (repaint)Optional Supplemental - OON Optional

File

Does this category include Out-of-Network benefits? <input type="radio"/> Yes <input type="radio"/> No	Is there an OON Copayment? <input type="radio"/> Yes <input type="radio"/> No
Are the OON cost shares the same as the In-Network cost shares? <input type="radio"/> Yes <input type="radio"/> No	Enter Minimum Copayment Amount: <input type="text"/>
Is there an OON Coinsurance? <input type="radio"/> Yes <input type="radio"/> No	Enter Maximum Copayment Amount: <input type="text"/>
Enter Minimum Coinsurance Percentage: <input type="text"/>	Notes (Optional): <input type="text"/>
Enter Maximum Coinsurance Percentage: <input type="text"/>	
Select the Coinsurance Coverage Basis: <input type="radio"/> Published Fee Schedule <input type="radio"/> MA Organization Developed Fee Schedule <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Other, describe	

SECTION D – STEP-UP – 17B – EYE WEAR – BASE 1 SCREEN

PBP 2010 Data Entry System - Step Up #17b Eye Wear - Base 1

File

DESCRIPTION OF BENEFIT

Even if you do not offer enhanced benefits, you must complete this section for your Medicare Covered Benefits.

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes
 No

Select enhanced benefits:

Contact Lenses
 Eye Glasses (Lenses and Frames)
 Eye Glass Lenses
 Eye Glass Frames
 Upgrades

Select type of benefit for Contact Lenses:

Mandatory
 Optional

Is this benefit unlimited for Contact Lenses?

Yes
 No, indicate number

Indicate quantity (number of pairs) for Contact Lenses:

Select Contact Lenses periodicity:

Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

Select type of benefit for Eye Glasses (Lenses and Frames):

Mandatory
 Optional

Is this benefit unlimited for Eye Glasses (Lenses and Frames)?

Yes
 No, indicate number

Indicate quantity for Eye Glasses (Lenses and Frames):

Select Eye Glasses (Lenses and Frames) periodicity:

Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

SECTION D – STEP-UP – 17B – EYE WEAR – BASE 2 SCREEN

PBP 2010 Data Entry System - Step Up #17b Eye Wear - Base 2

File

<p>Select type of benefit for Eye Glass Lenses:</p> <p><input type="radio"/> Mandatory</p> <p><input type="radio"/> Optional</p>	<p>Select type of benefit for Eye Glass Frames:</p> <p><input type="radio"/> Mandatory</p> <p><input type="radio"/> Optional</p>
<p>Is this benefit unlimited for Eye Glass Lenses?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No, indicate number</p>	<p>Is this benefit unlimited for Eye Glass Frames?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No, indicate number</p>
<p>Indicate quantity (number of pairs) for Eye Glass Lenses:</p> <p><input type="text"/></p>	<p>Indicate quantity for Eye Glass Frames:</p> <p><input type="text"/></p>
<p>Select Eye Glass Lenses periodicity:</p> <p><input type="radio"/> Every three years</p> <p><input type="radio"/> Every two years</p> <p><input type="radio"/> Every year</p> <p><input type="radio"/> Every six months</p> <p><input type="radio"/> Every three months</p> <p><input type="radio"/> Other, describe</p>	<p>Select Eye Glass Frames periodicity:</p> <p><input type="radio"/> Every three years</p> <p><input type="radio"/> Every two years</p> <p><input type="radio"/> Every year</p> <p><input type="radio"/> Every six months</p> <p><input type="radio"/> Every three months</p> <p><input type="radio"/> Other, describe</p>
<p>Select type of benefit for Upgrades:</p> <p><input type="radio"/> Mandatory</p> <p><input type="radio"/> Optional</p>	

SECTION D – STEP-UP – 17B – EYE WEAR – BASE 3 SCREEN

PBP 2010 Data Entry System - Step Up #17b Eye Wear - Base 3

File

<p>Is there a service-specific Maximum Plan Benefit Coverage amount?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p>	<p>Select the Maximum Plan Benefit Coverage Basis:</p> <p><input type="radio"/> Discount (___%) of Published Retail Price</p> <p><input type="radio"/> Published Retail Price</p> <p><input type="radio"/> Published Wholesale Price</p> <p><input type="radio"/> Published Fee Schedule</p> <p><input type="radio"/> MA Organization Developed Fee Schedule</p> <p><input type="radio"/> MA Organization Developed Cost Structure</p> <p><input type="radio"/> Other, describe</p>	<p>Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p>
<p>Select the Maximum Plan Benefit Coverage type:</p> <p><input type="radio"/> Covered under Eye Exams Category 17a</p> <p><input type="radio"/> Plan-specified amount per period</p>		<p>Select the Maximum Enrollee Out-of-Pocket Cost type:</p> <p><input type="radio"/> Covered under Eye Exams Category 17a</p> <p><input type="radio"/> Plan-specified amount per period</p>
<p>Indicate Maximum Plan Benefit Coverage amount:</p> <p><input type="text"/></p>	<p>Indicate percentage Discount of Published Retail Price for Maximum Plan Benefit Coverage:</p> <p><input type="text"/></p>	<p>Indicate Maximum Enrollee Out-of-Pocket Cost amount:</p> <p><input type="text"/></p>
<p>Select the Maximum Plan Benefit Coverage periodicity:</p> <p><input type="radio"/> Every three years</p> <p><input type="radio"/> Every two years</p> <p><input type="radio"/> Every year</p> <p><input type="radio"/> Every six months</p> <p><input type="radio"/> Every three months</p> <p><input type="radio"/> Other, describe</p>		<p>Select Maximum Enrollee Out-of-Pocket Cost periodicity:</p> <p><input type="radio"/> Every three years</p> <p><input type="radio"/> Every two years</p> <p><input type="radio"/> Every year</p> <p><input type="radio"/> Every six months</p> <p><input type="radio"/> Every three months</p> <p><input type="radio"/> Other, describe</p>

SECTION D – STEP-UP – 17B – EYE WEAR – BASE 4 SCREEN

PBP 2010 Data Entry System - Step Up #17b Eye Wear - Base 4

File

Is there an enrollee Coinsurance? <input type="radio"/> Yes <input type="radio"/> No	Indicate Coinsurance percentage for Eye Glasses (Lenses and Frames): <input type="text"/>	Indicate Coinsurance percentage for Eye Glass Frames: <input type="text"/>
Indicate Coinsurance percentage for Medicare Covered Benefits: <input type="text"/>	Select the Coinsurance Coverage Basis for Eye Glasses (Lenses and Frames): <input type="radio"/> Published Retail Price <input type="radio"/> Published Wholesale Price <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Other, describe	Select the Coinsurance Coverage Basis for Eye Glass Frames: <input type="radio"/> Published Retail Price <input type="radio"/> Published Wholesale Price <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Other, describe
Select the Coinsurance Coverage Basis for Medicare Covered Benefits: <input type="radio"/> Published Retail Price <input type="radio"/> Published Wholesale Price <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Other, describe	Indicate Coinsurance percentage for Eye Glass Lenses: <input type="text"/>	Indicate Coinsurance percentage for Upgrades: <input type="text"/>
Indicate Coinsurance percentage for Contact Lenses: <input type="text"/>	Select the Coinsurance Coverage Basis for Eye Glass Lenses: <input type="radio"/> Published Retail Price <input type="radio"/> Published Wholesale Price <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Other, describe	Select the Coinsurance Coverage Basis for Upgrades: <input type="radio"/> Published Retail Price <input type="radio"/> Published Wholesale Price <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Other, describe
Select the Coinsurance Coverage Basis for Contact Lenses: <input type="radio"/> Published Retail Price <input type="radio"/> Published Wholesale Price <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Other, describe		

SECTION D – STEP-UP – 17B – EYE WEAR – BASE 5 SCREEN

PBP 2010 Data Entry System - Step Up #17b Eye Wear - Base 5

File

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?
 Yes
 No

Indicate Copayment amount for Medicare Covered Benefits:

Indicate Copayment amount for Contact Lenses:

Indicate Copayment amount for Eye Glasses (Lenses and Frames):

Indicate Copayment amount for Eye Glass Lenses:

Indicate Copayment amount for Eye Glass Frames:

Indicate Copayment amount for Upgrades:

Enrollee must receive Authorization from one or more of the following:
 None
 Primary Care Physician (Internist/Family Practice, General Practice)
 Physician Specialist
 Organization Medical Director/Utilization Management/Utilization Review
 Other, describe

Is a referral required for Eye Wear?
 Yes
 No

SECTION D – STEP-UP – 17B – EYE WEAR – BASE 6 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - Step Up #17b Eye Wear - Base 6". The window has a standard Windows-style title bar with minimize, maximize, and close buttons. Below the title bar is a menu bar with a "File" option. The main content area is divided into several sections: a text input field labeled "Eye Wear Notes", a section labeled "Notes (Optional):" which contains a large, empty rectangular text area, and a button labeled "Import Text" located in the bottom right corner of the main content area.

SECTION D – OPTIONAL SUPPLEMENTAL – OUT-OF-NETWORK - 17B – EYE WEAR SCREEN

PBP 2010 Data Entry System - (repaint)Optional Supplemental - OON Optional

File

Does this category include Out-of-Network benefits?
 Yes
 No

Is there an OON Copayment?
 Yes
 No

Are the OON cost shares the same as the In-Network cost shares?
 Yes
 No

Enter Minimum Copayment Amount:

Enter Maximum Copayment Amount:

Is there an OON Coinsurance?
 Yes
 No

Enter Minimum Coinsurance Percentage:

Enter Maximum Coinsurance Percentage:

Select the Coinsurance Coverage Basis:
 Published Fee Schedule
 MA Organization Developed Fee Schedule
 MA Organization Developed Cost Structure
 Other, describe

Notes (Optional):

SECTION D – STEP-UP – 18A – HEARING EXAMS – BASE 1 SCREEN

PBP 2010 Data Entry System - Step Up #18a Hearing Exams - Base 1

File

DESCRIPTION OF BENEFIT

Even if you do not offer enhanced benefits, you must complete this section for your Medicare Covered Benefits.

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes
 No

Select enhanced benefits:

Routine Hearing Tests
 Fitting/Evaluation for Hearing Aid

Select type of benefit for Routine Hearing Tests:

Mandatory
 Optional

Is this benefit unlimited for Routine Hearing Tests?

Yes
 No, indicate number

Indicate number for Routine Hearing Tests:

Select Routine Hearing Tests periodicity:

Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

Select type of benefit for Fitting/Evaluation for Hearing Aid:

Mandatory
 Optional

Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?

Yes
 No, indicate number

Indicate number for Fitting/Evaluation for Hearing Aid:

Select Fitting/Evaluation for Hearing Aid periodicity:

Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

SECTION D – STEP-UP – 18A – HEARING EXAMS – BASE 2 SCREEN

PBP 2010 Data Entry System - Step Up #18a Hearing Exams - Base 2

File

<p>Is there a service-specific Maximum Plan Benefit Coverage amount?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p>	<p>Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p>	<p>Is there an enrollee Coinsurance?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p>
<p>Indicate Maximum Plan Benefit Coverage amount:</p> <input type="text"/>	<p>Indicate Maximum Enrollee Out-of-Pocket Cost amount:</p> <input type="text"/>	<p>Indicate the Minimum Coinsurance percentage for Medicare Covered Benefits:</p> <input type="text"/>
<p>Select the Maximum Plan Benefit Coverage periodicity:</p> <p><input type="radio"/> Every three years</p> <p><input type="radio"/> Every two years</p> <p><input type="radio"/> Every year</p> <p><input type="radio"/> Every six months</p> <p><input type="radio"/> Every three months</p> <p><input type="radio"/> Other, describe</p>	<p>Select Maximum Enrollee Out-of-Pocket Cost periodicity:</p> <p><input type="radio"/> Every three years</p> <p><input type="radio"/> Every two years</p> <p><input type="radio"/> Every year</p> <p><input type="radio"/> Every six months</p> <p><input type="radio"/> Every three months</p> <p><input type="radio"/> Other, describe</p>	<p>Indicate the Maximum Coinsurance percentage for Medicare Covered Benefits:</p> <input type="text"/>
<p>Select the Coverage Basis for Maximum Plan Benefit Coverage:</p> <p><input type="radio"/> Published Fee Schedule</p> <p><input type="radio"/> MA Organization Developed Fee Schedule</p> <p><input type="radio"/> MA Organization Developed Cost Structure</p> <p><input type="radio"/> Medicare Fee-for-Service Charge Structure</p> <p><input type="radio"/> Other, describe</p>		<p>Select the Coinsurance Coverage Basis for Medicare Covered Benefits:</p> <p><input type="radio"/> Published Fee Schedule</p> <p><input type="radio"/> MA Organization Developed Fee Schedule</p> <p><input type="radio"/> MA Organization Developed Cost Structure</p> <p><input type="radio"/> Medicare Fee-for-Service Charge Structure</p> <p><input type="radio"/> Other, describe</p>

SECTION D – STEP-UP – 18A – HEARING EXAMS – BASE 3 SCREEN

PBP 2010 Data Entry System - Step Up #18a Hearing Exams - Base 3

File

Indicate Minimum Coinsurance percentage for Routine Hearing Tests: <input type="text"/>	Indicate Minimum Coinsurance percentage for Fitting/Evaluation for Hearing Aid: <input type="text"/>	Is there an enrollee Deductible? <input type="radio"/> Yes <input type="radio"/> No
Indicate Maximum Coinsurance percentage for Routine Hearing Tests: <input type="text"/>	Indicate Maximum Coinsurance percentage for Fitting/Evaluation for Hearing Aid: <input type="text"/>	Indicate Deductible Amount: <input type="text"/>
Select the Coinsurance Coverage Basis for Routine Hearing Tests: <input type="radio"/> Published Fee Schedule <input type="radio"/> MA Organization Developed Fee Schedule <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Medicare Fee-for-Service Charge Structure <input type="radio"/> Other, describe	Select the Coinsurance Coverage Basis for Fitting/Evaluation for Hearing Aid: <input type="radio"/> Published Fee Schedule <input type="radio"/> MA Organization Developed Fee Schedule <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Medicare Fee-for-Service Charge Structure <input type="radio"/> Other, describe	

SECTION D – STEP-UP – 18A – HEARING EXAMS – BASE 4 SCREEN

PBP 2010 Data Entry System - Step Up #18a Hearing Exams - Base 4

File

Is there an enrollee Copayment?
 Yes
 No

Indicate Minimum Copayment amount for Medicare Covered Benefits:

Indicate Maximum Copayment amount for Medicare Covered Benefits:

Indicate Minimum Copayment amount for Routine Hearing Tests:

Indicate Maximum Copayment amount for Routine Hearing Tests:

Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:

Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:

Enrollee must receive Authorization from one or more of the following:
 None
 Primary Care Physician (Internist/Family Practice, General Practice)
 Physician Specialist
 Organization Medical Director/Utilization Management/Utilization Review
 Other, describe

Is a referral required for Hearing Exams?
 Yes
 No

SECTION D – STEP-UP – 18A – HEARING EXAMS – BASE 5 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - Step Up #18a Hearing Exams - Base 5". The window has a standard Windows-style title bar with minimize, maximize, and close buttons. Below the title bar is a menu bar with a "File" option. The main content area is divided into several sections: a "Hearing Exams Notes" text input field, a "Notes (Optional):" label, a large empty rectangular text area for notes, and an "Import Text" button located in the bottom right corner of the text area.

SECTION D – OPTIONAL SUPPLEMENTAL – OUT-OF-NETWORK - 18A – HEARING EXAMS SCREEN

PBP 2010 Data Entry System - (repaint)Optional Supplemental - OON Optional

File

Does this category include Out-of-Network benefits?
 Yes
 No

Is there an OON Copayment?
 Yes
 No

Are the OON cost shares the same as the In-Network cost shares?
 Yes
 No

Enter Minimum Copayment Amount:

Enter Maximum Copayment Amount:

Is there an OON Coinsurance?
 Yes
 No

Enter Minimum Coinsurance Percentage:

Enter Maximum Coinsurance Percentage:

Select the Coinsurance Coverage Basis:
 Published Fee Schedule
 MA Organization Developed Fee Schedule
 MA Organization Developed Cost Structure
 Other, describe

Notes (Optional):

SECTION D – STEP-UP – 18B – HEARING AIDS – BASE 1 SCREEN

PBP 2010 Data Entry System - Step Up #18b Hearing Aids - Base 1

File

DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?
 Yes
 No

Select enhanced benefits:
 Hearing Aids (all types)
 Hearing Aids - Inner Ear
 Hearing Aids - Outer Ear
 Hearing Aids - Over the Ear

Select type of benefit for Hearing Aids (all types):
 Mandatory
 Optional

Is this benefit unlimited for Hearing Aids (all types)?
 Yes
 No, indicate number

Indicate quantity for Hearing Aids (all types):

Select Hearing Aids (all types) periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

Select type of benefit for Hearing Aids - Inner Ear:
 Mandatory
 Optional

Is this benefit unlimited for Hearing Aids - Inner Ear?
 Yes
 No, indicate number

Indicate quantity for Hearing Aids - Inner Ear:

Select Hearing Aids - Inner Ear periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

Select type of benefit for Hearing Aids - Outer Ear:
 Mandatory
 Optional

Is this benefit unlimited for Hearing Aids - Outer Ear?
 Yes
 No, indicate number

Indicate quantity for Hearing Aids - Outer Ear:

Select Hearing Aids - Outer Ear periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

SECTION D – STEP-UP – 18B – HEARING AIDS – BASE 2 SCREEN

PBP 2010 Data Entry System - Step Up #18b Hearing Aids - Base 2

File

Select type of benefit for Hearing Aids - Over the Ear:
 Mandatory
 Optional

Select the Maximum Plan Benefit Coverage type:
 Covered under Hearing Exams Category - 18a
 Plan-specified amount per period

Indicate percentage Discount of Published Retail Price for Maximum Plan Benefit Coverage:

Is this benefit unlimited for Hearing Aids - Over the Ear?
 Yes
 No, indicate number

Indicate Maximum Plan Benefit Coverage amount:

Indicate quantity for Hearing Aids - Over the Ear:

Select Hearing Aids - Over the Ear periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

Indicate Maximum Plan Benefit Coverage periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

Is there a service-specific Maximum Plan Benefit Coverage amount?
 Yes
 No

Select the Coverage Basis for Maximum Plan Benefit Coverage:
 Discount (___%) of Published Retail Price
 Published Retail Price
 Published Wholesale Price
 Published National Average Wholesale Price
 Published Fee Schedule
 MA Organization Developed Fee Schedule
 MA Organization Developed Cost Structure
 Other, describe

SECTION D – STEP-UP – 18B – HEARING AIDS – BASE 3 SCREEN

PBP 2010 Data Entry System - Step Up #18b Hearing Aids - Base 3

File

<p>Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p>	<p>Indicate Coinsurance percentage for Hearing Aids (all types):</p> <input type="text"/>	<p>Indicate Coinsurance percentage for Hearing Aids - Outer Ear:</p> <input type="text"/>
<p>Select the Maximum Enrollee Out-of-Pocket Cost type:</p> <p><input type="radio"/> Covered under Hearing Exams Category - 18a</p> <p><input type="radio"/> Plan-specified amount per period</p>	<p>Select the Coinsurance Coverage Basis for Hearing Aids (all types):</p> <p><input type="radio"/> Published Retail Price</p> <p><input type="radio"/> Published Wholesale Price</p> <p><input type="radio"/> Published National Average Wholesale Price</p> <p><input type="radio"/> Published Fee Schedule</p> <p><input type="radio"/> MA Organization Developed Fee Schedule</p> <p><input type="radio"/> MA Organization Developed Cost Structure</p> <p><input type="radio"/> Other, describe</p>	<p>Select the Coinsurance Coverage Basis for Hearing Aids - Outer Ear:</p> <p><input type="radio"/> Published Retail Price</p> <p><input type="radio"/> Published Wholesale Price</p> <p><input type="radio"/> Published National Average Wholesale Price</p> <p><input type="radio"/> Published Fee Schedule</p> <p><input type="radio"/> MA Organization Developed Fee Schedule</p> <p><input type="radio"/> MA Organization Developed Cost Structure</p> <p><input type="radio"/> Other, describe</p>
<p>Indicate Maximum Enrollee Out-of-Pocket Cost amount:</p> <input type="text"/>	<p>Indicate Coinsurance percentage for Hearing Aids - Inner Ear:</p> <input type="text"/>	
<p>Select Maximum Enrollee Out-of-Pocket Cost periodicity:</p> <p><input type="radio"/> Every three years</p> <p><input type="radio"/> Every two years</p> <p><input type="radio"/> Every year</p> <p><input type="radio"/> Every six months</p> <p><input type="radio"/> Every three months</p> <p><input type="radio"/> Other, describe</p>	<p>Select the Coinsurance Coverage Basis for Hearing Aids - Inner Ear:</p> <p><input type="radio"/> Published Retail Price</p> <p><input type="radio"/> Published Wholesale Price</p> <p><input type="radio"/> Published National Average Wholesale Price</p> <p><input type="radio"/> Published Fee Schedule</p> <p><input type="radio"/> MA Organization Developed Fee Schedule</p> <p><input type="radio"/> MA Organization Developed Cost Structure</p> <p><input type="radio"/> Other, describe</p>	
<p>Is there an enrollee Coinsurance?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p>		

SECTION D – STEP-UP – 18B – HEARING AIDS – BASE 4 SCREEN

PBP 2010 Data Entry System - Step Up #18b Hearing Aids - Base 4

File

Indicate Coinsurance percentage for Hearing Aids - Over the Ear: <input type="text"/>	Is there an enrollee Copayment? <input type="radio"/> Yes <input type="radio"/> No	Indicate Copayment amount per Hearing Aid - Outer Ear: <input type="text"/>
Select the Coinsurance Coverage Basis for Hearing Aids - Over the Ear: <input type="radio"/> Published Retail Price <input type="radio"/> Published Wholesale Price <input type="radio"/> Published National Average Wholesale Price <input type="radio"/> Published Fee Schedule <input type="radio"/> MA Organization Developed Fee Schedule <input type="radio"/> MA Organization Developed Cost Structure <input type="radio"/> Other, describe	Indicate Minimum Copayment amount per Hearing Aid (all types): <input type="text"/>	Indicate Copayment amount per two Hearing Aids - Outer Ear: <input type="text"/>
Is there an enrollee Deductible? <input type="radio"/> Yes <input type="radio"/> No	Indicate Maximum Copayment amount per Hearing Aid (all types): <input type="text"/>	Indicate Copayment amount per Hearing Aid - Over the Ear: <input type="text"/>
Indicate Deductible Amount: <input type="text"/>	Indicate Copayment amount per Hearing Aid - Inner Ear: <input type="text"/>	Indicate Copayment amount per two Hearing Aids - Over the Ear: <input type="text"/>
	Indicate Copayment amount per two Hearing Aids - Inner Ear: <input type="text"/>	

SECTION D – STEP-UP – 18B – HEARING AIDS – BASE 5 SCREEN

File

Enrollee must receive Authorization from one or more of the following:

- None
- Primary Care Physician (Internist/Family Practice, General Practice)
- Physician Specialist
- Organization Medical Director/Utilization Management/Utilization Review
- Other, describe

Is a referral required for Hearing Aids?

- Yes
- No

Notes (Optional):

Import Text

SECTION D – OPTIONAL SUPPLEMENTAL – OUT-OF-NETWORK – STEP UP

PBP 2010 Data Entry System - (repaint)Optional Supplemental - OON Optional

File

Does this category include Out-of-Network benefits?
 Yes
 No

Is there an OON Copayment?
 Yes
 No

Are the OON cost shares the same as the In-Network cost shares?
 Yes
 No

Enter Minimum Copayment Amount:

Enter Maximum Copayment Amount:

Is there an OON Coinsurance?
 Yes
 No

Enter Minimum Coinsurance Percentage:

Enter Maximum Coinsurance Percentage:

Notes (Optional):