

SECTION B – 1A – INPATIENT HOSPITAL ACUTE – BASE 1 SCREEN

PBP 2010 Data Entry System - #1a Inpatient Hospital-Acute - Base 1

File

DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes
 No

Select enhanced benefits:

Additional Days
 Non-Medicare Covered Stay
 Upgrades

Select type of benefit for Additional Days:

Mandatory
 Optional

Is this benefit unlimited for Additional Days?

Yes
 No, indicate number

Indicate number of Additional Days per benefit period:

Select type of benefit for Non-Medicare Covered stay:

Mandatory
 Optional

Select type of benefit for Upgrades:

Mandatory
 Optional

SECTION B – 1A – INPATIENT HOSPITAL ACUTE – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)#1a Inpatient Hospital-Acute - Base 2

File

Maximum Plan Benefit Coverage is not applicable for this Service Category.

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

Yes
 No

Indicate the 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
 Every benefit period
 Every stay
 Other, describe

Is there an enrollee Coinsurance?

Yes
 No

Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)

Yes
 No

Indicate Coinsurance percentage for the Medicare Covered stay:

Indicate the number of day intervals for the Medicare Covered stay:

Zero (No Coinsurance per Day)
 One
 Two
 Three

Indicate the coinsurance percentage and day interval(s) for the Medicare Covered stay (e.g., 1 to 30; 31 to 90):

| | | |
|------------------------------------|--------------------------------|------------------------------|
| Coinsurance % Interval 1: _____ | Begin Day Interval 1: _____ | End Day Interval 1: _____ |
| Coinsurance % Interval 2: _____ | Begin Day Interval 2: _____ | End Day Interval 2: _____ |
| Coinsurance % Interval 3: _____ | Begin Day Interval 3: _____ | End Day Interval 3: _____ |

SECTION B – 1A – INPATIENT HOSPITAL ACUTE – BASE 3 SCREEN

PBP 2010 Data Entry System - (repaint)#1a Inpatient Hospital-Acute - Base 3

File

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:

Zero (No Coinsurance per Day)
 One
 Two
 Three

Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):

| | | |
|---|--|--|
| Coinsurance % Interval 1: <input type="text"/> | Lifetime Reserve Begin Day Interval 1: <input type="text"/> | Lifetime Reserve End Day Interval 1: <input type="text"/> |
| Coinsurance % Interval 2: <input type="text"/> | Lifetime Reserve Begin Day Interval 2: <input type="text"/> | Lifetime Reserve End Day Interval 2: <input type="text"/> |
| Coinsurance % Interval 3: <input type="text"/> | Lifetime Reserve Begin Day Interval 3: <input type="text"/> | Lifetime Reserve End Day Interval 3: <input type="text"/> |

SECTION B – 1A – INPATIENT HOSPITAL ACUTE – BASE 4 SCREEN

PBP 2010 Data Entry System - (repaint)#1a Inpatient Hospital-Acute - Base 4

File

Indicate the number of day intervals for Additional Days:

Zero (No Coinsurance per Day)

One

Two

Three

Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 91 to 999):

| | | |
|---|---|---|
| Coinsurance % Interval 1: <input type="text"/> | Begin Day Interval 1: <input type="text"/> | End Day Interval 1: <input type="text"/> |
| Coinsurance % Interval 2: <input type="text"/> | Begin Day Interval 2: <input type="text"/> | End Day Interval 2: <input type="text"/> |
| Coinsurance % Interval 3: <input type="text"/> | Begin Day Interval 3: <input type="text"/> | End Day Interval 3: <input type="text"/> |

SECTION B – 1A – INPATIENT HOSPITAL ACUTE – BASE 5 SCREEN

PBP 2010 Data Entry System - (repaint)#1a Inpatient Hospital-Acute - Base 5

File

Is the Coinsurance structure for the Non-Medicare Covered stay the same as the Coinsurance structure for the Medicare Covered stay?

Yes
 No

Indicate Coinsurance percentage for the Non-Medicare Covered stay:

Indicate the number of day intervals for the Non-Medicare Covered stay:

Zero (No Coinsurance per Day)
 One
 Two
 Three

Indicate the coinsurance percentage and day interval(s) for the Non-Medicare Covered stay (enter "999" if unlimited days are offered; e.g.: 1 to 999):

| | | |
|---|---|---|
| Coinsurance % Interval 1: <input type="text"/> | Begin Day Interval 1: <input type="text"/> | End Day Interval 1: <input type="text"/> |
| Coinsurance % Interval 2: <input type="text"/> | Begin Day Interval 2: <input type="text"/> | End Day Interval 2: <input type="text"/> |
| Coinsurance % Interval 3: <input type="text"/> | Begin Day Interval 3: <input type="text"/> | End Day Interval 3: <input type="text"/> |

Indicate Coinsurance percentage for Upgrades:

SECTION B – 1A – INPATIENT HOSPITAL ACUTE – BASE 6 SCREEN

PBP 2010 Data Entry System - #1a Inpatient Hospital-Acute - Base 6

File

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?
 Yes
 No

Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)
 Yes
 No

Indicate Copayment amount for the Medicare Covered stay:

Indicate the number of day intervals for the Medicare Covered stay:
 Zero (No Copayment per Day)
 One
 Two
 Three

Indicate the copayment amount and day interval(s) for the Medicare Covered stay (e.g., 1 to 30; 31 to 90):

| | | |
|---|---|---|
| Copayment Amt Interval 1: <input type="text"/> | Begin Day Interval 1: <input type="text"/> | End Day Interval 1: <input type="text"/> |
| Copayment Amt Interval 2: <input type="text"/> | Begin Day Interval 2: <input type="text"/> | End Day Interval 2: <input type="text"/> |
| Copayment Amt Interval 3: <input type="text"/> | Begin Day Interval 3: <input type="text"/> | End Day Interval 3: <input type="text"/> |

SECTION B – 1A – INPATIENT HOSPITAL ACUTE – BASE 7 SCREEN

PBP 2010 Data Entry System - #1a Inpatient Hospital-Acute - Base 7

File

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:

Zero (No Copayment per Day)
 One
 Two
 Three

Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):

| | | |
|---|--|--|
| Copayment Amt Interval 1: <input type="text"/> | Lifetime Reserve Begin Day Interval 1: <input type="text"/> | Lifetime Reserve End Day Interval 1: <input type="text"/> |
| Copayment Amt Interval 2: <input type="text"/> | Lifetime Reserve Begin Day Interval 2: <input type="text"/> | Lifetime Reserve End Day Interval 2: <input type="text"/> |
| Copayment Amt Interval 3: <input type="text"/> | Lifetime Reserve Begin Day Interval 3: <input type="text"/> | Lifetime Reserve End Day Interval 3: <input type="text"/> |

SECTION B – 1A – INPATIENT HOSPITAL ACUTE – BASE 8 SCREEN

PBP 2010 Data Entry System - #1a Inpatient Hospital-Acute - Base 8

File

Indicate the number of day intervals for Additional Days:

Zero (No Copayment per Day)
 One
 Two
 Three

Indicate the copayment amount and day interval(s) for Additional Days (enter '999' if unlimited days are offered; e.g., 91 to 999):

| | | |
|---|---|---|
| Copayment Amt Interval 1: <input type="text"/> | Begin Day Interval 1: <input type="text"/> | End Day Interval 1: <input type="text"/> |
| Copayment Amt Interval 2: <input type="text"/> | Begin Day Interval 2: <input type="text"/> | End Day Interval 2: <input type="text"/> |
| Copayment Amt Interval 3: <input type="text"/> | Begin Day Interval 3: <input type="text"/> | End Day Interval 3: <input type="text"/> |

SECTION B – 1A – INPATIENT HOSPITAL ACUTE – BASE 9 SCREEN

PBP 2010 Data Entry System - (repaint)#1a Inpatient Hospital-Acute - Base 9

File

Is the Copayment structure for the Non-Medicare Covered stay the same as the Copayment structure for the Medicare Covered stay?

Yes
 No

Indicate Copayment amount for the Non-Medicare Covered stay:

Indicate the number of day intervals for the Non-Medicare Covered stay:

Zero (No Copayment per Day)
 One
 Two
 Three

Indicate the copayment amount and day interval(s) for the Non-Medicare Covered stay (enter "999" if unlimited days are offered; e.g.: 1 to 999):

| | | |
|------------------------------------|--------------------------------|------------------------------|
| Copayment Amt Interval 1: _____ | Begin Day Interval 1: _____ | End Day Interval 1: _____ |
| Copayment Amt Interval 2: _____ | Begin Day Interval 2: _____ | End Day Interval 2: _____ |
| Copayment Amt Interval 3: _____ | Begin Day Interval 3: _____ | End Day Interval 3: _____ |

Indicate Copayment amount for Upgrades per stay:

Indicate Copayment amount for Upgrades per day:

Does cost sharing vary based on the hospital network?

Yes
 No

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

ESRD I Plans Only (Optional): If the beneficiary does not notify the plan of a planned inpatient admission, indicate the additional copayment amount per day:

ESRD I Plans Only (Optional): If the beneficiary does not notify the plan of a planned inpatient admission, indicate the maximum enrollee out-of-pocket cost amount per admission:

SECTION B – 1A – INPATIENT HOSPITAL ACUTE – BASE 10 SCREEN

PBP 2010 Data Entry System - #1a Inpatient Hospital-Acute - Base 10

File

Is a referral required for Inpatient Hospital - Acute Services?

Yes

No

Inpatient Hospital - Acute Notes

Notes (Optional):

Import Text

SECTION B – 1A – INPATIENT HOSPITAL ACUTE (B ONLY) – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#1a Inpatient Hospital-Acute (B Only) - Base 1

File

Do you offer Inpatient Hospital - Acute Services as a benefit?
 Yes
 No

Select type of benefit for Inpatient Hospital - Acute Services:
 Mandatory
 Optional

Does this benefit have unlimited days?
 Yes
 No, indicate number

Indicate number of days per period:

Select the days periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Every benefit period
 Every stay
 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
 Every benefit period
 Every stay
 Other, describe

SECTION B – 1A – INPATIENT HOSPITAL ACUTE (B ONLY) – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)#1a Inpatient Hospital-Acute (B Only) - Base 2

File

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

Indicate the 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
 Every benefit period
 Every stay
 Other, describe

Is there an enrollee Coinsurance?
 Yes
 No

Indicate Coinsurance percentage per stay:

Indicate the number of day intervals for the stay:
 Zero (No Coinsurance per Day)
 One
 Two
 Three

Indicate the coinsurance percentage and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g., 1 to 999):

| | | |
|---|---|---|
| Coinsurance % Interval 1: <input type="text"/> | Begin Day Interval 1: <input type="text"/> | End Day Interval 1: <input type="text"/> |
| Coinsurance % Interval 2: <input type="text"/> | Begin Day Interval 2: <input type="text"/> | End Day Interval 2: <input type="text"/> |
| Coinsurance % Interval 3: <input type="text"/> | Begin Day Interval 3: <input type="text"/> | End Day Interval 3: <input type="text"/> |

SECTION B – 1A – INPATIENT HOSPITAL ACUTE (B ONLY) – BASE 3 SCREEN

PBP 2010 Data Entry System - #1a Inpatient Hospital-Acute (B Only) - Base 3

File

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?
 Yes
 No

Indicate Copayment amount per stay:

Indicate the number of day intervals for the stay:
 Zero (No Copayment per Day)
 One
 Two
 Three

Indicate the copayment amount and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g., 1 to 999):

| | | |
|---|---|---|
| Copayment Amt Interval 1: <input type="text"/> | Begin Day Interval 1: <input type="text"/> | End Day Interval 1: <input type="text"/> |
| Copayment Amt Interval 2: <input type="text"/> | Begin Day Interval 2: <input type="text"/> | End Day Interval 2: <input type="text"/> |
| Copayment Amt Interval 3: <input type="text"/> | Begin Day Interval 3: <input type="text"/> | End Day Interval 3: <input type="text"/> |

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 Inpatient Hospital - Acute Services?
 Yes
 No

SECTION B – 1A – INPATIENT HOSPITAL ACUTE (B ONLY) – BASE 4 SCREEN

PBP 2010 Data Entry System - #1a Inpatient Hospital-Acute (B Only) - Base 4

File

Inpatient Hospital - Acute Notes

Notes (Optional):

Import Text

SECTION B – 1B – INPATIENT PSYCHIATRIC HOSPITAL – BASE 1 SCREEN

PBP 2010 Data Entry System - #1b Inpatient Psychiatric Hosp - Base 1

File

DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes
 No

Select enhanced benefit:

Additional Days
 Non-Medicare Covered Stay

Select type of benefit for Additional Days:

Mandatory
 Optional

Is this benefit unlimited for Additional Days?

Yes
 No, indicate number

Indicate number of Additional Days per benefit period:

Select type of benefit for Non-Medicare Covered stay:

Mandatory
 Optional

Maximum Plan Benefit Coverage is not applicable for this Service Category.

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

Yes
 No

Select the Maximum Enrollee Out-of-Pocket Cost type:

Covered under Inpatient Hospital Services Category 1a
 Plan-specified amount per period

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
 Every benefit period
 Every stay
 Other, describe

SECTION B – 1B – INPATIENT PSYCHIATRIC HOSPITAL – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)#1b Inpatient Psychiatric Hosp - Base 2

File

Is there an enrollee Coinsurance?

Yes
 No

Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)

Yes
 No

Indicate Coinsurance percentage for the Medicare Covered stay:

Indicate the number of day intervals for the Medicare Covered stay:

Zero (No Coinsurance per Day)
 One
 Two
 Three

Indicate the coinsurance percentage and day interval(s) for the Medicare Covered stay (e.g., 1 to 30; 31 to 90):

| | | |
|---|---|---|
| Coinsurance % Interval 1: <input type="text"/> | Begin Day Interval 1: <input type="text"/> | End Day Interval 1: <input type="text"/> |
| Coinsurance % Interval 2: <input type="text"/> | Begin Day Interval 2: <input type="text"/> | End Day Interval 2: <input type="text"/> |
| Coinsurance % Interval 3: <input type="text"/> | Begin Day Interval 3: <input type="text"/> | End Day Interval 3: <input type="text"/> |

SECTION B – 1B – INPATIENT PSYCHIATRIC HOSPITAL – BASE 3 SCREEN

PBP 2010 Data Entry System - (repaint)#1b Inpatient Psychiatric Hosp - Base 3

File

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:

Zero (No Coinsurance per Day)
 One
 Two
 Three

Indicate the coinsurance percentage and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):

| | | |
|---|--|--|
| Coinsurance % Interval 1: <input type="text"/> | Lifetime Reserve Begin Day Interval 1: <input type="text"/> | Lifetime Reserve End Day Interval 1: <input type="text"/> |
| Coinsurance % Interval 2: <input type="text"/> | Lifetime Reserve Begin Day Interval 2: <input type="text"/> | Lifetime Reserve End Day Interval 2: <input type="text"/> |
| Coinsurance % Interval 3: <input type="text"/> | Lifetime Reserve Begin Day Interval 3: <input type="text"/> | Lifetime Reserve End Day Interval 3: <input type="text"/> |

SECTION B – 1B – INPATIENT PSYCHIATRIC HOSPITAL – BASE 4 SCREEN

PBP 2010 Data Entry System - (repaint)#1b Inpatient Psychiatric Hosp - Base 4

File

Indicate the number of day intervals for Additional Days:

Zero (No Coinsurance per Day)

One

Two

Three

Indicate the coinsurance percentage and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 91 to 999):

| | | |
|---|---|---|
| Coinsurance % Interval 1: <input type="text"/> | Begin Day Interval 1: <input type="text"/> | End Day Interval 1: <input type="text"/> |
| Coinsurance % Interval 2: <input type="text"/> | Begin Day Interval 2: <input type="text"/> | End Day Interval 2: <input type="text"/> |
| Coinsurance % Interval 3: <input type="text"/> | Begin Day Interval 3: <input type="text"/> | End Day Interval 3: <input type="text"/> |

SECTION B – 1B – INPATIENT PSYCHIATRIC HOSPITAL – BASE 5 SCREEN

PBP 2010 Data Entry System - (repaint)#1b Inpatient Psychiatric Hosp - Base 5

File

Is the Coinsurance structure for the Non-Medicare Covered stay the same as the Coinsurance structure for the Medicare Covered stay?

Yes
 No

Indicate Coinsurance percentage for the Non-Medicare Covered stay:

Indicate the number of day intervals for the Non-Medicare Covered stay:

Zero (No Coinsurance per Day)
 One
 Two
 Three

Indicate the coinsurance percentage and day interval(s) for the Non-Medicare Covered stay (enter "999" if unlimited days are offered; e.g.: 1 to 999):

| | | |
|---|---|---|
| Coinsurance % Interval 1: <input type="text"/> | Begin Day Interval 1: <input type="text"/> | End Day Interval 1: <input type="text"/> |
| Coinsurance % Interval 2: <input type="text"/> | Begin Day Interval 2: <input type="text"/> | End Day Interval 2: <input type="text"/> |
| Coinsurance % Interval 3: <input type="text"/> | Begin Day Interval 3: <input type="text"/> | End Day Interval 3: <input type="text"/> |

Is there an enrollee Deductible?

Yes
 No

Indicate Deductible Amount:

SECTION B – 1B – INPATIENT PSYCHIATRIC HOSPITAL – BASE 6 SCREEN

PBP 2010 Data Entry System - #1b Inpatient Psychiatric Hosp - Base 6

File

Is there an enrollee Copayment?
 Yes
 No

Indicate the copayment amount and day interval(s) for the Medicare Covered stay (e.g., 1 to 30; 31 to 90):

| | | |
|---|---|---|
| Copayment Amt Interval 1: <input type="text"/> | Begin Day Interval 1: <input type="text"/> | End Day Interval 1: <input type="text"/> |
| Copayment Amt Interval 2: <input type="text"/> | Begin Day Interval 2: <input type="text"/> | End Day Interval 2: <input type="text"/> |
| Copayment Amt Interval 3: <input type="text"/> | Begin Day Interval 3: <input type="text"/> | End Day Interval 3: <input type="text"/> |

Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the inpatient facility.)
 Yes
 No

Indicate Copayment amount for the Medicare Covered stay:

Indicate the number of day intervals for the Medicare Covered stay:
 Zero (No Copayment per Day)
 One
 Two
 Three

SECTION B – 1B – INPATIENT PSYCHIATRIC HOSPITAL – BASE 7 SCREEN

PBP 2010 Data Entry System - #1b Inpatient Psychiatric Hosp - Base 7

File

Indicate the number of day intervals for the Medicare-covered Lifetime Reserve Days:

Zero (No Copayment per Day)
 One
 Two
 Three

Indicate the copayment amount and day interval(s) for the 60 Medicare-covered Lifetime Reserve Days (i.e., 1 - 60):

| | | |
|---|--|--|
| Copayment Amt Interval 1: <input type="text"/> | Lifetime Reserve Begin Day Interval 1: <input type="text"/> | Lifetime Reserve End Day Interval 1: <input type="text"/> |
| Copayment Amt Interval 2: <input type="text"/> | Lifetime Reserve Begin Day Interval 2: <input type="text"/> | Lifetime Reserve End Day Interval 2: <input type="text"/> |
| Copayment Amt Interval 3: <input type="text"/> | Lifetime Reserve Begin Day Interval 3: <input type="text"/> | Lifetime Reserve End Day Interval 3: <input type="text"/> |

SECTION B – 1B – INPATIENT PSYCHIATRIC HOSPITAL – BASE 8 SCREEN

PBP 2010 Data Entry System - #1b Inpatient Psychiatric Hosp - Base 8

File

Indicate the number of day intervals for Additional Days:

Zero (No Copayment per Day)
 One
 Two
 Three

Indicate the copayment amount and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 91 to 999):

| | | |
|---|---|---|
| Copayment Amt Interval 1: <input type="text"/> | Begin Day Interval 1: <input type="text"/> | End Day Interval 1: <input type="text"/> |
| Copayment Amt Interval 2: <input type="text"/> | Begin Day Interval 2: <input type="text"/> | End Day Interval 2: <input type="text"/> |
| Copayment Amt Interval 3: <input type="text"/> | Begin Day Interval 3: <input type="text"/> | End Day Interval 3: <input type="text"/> |

SECTION B – 1B – INPATIENT PSYCHIATRIC HOSPITAL – BASE 9 SCREEN

PBP 2010 Data Entry System - (repaint)#1b Inpatient Psychiatric Hosp - Base 9

File

Is the Copayment structure for the Non-Medicare Covered stay the same as the Copayment structure for the Medicare Covered stay?

Yes
 No

Indicate Copayment amount for the Non-Medicare Covered stay:

Indicate the number of day intervals for the Non-Medicare Covered stay:

Zero (No Copayment per Day)
 One
 Two
 Three

Indicate the copayment amount and day interval(s) for the Non-Medicare Covered stay (enter "999" if unlimited days are offered; e.g.: 1 to 999):

| | | |
|---|---|---|
| Copayment Amt Interval 1: <input type="text"/> | Begin Day Interval 1: <input type="text"/> | End Day Interval 1: <input type="text"/> |
| Copayment Amt Interval 2: <input type="text"/> | Begin Day Interval 2: <input type="text"/> | End Day Interval 2: <input type="text"/> |
| Copayment Amt Interval 3: <input type="text"/> | Begin Day Interval 3: <input type="text"/> | End Day Interval 3: <input type="text"/> |

Does cost sharing vary based on the hospital network?

Yes
 No

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

ESRD I Plans Only (Optional): If the beneficiary does not notify the plan of a planned inpatient admission, indicate the additional copayment amount per day:

ESRD I Plans Only (Optional): If the beneficiary does not notify the plan of a planned inpatient admission, indicate the maximum enrollee out-of-pocket cost amount per admission:

Is a referral required for Inpatient Psychiatric Hospital Services?

Yes
 No

SECTION B – 1B – INPATIENT PSYCHIATRIC HOSPITAL – BASE 10 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - #1b Inpatient Psychiatric Hosp - Base 10". 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 sections. At the top, there is a label "Inpatient Psychiatric Hospital Notes". Below this is a section labeled "Notes (Optional):" which contains a large, empty rectangular text input area. In the bottom right corner of the main content area, there is a button labeled "Import Text".

SECTION B – 1B – INPATIENT PSYCHIATRIC HOSPITAL (B ONLY) – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#1b Inpatient Psychiatric Hosp (B Only) - Base 1

File

| | | |
|---|--|---|
| <p>Do you offer Inpatient Psychiatric Hospital Services as a benefit?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> | <p>Indicate number of days per period:</p> <p><input type="text"/></p> | <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 type of benefit for Inpatient Psychiatric Hospital Services:</p> <p><input type="radio"/> Mandatory</p> <p><input type="radio"/> Optional</p> | <p>Select the days 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"/> Every benefit period</p> <p><input type="radio"/> Every stay</p> <p><input type="radio"/> Other, describe</p> | <p>Select the Maximum Plan Benefit Coverage type:</p> <p><input type="radio"/> Covered under Inpatient Hospital Services Category 1a</p> <p><input type="radio"/> Plan-specified amount per period</p> |
| <p>Does this benefit have unlimited days?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No, indicate number</p> | | <p>Indicate Maximum Plan Benefit Coverage amount:</p> <p><input type="text"/></p> |
| | | <p>Select 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"/> Every benefit period</p> <p><input type="radio"/> Every stay</p> <p><input type="radio"/> Other, describe</p> |

SECTION B – 1B – INPATIENT PSYCHIATRIC HOSPITAL (B ONLY) – BASE 2 SCREEN

PBP 2010 Data Entry System - #1b Inpatient Psychiatric Hosp (B Only) - Base 2

File

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

Yes
 No

Select the Maximum Enrollee Out-of-Pocket Cost type:

Covered under the Inpatient Hospital Services Category 1a
 Plan-specified amount per period

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
 Every benefit period
 Every stay
 Other, describe

SECTION B – 1B – INPATIENT PSYCHIATRIC HOSPITAL (B ONLY) – BASE 3 SCREEN

File

Is there an enrollee Coinsurance?
 Yes
 No

Indicate Coinsurance percentage per stay:

Indicate the number of day intervals for the stay:
 Zero (No Coinsurance per Day)
 One
 Two
 Three

Indicate the coinsurance percentage and day interval(s) for the stay
(enter "999" if unlimited days are offered; e.g., 1 to 999):

| | | |
|---|---|---|
| Coinsurance % Interval 1: <input type="text"/> | Begin Day Interval 1: <input type="text"/> | End Day Interval 1: <input type="text"/> |
| Coinsurance % Interval 2: <input type="text"/> | Begin Day Interval 2: <input type="text"/> | End Day Interval 2: <input type="text"/> |
| Coinsurance % Interval 3: <input type="text"/> | Begin Day Interval 3: <input type="text"/> | End Day Interval 3: <input type="text"/> |

SECTION B – 1B – INPATIENT PSYCHIATRIC HOSPITAL (B ONLY) – BASE 4 SCREEN

PBP 2010 Data Entry System - #1b Inpatient Psychiatric Hosp (B Only) - Base 4

File

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?
 Yes
 No

Indicate Copayment amount per stay:

Indicate the number of day intervals for the stay:
 Zero (No Copayment per Day)
 One
 Two
 Three

Indicate the copayment amount and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g., 1 to 999):

| | | |
|---|---|---|
| Copayment Amt Interval 1: <input type="text"/> | Begin Day Interval 1: <input type="text"/> | End Day Interval 1: <input type="text"/> |
| Copayment Amt Interval 2: <input type="text"/> | Begin Day Interval 2: <input type="text"/> | End Day Interval 2: <input type="text"/> |
| Copayment Amt Interval 3: <input type="text"/> | Begin Day Interval 3: <input type="text"/> | End Day Interval 3: <input type="text"/> |

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 Inpatient Psychiatric Hospital Services?
 Yes
 No

SECTION B – 1B – INPATIENT PSYCHIATRIC HOSPITAL (B ONLY) – BASE 5 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - #1b Inpatient Psychiatric Hosp (B Only) - Base 5". The window has a menu bar with "File" and a toolbar with minimize, maximize, and close buttons. Below the menu bar is a label "Inpatient Psychiatric Hospital Notes". Underneath is a large text area labeled "Notes (Optional):" which is currently empty. At the bottom right of the text area is a button labeled "Import Text".

SECTION B – 2 – SNF – BASE 1 SCREEN

PBP 2010 Data Entry System - #2 SNF - Base 1

File

DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes
 No

Select enhanced benefits:

Additional days beyond Medicare Covered
 Non-Medicare Covered stay

Select type of benefit for Additional Days beyond Medicare Covered:

Mandatory
 Optional

Is this benefit unlimited for Additional Days?

Yes
 No, indicate number

Indicate the number of Additional Days beyond Medicare Covered per benefit period:

Select type of benefit for the Non-Medicare Covered stay:

Mandatory
 Optional

Do you allow less than 3 day hospital stay prior to SNF admission?

Yes
 No

Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):

Zero
 One
 Two

Maximum Plan Benefit Coverage is not applicable for this Service Category.

SECTION B – 2 – SNF – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)#2 SNF - Base 2

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
 Every stay
 Other, describe

Is there an enrollee Coinsurance?
 Yes
 No

Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)
 Yes
 No

Indicate Coinsurance percentage for the Medicare Covered stay:

Indicate the number of day intervals for the Medicare Covered stay:
 Zero (No Coinsurance per Day)
 One
 Two
 Three

Indicate the coinsurance percentage and day interval(s) for Medicare Covered stay (e.g.; 1 to 20; 21 to 100):

| | | |
|---|---|---|
| Coinsurance % Interval 1: <input type="text"/> | Begin Day Interval 1: <input type="text"/> | End Day Interval 1: <input type="text"/> |
| Coinsurance % Interval 2: <input type="text"/> | Begin Day Interval 2: <input type="text"/> | End Day Interval 2: <input type="text"/> |
| Coinsurance % Interval 3: <input type="text"/> | Begin Day Interval 3: <input type="text"/> | End Day Interval 3: <input type="text"/> |

SECTION B – 2 – SNF – BASE 3 SCREEN

File

Indicate the number of day intervals for Additional Days:

Zero (No Coinsurance per Day)

One

Two

Three

Indicate the coinsurance percentage and day interval(s) for Additional Days
(enter "999" if unlimited days are offered; e.g., 101 to 999):

| | | |
|---|---|---|
| Coinsurance % Interval 1: <input type="text"/> | Begin Day Interval 1: <input type="text"/> | End Day Interval 1: <input type="text"/> |
| Coinsurance % Interval 2: <input type="text"/> | Begin Day Interval 2: <input type="text"/> | End Day Interval 2: <input type="text"/> |
| Coinsurance % Interval 3: <input type="text"/> | Begin Day Interval 3: <input type="text"/> | End Day Interval 3: <input type="text"/> |

SECTION B – 2 – SNF – BASE 4 SCREEN

PBP 2010 Data Entry System - (repaint)#2 SNF - Base 4

File

Is the Coinsurance structure for the Non-Medicare Covered stay the same as the Coinsurance structure for the Medicare Covered stay?

Yes
 No

Indicate Coinsurance percentage for the Non-Medicare Covered stay:

Indicate the number of day intervals for the Non-Medicare Covered stay:

Zero (No Coinsurance per Day)
 One
 Two
 Three

Indicate the coinsurance percentage and day interval(s) for the Non-Medicare Covered stay (enter "999" if unlimited days are offered; e.g., 1 to 999):

| | | |
|---|---|---|
| Coinsurance % Interval 1: <input type="text"/> | Begin Day Interval 1: <input type="text"/> | End Day Interval 1: <input type="text"/> |
| Coinsurance % Interval 2: <input type="text"/> | Begin Day Interval 2: <input type="text"/> | End Day Interval 2: <input type="text"/> |
| Coinsurance % Interval 3: <input type="text"/> | Begin Day Interval 3: <input type="text"/> | End Day Interval 3: <input type="text"/> |

Is there an enrollee Deductible?

Yes
 No

Indicate Deductible Amount:

SECTION B – 2 – SNF – BASE 5 SCREEN

PBP 2010 Data Entry System - #2 SNF - Base 5

File

Is there an enrollee Copayment?
 Yes
 No

Do you charge the Medicare-defined cost shares? (These are the total charges for all services provided to the enrollee in the SNF.)
 Yes
 No

Indicate Copayment amount for Medicare Covered stay:

Indicate the number of day intervals for the Medicare Covered stay:
 Zero (No Copayment per Day)
 One
 Two
 Three

Indicate the copayment amount and day interval(s) for Medicare Covered stay (e.g.; 1 to 20; 21 to 100):

| | | |
|---|---|---|
| Copayment Amt Interval 1: <input type="text"/> | Begin Day Interval 1: <input type="text"/> | End Day Interval 1: <input type="text"/> |
| Copayment Amt Interval 2: <input type="text"/> | Begin Day Interval 2: <input type="text"/> | End Day Interval 2: <input type="text"/> |
| Copayment Amt Interval 3: <input type="text"/> | Begin Day Interval 3: <input type="text"/> | End Day Interval 3: <input type="text"/> |

Indicate the number of day intervals for Additional Days:
 Zero (No Copayment per Day)
 One
 Two
 Three

Indicate the copayment amount and day interval(s) for Additional Days (enter "999" if unlimited days are offered; e.g., 101 to 999):

| | | |
|---|---|---|
| Copayment Amt Interval 1: <input type="text"/> | Begin Day Interval 1: <input type="text"/> | End Day Interval 1: <input type="text"/> |
| Copayment Amt Interval 2: <input type="text"/> | Begin Day Interval 2: <input type="text"/> | End Day Interval 2: <input type="text"/> |
| Copayment Amt Interval 3: <input type="text"/> | Begin Day Interval 3: <input type="text"/> | End Day Interval 3: <input type="text"/> |

SECTION B – 2 – SNF – BASE 6 SCREEN

PBP 2010 Data Entry System - (repaint)#2 SNF - Base 6

File

Is the Copayment structure for the Non-Medicare Covered stay the same as the Copayment structure for the Medicare Covered stay?

Yes
 No

Indicate Copayment amount for Non-Medicare covered stay:

Indicate the number of day intervals for the Non-Medicare Covered stay:

Zero (No Copayment per Day)
 One
 Two
 Three

Indicate the copayment amount and day interval(s) for the Non-Medicare Covered stay (enter "999" if unlimited days are offered; e.g.: 1 to 999):

| | | |
|---|---|---|
| Copayment Amt Interval 1: <input type="text"/> | Begin Day Interval 1: <input type="text"/> | End Day Interval 1: <input type="text"/> |
| Copayment Amt Interval 2: <input type="text"/> | Begin Day Interval 2: <input type="text"/> | End Day Interval 2: <input type="text"/> |
| Copayment Amt Interval 3: <input type="text"/> | Begin Day Interval 3: <input type="text"/> | End Day Interval 3: <input type="text"/> |

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

ESRD I Plans Only (Optional): If the beneficiary does not notify the plan of a planned inpatient admission, indicate the additional copayment amount per day:

ESRD I Plans Only (Optional): If the beneficiary does not notify the plan of a planned inpatient admission, indicate the maximum enrollee out-of-pocket cost amount per admission:

Is a referral required for SNF Services?

Yes
 No

SECTION B – 2 – SNF – BASE 7 SCREEN

PBP 2010 Data Entry System - #2 SNF - Base 7

File

SNF Notes

Notes (Optional):

Import Text

SECTION B – 2 – SNF (B ONLY) – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#2 SNF (B Only) - Base 1

File

Do you offer SNF Care as a benefit?
 Yes
 No

Select the type of benefit for SNF Care:
 Mandatory
 Optional

Does this benefit have unlimited days?
 Yes
 No, indicate number

Indicate number of days per period:

Select the days periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Every stay
 Other, describe

Is a hospital stay required before admission to a SNF?
 Yes
 No

Indicate number of days required for hospital stay:

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
 Every stay
 Other, describe

SECTION B – 2 – SNF (B ONLY) – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)#2 SNF (B Only) - Base 2

File

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

Indicate amount for Maximum Enrollee Out-of-Pocket Cost:

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

Is there an enrollee Coinsurance?
 Yes
 No

Indicate Coinsurance percentage:

Indicate the number of day intervals for the stay:
 Zero (No Coinsurance per Day)
 One
 Two
 Three

Indicate the coinsurance percentage and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g.: 1 to 999):

| | | |
|---|---|---|
| Coinsurance % Interval 1: <input type="text"/> | Begin Day Interval 1: <input type="text"/> | End Day Interval 1: <input type="text"/> |
| Coinsurance % Interval 2: <input type="text"/> | Begin Day Interval 2: <input type="text"/> | End Day Interval 2: <input type="text"/> |
| Coinsurance % Interval 3: <input type="text"/> | Begin Day Interval 3: <input type="text"/> | End Day Interval 3: <input type="text"/> |

SECTION B – 2 – SNF (B ONLY) – BASE 3 SCREEN

PBP 2010 Data Entry System - #2 SNF (B Only) - Base 3

File

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?
 Yes
 No

Indicate Copayment amount per Stay:

Indicate the number of day intervals for the stay:
 Zero (No Copayment per Day)
 One
 Two
 Three

Indicate the copayment amount and day interval(s) for the stay (enter "999" if unlimited days are offered; e.g., 1 to 999):

| | | |
|---|---|---|
| Copayment Amt Interval 1: <input type="text"/> | Begin Day Interval 1: <input type="text"/> | End Day Interval 1: <input type="text"/> |
| Copayment Amt Interval 2: <input type="text"/> | Begin Day Interval 2: <input type="text"/> | End Day Interval 2: <input type="text"/> |
| Copayment Amt Interval 3: <input type="text"/> | Begin Day Interval 3: <input type="text"/> | End Day Interval 3: <input type="text"/> |

SECTION B – 2 – SNF (B ONLY) – BASE 4 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 SNF Services?

Yes

No

Notes (Optional):

Import Text

SECTION B – 3 – CORF – BASE 1 SCREEN

DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

Maximum Plan Benefit Coverage is not applicable for this Service Category.

Is there an enrollee Coinsurance?
 Yes
 No

Indicate Coinsurance percentage for Medicare Covered Benefits:

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

Is there an enrollee Deductible?
 Yes
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate Deductible 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 Copayment?
 Yes
 No

Indicate Copayment amount per visit for Medicare Covered Benefits:

SECTION B – 3 – CORF – BASE 2 SCREEN

PBP 2010 Data Entry System - #3 CORF - Base 2

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 CORF Services?

Yes

No

Notes (Optional):

Import Text

SECTION B – 4A – EMERGENCY CARE – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#4a Emergency Care - Base 1

File

DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes
 No

Select enhanced benefit:

Worldwide Coverage

This supplemental benefit includes Worldwide coverage of urgent/emergent and post-stabilization care.

Select type of benefit for Worldwide Coverage:

Mandatory
 Optional

Is there a Maximum Plan Benefit Coverage amount for Worldwide Coverage?

Yes
 No

Indicate Maximum Plan Benefit Coverage amount:

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

Yes
 No

Indicate Maximum Enrollee Out-of-Pocket Cost 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 Maximum Enrollee Out-of-Pocket Cost periodicity:

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

SECTION B – 4A – EMERGENCY CARE – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)#4a Emergency Care - Base 2

File

Is there an enrollee Coinsurance?
 Yes
 No

Indicate Minimum Coinsurance percentage for Medicare Covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare Covered Benefits:

Is the Coinsurance for Medicare Covered Benefits waived if admitted to hospital?
 Yes
 No

Select either Days or Hours within which admission must occur for waiver:
 Days
 Hours

Enter number of Days or Hours:

Indicate Coinsurance percentage for Worldwide Coverage:

Is this Coinsurance waived for Worldwide Coverage if admitted to hospital?
 Yes
 No

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

SECTION B – 4A – EMERGENCY CARE – BASE 3 SCREEN

PBP 2010 Data Entry System - #4a Emergency Care - Base 3

File

| | |
|---|--|
| Is there an enrollee Copayment? <input type="radio"/> Yes <input type="radio"/> No | Indicate Copayment amount for Worldwide Coverage: <input type="text"/> |
| Indicate Minimum Copayment amount for Medicare Covered Benefits: <input type="text"/> | Is this Copayment for Worldwide Coverage waived if admitted to hospital? <input type="radio"/> Yes <input type="radio"/> No |
| Indicate Maximum Copayment amount for Medicare Covered Benefits: <input type="text"/> | Does ER cost sharing count towards any plan-level deductibles? <input type="radio"/> Yes <input type="radio"/> No |
| Is the Copayment for Medicare Covered Benefits waived if admitted to hospital? <input type="radio"/> Yes <input type="radio"/> No | Indicate the plan-level deductibles where ER cost sharing counts: <input type="checkbox"/> In-Network only <input type="checkbox"/> Out-of-Network only <input type="checkbox"/> Combined (In-Network and Out-of-Network) |
| Select either Days or Hours within which admission must occur for waiver: <input type="radio"/> Days <input type="radio"/> Hours | |
| Enter number of Days or Hours: <input type="text"/> | |

SECTION B – 4A – EMERGENCY CARE – BASE 4 SCREEN

File

Authorization is not applicable for this Service Category.

Referral is not applicable for this Service Category.

Notes (Optional):

Import Text

SECTION B – 4B –URGENTLY NEEDED SERVICES – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#4b Urgently Needed Services - Base 1

File

DESCRIPTION OF BENEFIT

Urgently needed services means covered services that are not emergency services provided when an enrollee is temporarily absent from the MA plan's service (or, if applicable, continuation) area (or, under unusual and extraordinary circumstances, provided

Maximum Plan Benefit Coverage is not applicable for this Service Category.

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

Yes
 No

Select the Maximum Enrollee Out-of-Pocket Cost type:

Covered under Emergency Care Service Category 4a
 Plan-specified amount per period

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 Minimum Coinsurance percentage for Medicare Covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare Covered Benefits:

Is the Coinsurance for Medicare Covered Benefits waived if admitted to hospital?

Yes
 No

Select either Days or Hours within which admission must occur for waiver:

Days
 Hours

Enter number of Days or Hours:

SECTION B – 4B – URGENTLY NEEDED SERVICES – BASE 2 SCREEN

PBP 2010 Data Entry System - #4b Urgently Needed Services - Base 2

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:

Is the Copayment for Medicare Covered Benefits waived if admitted to hospital?
 Yes
 No

Select either Days or Hours within which admission must occur for waiver:
 Days
 Hours

Enter number of Days or Hours:

SECTION B – 4B – URGENTLY NEEDED SERVICES – BASE 3 SCREEN

File

Authorization is not applicable for this Service Category.

Referral is not applicable for this Service Category.

Notes (Optional):

Import Text

SECTION B – 5 – PARTIAL HOSPITALIZATION – BASE 1 SCREEN

File

DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

Maximum Plan Benefit Coverage is not applicable for this Service Category.

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 for Medicare Covered Benefits:

Is there an enrollee Deductible?

Yes
 No

Indicate Deductible Amount:

SECTION B – 5 – PARTIAL HOSPITALIZATION – BASE 2 SCREEN

PBP 2010 Data Entry System - #5 Partial Hosp - Base 2

File

Is there an enrollee Copayment?
 Yes
 No

Indicate Copayment amount for Medicare Covered Benefits per day:

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 Partial Hospitalization?
 Yes
 No

Notes (Optional):

Import Text

SECTION B – 6 –HOME HEALTH – BASE 1 SCREEN

DESCRIPTION OF BENEFIT

Maximum Plan Benefit Coverage is not applicable for this Service Category.

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes
 No

Select enhanced benefit:

Respite Care, describe

Select type of benefit for Custodial Care:

Mandatory
 Optional

Select type of benefit for Respite Care:

Mandatory
 Optional

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 Minimum Coinsurance percentage for Medicare Covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare Covered Benefits:

SECTION B – 6 –HOME HEALTH – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)#6 Home Health - Base 2

File

Indicate Minimum Coinsurance percentage for Respite Care:

Indicate Maximum Coinsurance percentage for Respite Care:

SECTION B – 6 –HOME HEALTH – BASE 3 SCREEN

PBP 2010 Data Entry System - (repaint)#6 Home Health - Base 3

File

Is there an enrollee Deductible?

Yes

No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes

No

Indicate Minimum Copayment amount per visit for Medicare Covered Benefits:

Indicate Maximum Copayment amount per visit for Medicare Covered Benefits:

Indicate Minimum Copayment amount per visit for Respite Care:

Indicate Maximum Copayment amount per visit for Respite Care:

SECTION B – 6 –HOME HEALTH – BASE 4 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 Home Health Services?

- Yes
- No

Notes (Optional):

Import Text

SECTION B – 7A – PRIMARY CARE PHYSICIAN – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#7a Primary Care - Base 1

File

DESCRIPTION OF BENEFIT

If your plan offers in-network coverage such as through walk-in clinics or urgent care clinics during regular hours or after hours, then this benefit should be included in this category.

If cost sharing for this benefit is not the same as primary care, reflect the cost sharing in the range.

Enhanced Benefits are not applicable for this Service Category.

Maximum Plan Benefit Coverage is not applicable for this Service Category.

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

Indicate Minimum Coinsurance percentage for Medicare Covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare Covered Benefits:

Is there an enrollee Deductible?

Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes
 No

Indicate Minimum Copayment amount per visit for Medicare Covered Benefits:

Indicate Maximum Copayment amount per visit for Medicare Covered Benefits:

SECTION B – 7A – PRIMARY CARE PHYSICIAN – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)#7a Primary Care - Base 2

File

Do you offer In-Area Network Urgent Care Services?

Yes
 No

Do you have a separate Coinsurance for In-Area, Network Urgent Care services?

Yes
 No

Do you have a separate Copayment for In-Area, Network Urgent Care services?

Yes
 No

Indicate the Minimum Coinsurance percentage for In-Area, Network Urgent Care services:

Indicate the Minimum Copayment for In-Area, Network Urgent Care services:

Indicate the Maximum Coinsurance percentage for In-Area, Network Urgent Care services:

Indicate the Maximum Copayment for In-Area, Network Urgent Care services:

SECTION B – 7B – CHIROPRACTIC SERVICES – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#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

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 B – 7B – CHIROPRACTIC SERVICES – BASE 2 SCREEN

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:

Indicate the Minimum Coinsurance percentage per visit for Routine Care:

Indicate the Maximum Coinsurance percentage per visit for Routine Care:

SECTION B – 7B – CHIROPRACTIC SERVICES – BASE 3 SCREEN

PBP 2010 Data Entry System - #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 B – 7B – CHIROPRACTIC SERVICES – BASE 4 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - #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 main content area, there is a button labeled "Import Text".

SECTION B – 7C – OCCUPATIONAL THERAPY – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#7c Occupational Therapy - Base 1

File

DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

Maximum Plan Benefit Coverage is not applicable for this Service Category.

Do you apply the Medicare coverage limit?
 Yes
 No

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

Indicate Minimum Coinsurance percentage for Medicare Covered Benefits per visit:

Indicate Maximum Coinsurance percentage for Medicare Covered Benefits per visit:

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?
 Yes
 No

Indicate Minimum Copayment amount per visit for Medicare Covered Benefits:

Indicate Maximum Copayment amount per visit for Medicare Covered Benefits:

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

SECTION B – 7C – OCCUPATIONAL THERAPY – BASE 2 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 Occupational Therapy Services?

Yes

No

Notes (Optional):

Import Text

SECTION B – 7D – PHYSICIAN SPECIALIST – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#7d Physician Specialist - Base 1

File

DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

Maximum Plan Benefit Coverage is not applicable for this Service Category.

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

Indicate Minimum Coinsurance percentage for Medicare Covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare Covered Benefits:

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?
 Yes
 No

Indicate Minimum Copayment amount per visit for Medicare Covered Benefits:

Indicate Maximum Copayment amount per visit for Medicare Covered Benefits:

SECTION B – 7D – PHYSICIAN SPECIALIST – BASE 2 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 Physician Specialist Services?

- Yes
- No

Notes (Optional):

Import Text

SECTION B – 7E – MENTAL HEALTH SERVICES – BASE 1 SCREEN

PBP 2010 Data Entry System - #7e Mental Health - Base 1

File

DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

Maximum Plan Benefit Coverage is not applicable for this Service Category.

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

SECTION B – 7E – MENTAL HEALTH SERVICES – BASE 2 SCREEN

File

Is there an enrollee Coinsurance?

Yes

No

Indicate the number of session intervals for an Individual Session for the Medicare Covered Benefits:

One

Two

Three

Indicate the coinsurance percentage and session interval(s) for an Individual Session for Medicare Covered Benefits (always enter "999" as the last interval number; e.g., 1 to 10; 11 to 20; 21 to 999):

| | | |
|------------------------------------|------------------------------------|----------------------------------|
| Coinsurance % Interval 1: _____ | Begin Session Interval 1: _____ | End Session Interval 1: _____ |
| Coinsurance % Interval 2: _____ | Begin Session Interval 2: _____ | End Session Interval 2: _____ |
| Coinsurance % Interval 3: _____ | Begin Session Interval 3: _____ | End Session Interval 3: _____ |

SECTION B – 7E – MENTAL HEALTH SERVICES – BASE 3 SCREEN

PBP 2010 Data Entry System - (repaint)#7e Mental Health - Base 3

File

Indicate the number of session intervals for a Group Session for the Medicare Covered Benefits:

One
 Two
 Three

Indicate the coinsurance percentage and session interval(s) for a Group Session for Medicare Covered Benefits (always enter "999" as the last interval number; e.g., 1 to 10; 11 to 20; 21 to 999):

| | | |
|---|---|---|
| Coinsurance % Interval 1: <input type="text"/> | Begin Session Interval 1: <input type="text"/> | End Session Interval 1: <input type="text"/> |
| Coinsurance % Interval 2: <input type="text"/> | Begin Session Interval 2: <input type="text"/> | End Session Interval 2: <input type="text"/> |
| Coinsurance % Interval 3: <input type="text"/> | Begin Session Interval 3: <input type="text"/> | End Session Interval 3: <input type="text"/> |

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

SECTION B – 7E – MENTAL HEALTH SERVICES – BASE 4 SCREEN

PBP 2010 Data Entry System - #7e Mental Health - Base 4

File

Is there an enrollee Copayment?

Yes

No

Indicate the number of session intervals for an Individual Session for the Medicare Covered Benefits:

One

Two

Three

Indicate the copayment amount and session interval(s) for an Individual Session for Medicare Covered Benefits (always enter "999" as the last interval number; e.g., 1 to 10; 11 to 20; 21 to 999):

| | | |
|--|--|--|
| Copayment Amt Interval 1: <input style="width: 100%;" type="text"/> | Begin Session Interval 1: <input style="width: 100%;" type="text"/> | End Session Interval 1: <input style="width: 100%;" type="text"/> |
| Copayment Amt Interval 2: <input style="width: 100%;" type="text"/> | Begin Session Interval 2: <input style="width: 100%;" type="text"/> | End Session Interval 2: <input style="width: 100%;" type="text"/> |
| Copayment Amt Interval 3: <input style="width: 100%;" type="text"/> | Begin Session Interval 3: <input style="width: 100%;" type="text"/> | End Session Interval 3: <input style="width: 100%;" type="text"/> |

Indicate the number of session intervals for a Group Session for the Medicare Covered Benefits:

One

Two

Three

Indicate the copayment amount and session interval(s) for a Group Session for Medicare Covered Benefits (always enter "999" as the last interval number; e.g., 1 to 10; 11 to 20; 21 to 999):

| | | |
|--|--|--|
| Copayment Amt Interval 1: <input style="width: 100%;" type="text"/> | Begin Session Interval 1: <input style="width: 100%;" type="text"/> | End Session Interval 1: <input style="width: 100%;" type="text"/> |
| Copayment Amt Interval 2: <input style="width: 100%;" type="text"/> | Begin Session Interval 2: <input style="width: 100%;" type="text"/> | End Session Interval 2: <input style="width: 100%;" type="text"/> |
| Copayment Amt Interval 3: <input style="width: 100%;" type="text"/> | Begin Session Interval 3: <input style="width: 100%;" type="text"/> | End Session Interval 3: <input style="width: 100%;" type="text"/> |

SECTION B – 7E – MENTAL HEALTH SERVICES – 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 Mental Health Specialty Services - Non-Physician?

Yes

No

Notes (Optional):

Import Text

SECTION B – 7F – PODIATRY SERVICES – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#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

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 B – 7F – PODIATRY SERVICES – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)#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"/> | Is there an enrollee Deductible? <input type="radio"/> Yes <input type="radio"/> No | Indicate Maximum Copayment amount per visit for Medicare Covered Benefits: <input type="text"/> |
| | Indicate Deductible Amount: <input type="text"/> | Indicate Minimum Copayment amount per visit for Routine Footcare: <input type="text"/> |
| | | Indicate Maximum Copayment amount per visit for Routine Footcare: <input type="text"/> |

SECTION B – 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 B – 7G – OTHER HEALTH CARE PROFESSIONALS – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#7g Other Health Care - Base 1

File

DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

Maximum Plan Benefit Coverage is not applicable for this Service Category.

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

Indicate Minimum Coinsurance percentage for Medicare Covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare Covered Benefits:

Is there an enrollee Deductible?

Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes
 No

Indicate Minimum Copayment amount per visit for Medicare Covered Benefits:

Indicate Maximum Copayment amount per visit for Medicare Covered Benefits:

SECTION B – 7G – OTHER HEALTH CARE PROFESSIONALS – BASE 2 SCREEN

PBP 2010 Data Entry System - #7g Other Health Care - Base 2

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 Other Health Care Professional Services?

Yes

No

Notes (Optional):

Import Text

SECTION B – 7H – PSYCHIATRIC SERVICES – BASE 1 SCREEN

PBP 2010 Data Entry System - #7h Psychiatric Services - Base 1

File

DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

Maximum Plan Benefit Coverage is not applicable for this Service Category.

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 B – 7H – PSYCHIATRIC SERVICES – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)#7h Psychiatric Services - Base 2

File

Is there an enrollee Coinsurance?

Yes
 No

Indicate the number of session intervals for an Individual Session for the Medicare Covered Benefits:

One
 Two
 Three

Indicate the coinsurance percentage and session interval(s) for an Individual Session for Medicare Covered Benefits (always enter "999" as the last interval number; e.g., 1 to 10; 11 to 20; 21 to 999):

| | | |
|---|---|---|
| Coinsurance % Interval 1: <input type="text"/> | Begin Session Interval 1: <input type="text"/> | End Session Interval 1: <input type="text"/> |
| Coinsurance % Interval 2: <input type="text"/> | Begin Session Interval 2: <input type="text"/> | End Session Interval 2: <input type="text"/> |
| Coinsurance % Interval 3: <input type="text"/> | Begin Session Interval 3: <input type="text"/> | End Session Interval 3: <input type="text"/> |

SECTION B – 7H – PSYCHIATRIC SERVICES – BASE 3 SCREEN

PBP 2010 Data Entry System - (repaint)#7h Psychiatric Services - Base 3

File

Indicate the number of session intervals for a Group Session for the Medicare Covered Benefits:

One
 Two
 Three

Indicate the coinsurance percentage and session interval(s) for a Group Session for Medicare Covered Benefits (always enter "999" as the last interval number; e.g., 1 to 10; 11 to 20; 21 to 999):

| | | |
|---|---|---|
| Coinsurance % Interval 1: <input type="text"/> | Begin Session Interval 1: <input type="text"/> | End Session Interval 1: <input type="text"/> |
| Coinsurance % Interval 2: <input type="text"/> | Begin Session Interval 2: <input type="text"/> | End Session Interval 2: <input type="text"/> |
| Coinsurance % Interval 3: <input type="text"/> | Begin Session Interval 3: <input type="text"/> | End Session Interval 3: <input type="text"/> |

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

SECTION B – 7H – PSYCHIATRIC SERVICES – BASE 4 SCREEN

PBP 2010 Data Entry System - #7h Psychiatric Services - Base 4

File

Is there an enrollee Copayment?
 Yes
 No

Indicate the number of session intervals for an Individual Session for the Medicare Covered Benefits:
 One
 Two
 Three

Indicate the copayment amount and session interval(s) for an Individual Session for Medicare Covered Benefits (always enter "999" as the last interval number; e.g., 1 to 10; 11 to 20; 21 to 999):

| | | |
|------------------------------------|------------------------------------|----------------------------------|
| Copayment Amt Interval 1: _____ | Begin Session Interval 1: _____ | End Session Interval 1: _____ |
| Copayment Amt Interval 2: _____ | Begin Session Interval 2: _____ | End Session Interval 2: _____ |
| Copayment Amt Interval 3: _____ | Begin Session Interval 3: _____ | End Session Interval 3: _____ |

Indicate the number of session intervals for a Group Session for the Medicare Covered Benefits:
 One
 Two
 Three

Indicate the copayment amount and session interval(s) for a Group Session for Medicare Covered Benefits (always enter "999" as the last interval number; e.g., 1 to 10; 11 to 20; 21 to 999):

| | | |
|------------------------------------|------------------------------------|----------------------------------|
| Copayment Amt Interval 1: _____ | Begin Session Interval 1: _____ | End Session Interval 1: _____ |
| Copayment Amt Interval 2: _____ | Begin Session Interval 2: _____ | End Session Interval 2: _____ |
| Copayment Amt Interval 3: _____ | Begin Session Interval 3: _____ | End Session Interval 3: _____ |

SECTION B – 7H – PSYCHIATRIC SERVICES – BASE 5 SCREEN

PBP 2010 Data Entry System - #7h Psychiatric Services - Base 5

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 Psychiatric Services?

Yes

No

Notes (Optional):

Import Text

SECTION B – 7I – PHYSICAL THERAPY AND SPEECH-LANGUAGE SERVICES – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#7i PT and SP Services - Base 1

File

DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

Maximum Plan Benefit Coverage is not applicable for this Service Category.

Do you apply the Medicare coverage limit?
 Yes
 No

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

Indicate Minimum Coinsurance percentage per visit for Medicare Covered Benefits:

Indicate Maximum Coinsurance percentage per visit for Medicare Covered Benefits:

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?
 Yes
 No

Indicate Minimum Copayment amount per visit for Medicare Covered Benefits:

Indicate Maximum Copayment amount per visit for Medicare Covered Benefits:

Is there a separate cost share for the facility in which the service is received?
 Yes
 No

SECTION B – 7I – PHYSICAL THERAPY AND SPEECH-LANGUAGE SERVICES – BASE 2 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 Physical Therapy and Speech-Language Therapy Services?

Yes

No

Notes (Optional):

Import Text

SECTION B – 8A – OUTPATIENT DIAGNOSTIC PROCEDURES AND TESTS AND LAB SERVICES – BASE 1 SCREEN

The screenshot shows a web browser window titled "PBP 2010 Data Entry System - (repaint)#8a Outpatient Diag Procs/Tests/Lab Services - Base 1". The page content is as follows:

DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

Maximum Plan Benefit Coverage is not applicable for this Service Category.

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

SECTION B – 8A – OUTPATIENT DIAGNOSTIC PROCEDURES AND TESTS AND LAB SERVICES – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)#8a Outpatient Diag Procs/Tests/Lab Services - Base 2

File

Is there an enrollee Coinsurance?

Yes

No

Indicate Minimum Coinsurance percentage for Medicare Covered Diagnostic Procedures/Tests:

Indicate Maximum Coinsurance percentage for Medicare Covered Diagnostic Procedures/Tests:

Indicate Minimum Coinsurance percentage for Medicare Covered Lab Services:

Indicate Maximum Coinsurance percentage for Medicare Covered Lab Services:

SECTION B – 8A – OUTPATIENT DIAGNOSTIC PROCEDURES AND TESTS AND LAB SERVICES – BASE 3 SCREEN

PBP 2010 Data Entry System - (repaint)#8a Outpatient Diag Procs/Tests/Lab 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 Diagnostic Procedures/Tests:

Indicate Maximum Copayment amount for Medicare Covered Diagnostic Procedures/Tests:

Indicate Minimum Copayment amount for Medicare Covered Lab Services:

Indicate Maximum Copayment amount for Medicare Covered Lab Services:

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

SECTION B – 8A – OUTPATIENT DIAGNOSTIC PROCEDURES AND TESTS AND LAB SERVICES – BASE 4 SCREEN

PBP 2010 Data Entry System - #8a Outpatient Diag Procs/Tests/Lab Services - Base 4

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 Outpatient Diagnostic Procedures/Test/Lab Services?

Yes

No

Notes (Optional):

Import Text

SECTION B – 8B – OUTPATIENT DIAGNOSTIC AND THERAPEUTIC RADIOLOGICAL SERVICES – BASE 1 SCREEN

DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

Maximum Plan Benefit Coverage is not applicable for this Service Category.

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 Minimum Coinsurance percentage for Medicare Covered X-Ray Services:

Indicate Maximum Coinsurance percentage for Medicare Covered X-Ray Services:

SECTION B – 8B – OUTPATIENT DIAGNOSTIC AND THERAPEUTIC RADIOLOGICAL SERVICES – BASE 2 SCREEN

The screenshot shows a window titled "PBP 2010 Data Entry System - (repaint)#8b Outpatient Diag/Therapeutic Rad Services - Base 2". The window has a "File" menu bar. The main content area contains four vertically stacked input boxes, each with a label and a text input field:

- Indicate Minimum Coinsurance percentage for Medicare Covered Diagnostic Radiological Services:
- Indicate Maximum Coinsurance percentage for Medicare Covered Diagnostic Radiological Services:
- Indicate Minimum Coinsurance percentage for other Medicare Covered Therapeutic Radiological Services:
- Indicate Maximum Coinsurance percentage for other Medicare Covered Therapeutic Radiological Services:

SECTION B – 8B – OUTPATIENT DIAGNOSTIC AND THERAPEUTIC RADIOLOGICAL SERVICES – BASE 3 SCREEN

PBP 2010 Data Entry System - #8b Outpatient Diag/Therapeutic Rad 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 X-Ray Services:

Indicate Maximum Copayment amount for Medicare Covered X-Ray Services:

Indicate Minimum Copayment amount for other Medicare Covered Diagnostic Radiological Services:

Indicate Maximum Copayment amount for other Medicare Covered Diagnostic Radiological Services:

Indicate Minimum Copayment amount for Medicare Covered Therapeutic Radiological Services:

Indicate Maximum Copayment amount for Medicare Covered Therapeutic Radiological Services:

Indicate whether a separate office visit cost share applies for services:
 Yes
 No
 Sometimes, describe

Is there a separate cost share for the facility in which the service is received?
 Yes
 No

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 Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?
 Yes
 No

SECTION B – 8B – OUTPATIENT DIAGNOSTIC AND THERAPEUTIC RADIOLOGICAL SERVICES – BASE 4 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - #8b Outpatient Diag/Therapeutic Rad 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 sections: a header box containing the text "Outpatient Diagnostic and Therapeutic Radiological Services Notes", a label "Notes (Optional):" followed by a large, empty rectangular text input area, and a button labeled "Import Text" located in the bottom right corner of the text area.

SECTION B – 9A – OUTPATIENT HOSPITAL – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#9a Outpatient Hospital - Base 1

File

DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

Maximum Plan Benefit Coverage is not applicable for this Service Category.

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 Minimum Coinsurance percentage for Medicare Covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare Covered Benefits:

SECTION B – 9A – OUTPATIENT HOSPITAL – BASE 2 SCREEN

File

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?
 Yes
 No

Indicate Minimum Copayment amount per visit for Medicare Covered Benefits:

Indicate Maximum Copayment amount per visit for Medicare Covered Benefits:

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

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 Outpatient Hospital Services?
 Yes
 No

SECTION B – 9A – OUTPATIENT HOSPITAL – BASE 3 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - #9a Outpatient Hospital - Base 3". 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 sections. At the top, there is a label "Outpatient Hospital Services Notes". Below this is a section labeled "Notes (Optional):" which contains a large, empty rectangular text input area. In the bottom right corner of this text area, there is a button labeled "Import Text".

SECTION B – 9B – AMBULATORY SURGICAL CENTER SERVICES – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#9b ASC Services - Base 1

File

DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

Maximum Plan Benefit Coverage is not applicable for this Service Category.

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

Yes
 No

Select the Maximum Enrollee Out-of-Pocket Cost type:

Covered under Outpatient Hospital Services Category 9a
 Plan-specified amount per period

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 Minimum Coinsurance percentage for Medicare Covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare Covered Benefits:

SECTION B – 9B – AMBULATORY SURGICAL CENTER SERVICES – BASE 2 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - (repaint)#9b ASC Services - Base 2". The window has a "File" menu bar. The main content area is divided into several sections:

- Is there an enrollee Deductible?**
 - Yes
 - No
- Indicate Deductible Amount:**
 -
- Is there an enrollee Copayment?**
 - Yes
 - No
- Indicate Minimum Copayment amount per visit for Medicare Covered Benefits:**
 -
- Indicate Maximum Copayment amount per visit for Medicare Covered Benefits:**
 -
- You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.**
- 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 Ambulatory Surgical Center Services?**
 - Yes
 - No

SECTION B – 9B – AMBULATORY SURGICAL CENTER SERVICES – BASE 3 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - #9b ASC Services - Base 3". 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 "ASC Services Notes", a section labeled "Notes (Optional):" which contains a large, empty text area for input, and a button labeled "Import Text" located in the bottom right corner of the main content area.

SECTION B – 9C – OUTPATIENT SUBSTANCE ABUSE SERVICES – BASE 1 SCREEN

PBP 2010 Data Entry System - #9c Outpatient Sub Abuse - Base 1

File

DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

Maximum Plan Benefit Coverage is not applicable for this Service Category.

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

Yes

No

Select the Maximum Enrollee Out-of-Pocket Cost type:

Covered under Outpatient Hospital Services Category 9a

Plan-specified amount per period

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

SECTION B – 9C – OUTPATIENT SUBSTANCE ABUSE SERVICES – BASE 2 SCREEN

File

Is there an enrollee Coinsurance?

Yes

No

Indicate the number of session intervals for an Individual Session for the Medicare Covered Benefits:

One

Two

Three

Indicate the coinsurance percentage and session interval(s) for an Individual Session for Medicare Covered Benefits (always enter "999" as the last interval number; e.g., 1 to 10; 11 to 20; 21 to 999):

| | | |
|---|---|---|
| Coinsurance % Interval 1: <input type="text"/> | Begin Session Interval 1: <input type="text"/> | End Session Interval 1: <input type="text"/> |
| Coinsurance % Interval 2: <input type="text"/> | Begin Session Interval 2: <input type="text"/> | End Session Interval 2: <input type="text"/> |
| Coinsurance % Interval 3: <input type="text"/> | Begin Session Interval 3: <input type="text"/> | End Session Interval 3: <input type="text"/> |

SECTION B – 9C – OUTPATIENT SUBSTANCE ABUSE SERVICES – BASE 3 SCREEN

PBP 2010 Data Entry System - (repaint)#9c Outpatient Sub Abuse - Base 3

File

Indicate the number of session intervals for a Group Session for the Medicare Covered Benefits:

One
 Two
 Three

Indicate the coinsurance percentage and session interval(s) for a Group Session for Medicare Covered Benefits (always enter "999" as the last interval number; e.g., 1 to 10; 11 to 20; 21 to 999):

| | | |
|---|---|---|
| Coinsurance % Interval 1: <input type="text"/> | Begin Session Interval 1: <input type="text"/> | End Session Interval 1: <input type="text"/> |
| Coinsurance % Interval 2: <input type="text"/> | Begin Session Interval 2: <input type="text"/> | End Session Interval 2: <input type="text"/> |
| Coinsurance % Interval 3: <input type="text"/> | Begin Session Interval 3: <input type="text"/> | End Session Interval 3: <input type="text"/> |

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

SECTION B – 9C – OUTPATIENT SUBSTANCE ABUSE SERVICES – BASE 4 SCREEN

PBP 2010 Data Entry System - #9c Outpatient Sub Abuse - Base 4

File

Is there an enrollee Copayment?
 Yes
 No

Indicate the number of session intervals for an Individual Session for the Medicare Covered Benefits:
 One
 Two
 Three

Indicate the copayment amount and session interval(s) for an Individual Session for Medicare Covered Benefits (always enter "999" as the last interval number; e.g., 1 to 10; 11 to 20; 21 to 999):

| | | |
|---|---|---|
| Copayment Amt Interval 1: <input type="text"/> | Begin Session Interval 1: <input type="text"/> | End Session Interval 1: <input type="text"/> |
| Copayment Amt Interval 2: <input type="text"/> | Begin Session Interval 2: <input type="text"/> | End Session Interval 2: <input type="text"/> |
| Copayment Amt Interval 3: <input type="text"/> | Begin Session Interval 3: <input type="text"/> | End Session Interval 3: <input type="text"/> |

Indicate the number of session intervals for a Group Session for the Medicare Covered Benefits:
 One
 Two
 Three

Indicate the copayment amount and session interval(s) for a Group Session for Medicare Covered Benefits (always enter "999" as the last interval number; e.g., 1 to 10; 11 to 20; 21 to 999):

| | | |
|---|---|---|
| Copayment Amt Interval 1: <input type="text"/> | Begin Session Interval 1: <input type="text"/> | End Session Interval 1: <input type="text"/> |
| Copayment Amt Interval 2: <input type="text"/> | Begin Session Interval 2: <input type="text"/> | End Session Interval 2: <input type="text"/> |
| Copayment Amt Interval 3: <input type="text"/> | Begin Session Interval 3: <input type="text"/> | End Session Interval 3: <input type="text"/> |

SECTION B – 9C – OUTPATIENT SUBSTANCE ABUSE SERVICES – BASE 5 SCREEN

PBP 2010 Data Entry System - (repaint)#9c Outpatient Sub Abuse - Base 5

File

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

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 Outpatient Substance Abuse Services?

Yes

No

Notes (Optional):

Import Text

SECTION B – 9D – CARDIAC REHAB SERVICES – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#9d Cardiac Rehab Services - Base 1

File

DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

Maximum Plan Benefit Coverage is not applicable for this Service Category.

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

Yes
 No

Select the Maximum Enrollee Out-of-Pocket Cost type:

Covered under Outpatient Hospital Services Category 9a
 Plan-specified amount per period

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 Minimum Coinsurance percentage for Medicare Covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare Covered Benefits:

SECTION B – 9D – CARDIAC REHAB SERVICES – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)#9d Cardiac Rehab Services - Base 2

File

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?
 Yes
 No

Indicate Minimum Copayment amount per visit for Medicare Covered Benefits:

Indicate Maximum Copayment amount per visit for Medicare Covered Benefits:

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

Is there a separate cost share for the facility in which the service is received?
 Yes
 No

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

SECTION B – 9D – CARDIAC REHAB SERVICES – BASE 3 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - #9d Cardiac Rehab Services - Base 3". 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 light gray and contains a label "Cardiac Rehabilitation Services Notes" above a larger label "Notes (Optional):". Below these labels is a large, empty white rectangular box for text entry. At the bottom right of this box is a button labeled "Import Text".

SECTION B – 10A – AMBULANCE – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#10a Ambulance - Base 1

File

| | | |
|--|--|--|
| DESCRIPTION OF BENEFIT | Is there an enrollee Coinsurance? <input type="radio"/> Yes <input type="radio"/> No | Is there an enrollee Copayment? <input type="radio"/> Yes <input type="radio"/> No |
| Enhanced Benefits are not applicable for this Service Category. | Indicate the Minimum Coinsurance percentage for Medicare Covered Benefits: _____ | Indicate the Minimum Copayment amount for Medicare Covered Benefits: _____ |
| Maximum Plan Benefit Coverage is not applicable for this Service Category. | Indicate the Maximum Coinsurance percentage for Medicare Covered Benefits: _____ | Indicate the Maximum Copayment amount for Medicare Covered Benefits: _____ |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? <input type="radio"/> Yes <input type="radio"/> No | Is this Coinsurance waived if admitted to hospital? <input type="radio"/> Yes <input type="radio"/> No | Is this Copayment waived if admitted to hospital? <input type="radio"/> Yes <input type="radio"/> No |
| Indicate Maximum Enrollee Out-of-Pocket Cost amount: _____ | Is there an enrollee Deductible? <input type="radio"/> Yes <input type="radio"/> No | |
| Select Maximum Enrollee Out-of-Pocket Cost 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 | Indicate Deductible Amount: _____ | |

SECTION B – 10A – AMBULANCE – BASE 2 SCREEN

File

Enrollee must receive Authorization for non-emergency Medicare services 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 Ambulance Services?

Yes

No

Notes (Optional):

Import Text

SECTION B – 10B – TRANSPORTATION – BASE 1 SCREEN

PBP 2010 Data Entry System - #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 B – 10B – TRANSPORTATION – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)#10b Transportation - 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 Coinsurance percentage:</p> <input type="text"/> |
| <p>Select 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>Is there an enrollee Deductible?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> |
| | | <p>Indicate Deductible Amount:</p> <input type="text"/> |

SECTION B – 10B – TRANSPORTATION – BASE 3 SCREEN

PBP 2010 Data Entry System - #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 B – 11A – DME – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#11a DME - Base 1

File

| | | |
|---|--|---|
| DESCRIPTION OF BENEFIT | Select Maximum Enrollee Out-of-Pocket Cost 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 | Is there an enrollee Deductible? <input type="radio"/> Yes <input type="radio"/> No |
| Enhanced Benefits are not applicable for this Service Category. | | Indicate Deductible Amount: <input type="text"/> |
| Maximum Plan Benefit Coverage is not applicable for this Service Category. | | |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? <input type="radio"/> Yes <input type="radio"/> No | Is there an enrollee Coinsurance? <input type="radio"/> Yes <input type="radio"/> No | Is there an enrollee Copayment? <input type="radio"/> Yes <input type="radio"/> No |
| Indicate Maximum Enrollee Out-of-Pocket Cost amount: <input type="text"/> | Indicate Minimum Coinsurance percentage for Medicare Covered Benefits: <input type="text"/> | Indicate Minimum Copayment amount per item for Medicare Covered Benefits: <input type="text"/> |
| | Indicate Maximum Coinsurance percentage for Medicare Covered Benefits: <input type="text"/> | Indicate Maximum Copayment amount per item for Medicare Covered Benefits: <input type="text"/> |

SECTION B – 11A – DME – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)#11a DME - Base 2

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

ESRD I Plans Only (Optional): Enter the maximum amount of an equipment or device purchase that the plan would allow before charging the beneficiary a penalty for not receiving prior authorization from the plan:

ESRD I Plans Only (Optional): Enter the percentage of billed charges that a beneficiary must pay if prior authorization is not received from the plan:

Referral is not applicable for this Service Category.

Notes (Optional):

Import Text

SECTION B – 11B – PROSTHETICS AND MEDICAL SUPPLIES – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#11b Pros./Med, Supp. - Base 1

File

DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

Maximum Plan Benefit Coverage is not applicable for this Service Category.

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

Yes
 No

Select Maximum Enrollee Out-of-Pocket Cost type:

Covered under DME Category 11a
 Plan-specified amount per period

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 Minimum Coinsurance percentage for Medicare Covered Prosthetic Devices:

Indicate Maximum Coinsurance percentage for Medicare Covered Prosthetic Devices:

SECTION B – 11B – PROSTHETICS AND MEDICAL SUPPLIES – BASE 2 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - (repaint)#11b Pros./Med. Supp. - Base 2". The window has a "File" menu and standard window controls (minimize, maximize, close). The main content area contains the following fields and options:

- Indicate Minimum Coinsurance percentage for Medicare Covered Medical Supplies:** [Text input field]
- Indicate Maximum Coinsurance percentage for Medicare Covered Medical Supplies:** [Text input field]
- Is there an enrollee Deductible?**
 - Yes
 - No
- Indicate Deductible Amount:** [Text input field]
- Is there an enrollee Copayment?**
 - Yes
 - No
- Indicate Minimum Copayment amount per item for Medicare Covered Prosthetic Devices:** [Text input field]
- Indicate Maximum Copayment amount per item for Medicare Covered Prosthetic Devices:** [Text input field]
- Indicate Minimum Copayment amount per item for Medicare Covered Medical Supplies:** [Text input field]
- Indicate Maximum Copayment amount per item for Medicare Covered Medical Supplies:** [Text input field]

SECTION B – 11B – PROSTHETICS AND MEDICAL SUPPLIES – BASE 3 SCREEN

PBP 2010 Data Entry System - (repaint)#11b Pros./Med, Supp. - Base 3

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

Notes (Optional):

ESRD I Plans Only (Optional): Enter the maximum amount of an equipment or device purchase that the plan would allow before charging the beneficiary a penalty for not receiving prior authorization from the plan:

PFFS and ESRD I Plans Only (Optional): Enter the percentage of billed charges that a beneficiary must pay if prior authorization is not received from the plan:

Referral is not applicable for this Service Category.

Import Text

SECTION B – 11C – DIABETES MONITORING SUPPLIES – BASE 1 SCREEN

DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

Maximum Plan Benefit Coverage is not applicable for this Service Category.

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

Yes
 No

Select Maximum Enrollee Out-of-Pocket Cost type:

Covered under DME Category 11a
 Plan-specified amount per period

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 Minimum Coinsurance percentage for Medicare Covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare Covered Benefits:

SECTION B – 12 – RENAL DIALYSIS – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#12 End-Stage Renal Disease - Base 1

File

DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

Maximum Plan Benefit Coverage is not applicable for this Service Category.

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 Minimum Coinsurance percentage for Medicare Covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare Covered Benefits:

Is there an enrollee Deductible?

Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?

Yes
 No

Indicate Minimum Copayment amount per session for Medicare Covered Benefits:

Indicate Maximum Copayment amount per session for Medicare Covered Benefits:

Is there a separate cost share for the facility in which the service is received?

Yes
 No

SECTION B – 12 – RENAL DIALYSIS – BASE 2 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 End-Stage Renal Disease?

- Yes
- No

Notes (Optional):

Import Text

SECTION B – 13A – BLOOD SERVICES – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#13a Blood - Base 1

File

DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes
 No

Select enhanced benefit:

Three (3) pint deductible waived

Select type of benefit for Three (3) Pint Deductible Waived:

Mandatory
 Optional

Maximum Plan Benefit Coverage is not applicable for this Service Category.

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 for Medicare Covered Benefits:

SECTION B – 13A – BLOOD SERVICES – BASE 2 SCREEN

PBP 2010 Data Entry System - #13a Blood - Base 2

File

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?
 Yes
 No

Indicate Copayment amount per unit for Medicare Covered Benefits:

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 Outpatient Blood Services?
 Yes
 No

Notes (Optional):

Import Text

SECTION B – 13B – ACUPUNCTURE – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#13b Acupuncture - Base 1

File

DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes
 No

Select enhanced benefit:

Number of Treatments

Select the type of benefit for Number of Treatments:

Mandatory
 Optional

Is this benefit unlimited for Number of Treatments?

Yes
 No

Indicate limit for Number of Treatments:

Indicate Number of Treatments 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:

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 Enrollee Out-of-Pocket Cost?

Yes
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:

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

SECTION B – 13B – ACUPUNCTURE – BASE 2 SCREEN

The screenshot shows a window titled "PBP 2010 Data Entry System - (repaint)#13b Acupuncture - Base 2". The window contains the following form elements:

- Is there an enrollee Coinsurance?**
 - Yes
 - No
- Indicate Coinsurance percentage:**
- Is there an enrollee Copayment?**
 - Yes
 - No
- Indicate Copayment amount per treatment:**
- Is there an enrollee Deductible?**
 - Yes
 - No
- Indicate Deductible Amount:**
- 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 Acupuncture Services?**
 - Yes
 - No

SECTION B – 13B – ACUPUNCTURE – BASE 3 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - #13b Acupuncture - Base 3". 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 "Acupuncture Notes" field at the top, followed by a "Notes (Optional):" label and a large, empty text input area. At the bottom right of the text area, there is a button labeled "Import Text".

SECTION B – 13C – PART-C OTC DRUGS – BASE 1 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - (repaint)#13c OTC - Base 1". The window has a "File" menu bar. The main content area contains several form sections:

- Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?**
 - Yes
 - No
- Select the type of benefit for OTC items:**
 - Mandatory
 - Optional
- Is there a service-specific Maximum Plan Benefit Coverage amount?**
 - Yes
 - No
- Indicate Maximum Plan Benefit Coverage amount:**
- 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 Enrollee Out-of-Pocket Cost?**
 - Yes
 - No
- Indicate Maximum Enrollee Out-of-Pocket Cost amount:**
- Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:**
 - Every three years
 - Every two years
 - Every year
 - Every six months
 - Every three months
 - Other, describe

SECTION B – 13C – PART-C OTC DRUGS – BASE 2 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - (repaint)#13c OTC - Base 2". The window has a standard Windows-style title bar with minimize, maximize, and close buttons. Below the title bar is a menu bar with "File". The main content area contains several form panels:

- Is there an enrollee Coinsurance?**
 - Yes
 - No
- Indicate Coinsurance percentage:**
 -
- Is there an enrollee Deductible?**
 - Yes
 - No
- Indicate Deductible Amount:**
 -
- Is there an enrollee Copayment?**
 - Yes
 - No
- Indicate Copayment amount:**
 -
- 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 OTC Items?**
 - Yes
 - No
- Does this cover all of the FSA Feds OTC list?**
 - Yes
 - No

SECTION B – 13C – PART-C OTC DRUGS – BASE 3 SCREEN

The screenshot shows a standard Windows-style application window. The title bar contains the text "PBP 2010 Data Entry System - (repaint)#13c OTC - Base 3" and standard 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 small rectangular field labeled "OTC Notes" at the top; a larger section labeled "Notes (Optional):" which contains a large, empty text box for input; and a small button labeled "Import Text" located in the bottom right corner of the main content area.

SECTION B – 13D – MEAL BENEFIT – BASE 1 SCREEN

File

Does the plan provide a Meal Benefit as a supplemental benefit under Part C?

Yes
 No

Select the type of benefit:

Mandatory
 Optional

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

Yes
 No

Indicate Maximum Plan Benefit Coverage amount:

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 Enrollee Out-of-Pocket Cost?

Yes
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:

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

SECTION B – 13D – MEAL BENEFIT – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)#13d Meal Benefit - Base 2

File

Is there an enrollee Coinsurance?
 Yes
 No

Indicate Coinsurance percentage:

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?
 Yes
 No

Indicate Copayment amount:

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 the Meal Benefit?
 Yes
 No

SECTION B – 13D – MEAL BENEFIT – BASE 3 SCREEN

The screenshot shows a standard Windows-style application window. The title bar contains the text "PBP 2010 Data Entry System - (repaint)#13d Meal Benefit - Base 3" and standard minimize, maximize, and close buttons. Below the title bar is a menu bar with a "File" option. The main content area is divided into two sections: a smaller "Meal Benefit Notes" section at the top and a larger "Notes (Optional):" section below it. The "Notes (Optional):" section is a large, empty text input area. In the bottom right corner of the main content area, there is a button labeled "Import Text".

SECTION B – 13E – OTHER – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#13e Other - Base 1

File

Note: After completing your data entry in this category, if you delete ALL text in the 'Enter name of Service (Optional):' field you will lose all previously entered data.

You may edit the name of the service text partially without losing all previously entered data.

Do not put Medicare-covered benefits in this service category (e.g., do not include home health, nutritional support, respite, transportation, medical devices etc).

Over-the-Counter (e.g., adult diapers, band-aids, etc) benefits should only be entered in B-13C.

Enter name of Service (Optional):

Select the type of benefit:

- Mandatory
- Optional

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

- Yes
- No

Indicate Maximum Plan Benefit Coverage amount:

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 Enrollee Out-of-Pocket Cost?

- Yes
- No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate Maximum Enrollee Out-of-Pocket Cost periodicity:

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

SECTION B – 13E – OTHER – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)#13e Other - Base 2

File

Is there an enrollee Coinsurance?
 Yes
 No

Indicate Coinsurance percentage:

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?
 Yes
 No

Indicate Copayment amount:

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 Other Services?
 Yes
 No

SECTION B – 13E – OTHER – BASE 3 SCREEN

The screenshot shows a window titled "PBP 2010 Data Entry System - (repaint)#13e Other - Base 3". The window has a "File" menu bar. Below the menu bar, there is a section labeled "Other Services Notes" which is currently empty. Below that is a section labeled "Notes (Optional):" which contains a large, empty text area. In the bottom right corner of the text area, there is a button labeled "Import Text".

SECTION B – 14A – HEALTH EDUCATION AND WELLNESS – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#14a Health Ed/Wellness - 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 benefit:

- Written health education materials, incl. newsletters
- Nutritional Training
- Nutritional Benefit
- Additional Smoking Cessation
- Membership in Health Club/Fitness Classes
- Nursing Hotline
- Other, describe

Select type of benefit for Written health education materials, incl. newsletters:

Mandatory
 Optional

Select type of benefit for Nutritional Training:

Mandatory
 Optional

Select type of benefit for Nutritional Benefit:

Mandatory
 Optional

Select type of benefit for Additional Smoking Cessation:

Mandatory
 Optional

Select type of benefit for Membership in Health Club/Fitness Classes:

Mandatory
 Optional

Select type of benefit for Nursing Hotline:

Mandatory
 Optional

Select type of benefit for Other:

Mandatory
 Optional

SECTION B – 14A – HEALTH EDUCATION AND WELLNESS – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)#14a Health Ed/Wellness - Base 2

File

| | | |
|--|--|--|
| Is there a service-specific Maximum Plan Benefit Coverage amount? <input type="radio"/> Yes <input type="radio"/> No | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? <input type="radio"/> Yes <input type="radio"/> No | Is there an enrollee Coinsurance? <input type="radio"/> Yes <input type="radio"/> No |
| Indicate Maximum Plan Benefit Coverage amount: <input type="text"/> | Indicate Maximum Enrollee Out-of-Pocket Cost amount: <input type="text"/> | Indicate the Minimum Coinsurance percentage for the Medicare-Covered Smoking Cessation <input type="text"/> |
| Select Maximum Plan Benefit Coverage 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 Maximum Enrollee Out-of-Pocket Cost 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 | Indicate the Maximum Coinsurance percentage for the Medicare-Covered Smoking Cessation benefit: <input type="text"/> |
| | | Indicate Minimum Coinsurance percentage for Written health education materials, incl. newsletters: <input type="text"/> |
| | | Indicate Maximum Coinsurance percentage for Written health education materials, incl. newsletters: <input type="text"/> |
| | | Indicate Coinsurance percentage for Nutritional Benefit: <input type="text"/> |
| | | Indicate Coinsurance percentage for Nutritional Training: <input type="text"/> |

SECTION B – 14A – HEALTH EDUCATION AND WELLNESS – BASE 3 SCREEN

File

| | | |
|---|--|--|
| Is there an enrollee Deductible? <input type="radio"/> Yes <input type="radio"/> No | Indicate Copayment amount for Nutritional Training: <input type="text"/> | Indicate Copayment amount for Nursing Hotline: <input type="text"/> |
| Indicate Deductible Amount: <input type="text"/> | Indicate Copayment amount for Nutritional Benefit: <input type="text"/> | Indicate Minimum Copayment amount for Other: <input type="text"/> |
| Is there an enrollee Copayment? <input type="radio"/> Yes <input type="radio"/> No | Indicate Copayment amount for Additional Smoking Cessation: <input type="text"/> | Indicate Maximum Copayment amount for Other: <input type="text"/> |
| Indicate the Minimum Copayment amount for the Medicare-Covered Smoking Cessation benefit: <input type="text"/> | Indicate Minimum Copayment amount for Membership in Health Club/Fitness Classes: <input type="text"/> | |
| Indicate the Maximum Copayment amount for the Medicare-Covered Smoking Cessation benefit: <input type="text"/> | Indicate Maximum Copayment amount for Membership in Health Club/Fitness Classes: <input type="text"/> | |
| Indicate Copayment amount for Written health education materials, incl. newsletters: <input type="text"/> | | |

SECTION B – 14A – HEALTH EDUCATION AND WELLNESS – BASE 4 SCREEN

PBP 2010 Data Entry System - (repaint)#14a Health Ed/Wellness - Base 4

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 Health Education/Wellness Programs?

Yes

No

Notes (Optional):

Import Text

SECTION B – 14B – IMMUNIZATIONS – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#14b Immunizations - Base 1

File

DESCRIPTION OF BENEFIT

Maximum Plan Benefit Coverage is not applicable for this Service Category.

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes
 No

Select enhanced benefit:

Other Immunizations, describe

Select type of benefit for Other Immunizations:

Mandatory
 Optional

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

Yes
 No

Select the Maximum Enrollee Out-of-Pocket Cost type:

Covered under the Preventive Services Category 14a
 Plan-specified amount per period

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 for Medicare Covered Benefits - Hepatitis B:

SECTION B – 14B – IMMUNIZATIONS – BASE 2 SCREEN

File

Indicate Minimum Coinsurance percentage for Other Immunizations:

Indicate Maximum Coinsurance percentage for Other Immunizations:

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?
 Yes
 No

Indicate Copayment amount per unit for Medicare Covered Benefits - Hepatitis B:

Indicate Minimum Copayment amount for Other Immunizations:

Indicate Maximum Copayment amount for Other Immunizations:

Indicate whether a separate office visit cost share applies for services:
 Yes
 No
 Sometimes, describe

SECTION B – 14B – IMMUNIZATIONS – BASE 3 SCREEN

PBP 2010 Data Entry System - #14b Immunizations - Base 3

File

Enrollee must receive Authorization from one or more of the following, except for Influenza Immunization:

- 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 Other Immunizations?

Yes

No

Notes (Optional):

Import Text

SECTION B – 14C –PHYSICAL EXAMS – BASE 1 SCREEN

PBP 2010 Data Entry System - #14c Physical Exams - Base 1

File

DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes

No

Select enhanced benefit:

Routine Exams

Select the type of benefit for Routine Exams:

Mandatory

Optional

Is this benefit unlimited for Routine Exams?

Yes

No, indicate number

Indicate limit for Routine Exams:

Select the Routine Exams periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, describe

SECTION B – 14C – PHYSICAL EXAMS – BASE 2 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - (repaint)#14c Physical Exams - Base 2". The window has a "File" menu bar. The main content area is divided into two columns of form fields. Each column contains a question with radio button options, a selection of types with radio button options, a text input field for an amount, and a selection of periodicity with radio button options.

| Field | Options |
|---|---|
| Is there a service-specific Maximum Plan Benefit Coverage amount? | <input type="radio"/> Yes <input type="radio"/> No |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? | <input type="radio"/> Yes <input type="radio"/> No |
| Select the Maximum Plan Benefit Coverage type: | <input type="radio"/> Covered under Preventive Services Category 14a <input type="radio"/> Plan-specified amount per period |
| Select the Maximum Enrollee Out-of-Pocket Cost type: | <input type="radio"/> Covered under Preventive Services Category 14a <input type="radio"/> Plan-specified amount per period |
| Indicate Maximum Plan Benefit Coverage amount: | [Text Input Field] |
| Indicate Maximum Enrollee Out-of-Pocket Cost amount: | [Text Input Field] |
| Select the Maximum Plan Benefit Coverage 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 Maximum Enrollee Out-of-Pocket Cost 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 B – 14C – PHYSICAL EXAMS – BASE 3 SCREEN

PBP 2010 Data Entry System - (repaint)#14c Physical Exams - Base 3

File

| | |
|--|---|
| Is there an enrollee Coinsurance? <input type="radio"/> Yes <input type="radio"/> No | Is there an enrollee Copayment? <input type="radio"/> Yes <input type="radio"/> No |
| Indicate Coinsurance percentage for Medicare-Covered initial preventive physical exam: <input type="text"/> | Indicate Copayment amount for Medicare-Covered initial preventive physical exam: <input type="text"/> |
| Indicate Coinsurance percentage for Routine Exams: <input type="text"/> | Indicate Copayment amount per Routine Exam: <input type="text"/> |
| Is there an enrollee Deductible? <input type="radio"/> Yes <input type="radio"/> No | Indicate whether a separate office visit cost share applies for services: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes, describe |
| Indicate Deductible Amount: <input type="text"/> | Enrollee must receive Authorization from one or more of the following: <input type="checkbox"/> None <input type="checkbox"/> Primary Care Physician (Internist/Family Practice, General Practice) <input type="checkbox"/> Physician Specialist <input type="checkbox"/> Organization Medical Director/Utilization Management/Utilization Review <input type="checkbox"/> Other, describe |
| | Is a referral required for Routine Exams? <input type="radio"/> Yes <input type="radio"/> No |

SECTION B – 14C –PHYSICAL EXAMS – BASE 4 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - #14c Physical Exams - 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 "Routine Exam Notes" text box at the top; a "Notes (Optional):" section below it, which contains a large, empty white rectangular area for text entry; and an "Import Text" button located in the bottom right corner of the main content area. The background of the window is a light gray color.

SECTION B – 14D – PAP/PELVIC EXAMS – BASE 1 SCREEN

PBP 2010 Data Entry System - #14d Pap/Pelvic - Base 1

File

DESCRIPTION OF BENEFIT

Indicate number of Additional Pap Smears:

Select the type of benefit for Additional Pelvic Exams:
 Mandatory
 Optional

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

Select enhanced benefits:
 Additional Pap Smears
 Additional Pelvic Exams

Select the type of benefit for Additional Pap Smears:
 Mandatory
 Optional

Is this benefit unlimited for Additional Pap Smears?
 Yes
 No, indicate number

Select the Additional Pap Smears periodicity:
 Every three years
 Every two years
 Every year
 Every six months
 Every three months
 Other, describe

Indicate number of Additional Pelvic Exams:

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

SECTION B – 14D – PAP/PELVIC EXAMS – BASE 2 SCREEN

File

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

Select the Maximum Plan Benefit Coverage type:
 Covered under Preventive Services Category 14a
 Plan-specified amount per period

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

Select the Maximum Enrollee Out-of-Pocket Cost type:
 Covered under Preventive Services Category 14a
 Plan-specified amount per period

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 B – 14D – PAP/PELVIC EXAMS – BASE 3 SCREEN

PBP 2010 Data Entry System - (repaint)#14d Pap/Pelvic - Base 3

File

Is there an enrollee Coinsurance?

Yes

No

Indicate Coinsurance percentage for Medicare covered Pap Smears:

Indicate Coinsurance percentage for Additional Pap Smears:

Indicate Coinsurance percentage for Medicare covered Pelvic Exams:

Indicate Coinsurance percentage for Additional Pelvic Exams:

SECTION B – 14D – PAP/PELVIC EXAMS – BASE 4 SCREEN

PBP 2010 Data Entry System - (repaint)#14d Pap/Pelvic - Base 4

File

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?
 Yes
 No

Indicate Copayment amount per Medicare covered Pap Smear:

Indicate Copayment amount per Medicare covered Pelvic Exam:

Indicate Copayment amount per Additional Pap Smear:

Indicate Copayment amount per Additional Pelvic Exam:

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

Enrollee must receive Authorization for Additional Smears/Exams 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 Pap Smears and Pelvic Exams?
 Yes
 No

SECTION B – 14D – PAP/PELVIC EXAMS – BASE 5 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - #14d Pap/Pelvic - 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 label "Pap Smear/Pelvic Exam Notes" at the top, followed by a label "Notes (Optional):" and a large, empty rectangular text input field. At the bottom right of the text field is a button labeled "Import Text".

SECTION B – 14E – PROSTATE SCREENING – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#14e Prostate Screening - Base 1

File

DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes
 No

Select enhanced benefit:

Additional Prostate Screenings

Select type of benefit for Additional Prostate Screenings:

Mandatory
 Optional

Is this benefit unlimited for Additional Prostate Screenings?

Yes
 No, indicate number

Indicate number of Additional Prostate Screenings:

Select the Additional Prostate Screenings 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 Maximum Plan Benefit Coverage type:

Covered under Preventive Services Category 14a
 Plan-specified amount per period

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

SECTION B – 14E – PROSTATE SCREENING – BASE 2 SCREEN

File

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

Select the Maximum Enrollee Out-of-Pocket Cost type:
 Covered under Preventive Services Category 14a
 Plan-specified amount per period

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

Indicate Coinsurance percentage for Medicare Covered Benefits:

Indicate Coinsurance percentage for Additional Screenings:

SECTION B – 14E – PROSTATE SCREENING – BASE 3 SCREEN

PBP 2010 Data Entry System - (repaint)#14e Prostate Screening - Base 3

File

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

Is there an enrollee Copayment?
 Yes
 No

Indicate Copayment amount per screening for Medicare Covered Benefits:

Indicate Copayment amount per screening for Additional Screenings:

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

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 Prostate Cancer Screenings?
 Yes
 No

SECTION B – 14E – PROSTATE SCREENING – BASE 4 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - #14e Prostate Screening - 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 sections: a header section labeled "Prostate Cancer Screening Notes", a section labeled "Notes (Optional):" which contains a large, empty white rectangular area for text entry, and a footer section containing an "Import Text" button.

SECTION B – 14F – COLORECTAL SCREENING – BASE 1 SCREEN

PBP 2010 Data Entry System - #14f Colorectal Screening - Base 1

File

DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?

Yes

No

Select enhanced benefit:

Additional Colorectal Screenings

Select type of benefit for Additional Colorectal Screenings:

Mandatory

Optional

Is this benefit unlimited for Additional Colorectal Screenings?

Yes

No, indicate number

Indicate number of Additional Colorectal Screenings:

Select the Additional Colorectal Screenings periodicity:

Every three years

Every two years

Every year

Every six months

Every three months

Other, describe

SECTION B – 14F – COLORECTAL SCREENING – BASE 2 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - (repaint)#14f Colorectal Screening - Base 2". The window has a menu bar with "File" and standard window controls (minimize, maximize, close). The main area is divided into two columns of form fields:

- Left Column:**
 - Is there a service-specific Maximum Plan Benefit Coverage amount?
 Yes
 No
 - Select the Maximum Plan Benefit Coverage type:
 Covered under Preventive Services Category 14a
 Plan-specified amount per period
 - 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
- Right Column:**
 - Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
 Yes
 No
 - Select the Maximum Enrollee Out-of-Pocket Cost type:
 Covered under Preventive Services Category 14a
 Plan-specified amount per period
 - 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 B – 14F – COLORECTAL SCREENING – BASE 3 SCREEN

The screenshot shows a web browser window with the following content:

- Browser title bar: PBP 2010 Data Entry System - (repaint)#14f Colorectal Screening - Base 3
- File menu: File
- Form fields:
 - Is there an enrollee Coinsurance?
 - Yes
 - No
 - Indicate Minimum Coinsurance percentage for Medicare Covered Benefits:
 -
 - Indicate Maximum Coinsurance percentage for Medicare Covered Benefits:
 -
 - Indicate Minimum Coinsurance percentage for Additional Screenings:
 -
 - Indicate Maximum Coinsurance percentage for Additional Screenings:
 -

SECTION B – 14F – COLORECTAL SCREENING – BASE 4 SCREEN

PBP 2010 Data Entry System - (repaint)#14f Colorectal Screening - Base 4

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 for Additional Screenings:

Indicate Maximum Copayment amount for Additional Screenings:

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

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 Colorectal Screenings?
 Yes
 No

SECTION B – 14F – COLORECTAL SCREENING – BASE 5 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - #14f Colorectal Screening - 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 sections: a header labeled "Colorectal Screening Notes", a label "Notes (Optional):" followed by a large, empty rectangular text input field, and a button labeled "Import Text" located in the bottom right corner of the input field area.

SECTION B – 14G – BONE MASS MEASUREMENT – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#14g Bone Mass Meas. - Base 1

File

DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

Maximum Plan Benefit Coverage is not applicable for this Service Category.

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

Yes
 No

Select the Maximum Enrollee Out-of-Pocket Cost type:

Covered under Preventive Services Category 14a
 Plan-specified amount per period

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

Indicate Minimum Coinsurance percentage for Medicare Covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare Covered Benefits:

SECTION B – 14G – BONE MASS MEASUREMENT – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)#14g Bone Mass Meas. - Base 2

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:

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

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 Bone Mass Measurement?
 Yes
 No

SECTION B – 14G – BONE MASS MEASUREMENT – BASE 3 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - #14g Bone Mass Meas. - Base 3". 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 sections: a header section labeled "Bone Mass Measurement Screening Notes", a section labeled "Notes (Optional):" which contains a large, empty white rectangular area for text entry, and a footer section containing an "Import Text" button.

SECTION B – 14H – MAMMOGRAPHY – BASE 1 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - (repaint)#14h Mammography - Base 1". The window contains a "File" menu and several form sections:

- DESCRIPTION OF BENEFIT**
- Do you offer any Mandatory or Optional Supplemental Benefits?**
 - Yes
 - No
- Select enhanced benefit:**
 - Additional Mammography Screenings
- Select type of benefit for Additional Mammography Screenings:**
 - Mandatory
 - Optional
- Is this benefit unlimited for Additional Mammography Screenings?**
 - Yes
 - No, indicate number
- Indicate number of Additional Mammography Screenings:**
 - _____
- Select the Additional Mammography Screenings periodicity:**
 - Every three years
 - Every two years
 - Every year
 - Every six months
 - Every three months
 - Other, describe
- 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 there a service-specific Maximum Plan Benefit Coverage amount?**
 - Yes
 - No
- Select the Maximum Plan Benefit Coverage type:**
 - Covered under Preventive Services Category 14a
 - Plan-specified amount per period

SECTION B – 14H – MAMMOGRAPHY – BASE 2 SCREEN

File

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

Yes
 No

Is there an enrollee Coinsurance?

Yes
 No

Select the Maximum Enrollee Out-of-Pocket Cost type:

Covered under Preventive Services Category 14a
 Plan-specified amount per period

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Indicate Coinsurance percentage for Medicare Covered Benefits:

Indicate Coinsurance percentage for Additional Screenings:

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 B – 14H – MAMMOGRAPHY – BASE 3 SCREEN

PBP 2010 Data Entry System - (repaint)#14h Mammography - 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 Copayment amount per screening for Additional Screenings:

You must include total cost sharing to the beneficiary, including any facility cost sharing. If you have a variety of cost sharing, please utilize the minimum and maximum fields to reflect the lowest and highest cost sharing that a beneficiary may pay.

Enrollee must receive Authorization for Additional Screenings 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 Additional Screening Mammographies?
 Yes
 No

SECTION B – 14H – MAMMOGRAPHY – BASE 4 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - #14h Mammography - 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 "Mammography Screening Notes" at the top, followed by a label "Notes (Optional):" and a large, empty rectangular text input field. At the bottom right of the text input field, there is a button labeled "Import Text".

SECTION B – 14i – DIABETES MONITORING – BASE 1 SCREEN

DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

Maximum Plan Benefit Coverage is not applicable for this Service Category.

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

Yes
 No

Select the Maximum Enrollee Out-of-Pocket Cost type:

Covered under Preventive Services Category 14a
 Plan-specified amount per period

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

Indicate Minimum Coinsurance percentage for Medicare Covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare Covered Benefits:

SECTION B – 14i – DIABETES MONITORING – BASE 2 SCREEN

PBP 2010 Data Entry System - #14i Diabetes Monitoring - Base 2

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 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 Diabetes Monitoring Training?
 Yes
 No

SECTION B – 14i – DIABETES MONITORING – BASE 3 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - #14i Diabetes Monitoring - Base 3". 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 sections: a header labeled "Diabetes Monitoring Notes", a "Notes:" label, and a large, empty rectangular text input area. At the bottom right of the text area, there is a button labeled "Import Text".

SECTION B – 14J – NUTRITION THERAPY FOR DIABETES AND RENAL DISEASE – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#14j Nutrition Therapy - Base 1

File

DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

Maximum Plan Benefit Coverage is not applicable for this Service Category.

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

Yes
 No

Select the Maximum Enrollee Out-of-Pocket Cost type:

Covered under Preventive Services Category 14a
 Plan-specified amount per period

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

Indicate Minimum Coinsurance percentage for Medicare Covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare Covered Benefits:

SECTION B –14J – NUTRITION THERAPY FOR DIABETES AND RENAL DISEASE – BASE 2 SCREEN

PBP 2010 Data Entry System - #14j Nutrition Therapy - Base 2

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:

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 Nutrition Therapy?
 Yes
 No

SECTION B –14J – NUTRITION THERAPY FOR DIABETES AND RENAL DISEASE – BASE 3 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - #14j Nutrition Therapy - Base 3". 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 two sections: a text input field at the top labeled "Nutrition Therapy for Diabetes and Renal Disease Notes" and a larger text area below it labeled "Notes:". The "Notes:" area is currently empty. At the bottom right of the "Notes:" area, there is a button labeled "Import Text".

SECTION B – 15 – MEDICARE PART B PRESCRIPTION DRUGS – BASE 1 SCREEN

DESCRIPTION OF BENEFIT

Is there a 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
 Every month
 Other, describe

Is there an enrollee Coinsurance?

Yes
 No

Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:

Indicate the Maximum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:

SECTION B – 15 – MEDICARE PART B PRESCRIPTION DRUGS – BASE 2 SCREEN

PBP 2010 Data Entry System - #15 Medicare Part B Rx Drugs - Base 2

File

| | |
|---|---|
| Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs: <input type="text"/> | Indicate percentage Discount of Published Retail Price for Coinsurance for other Medicare Part B Drugs: <input type="text"/> |
| Indicate Maximum Coinsurance percentage for other Medicare Part B Drugs: <input type="text"/> | Indicate Minimum Dispensing Fee amount for Coinsurance for other Medicare Part B Drugs: <input type="text"/> |
| Select the Coinsurance Coverage Basis for other Medicare Part B Drugs: <input type="radio"/> Discount (___%) of Published Retail Price <input type="radio"/> Published Retail Price <input type="radio"/> Published Wholesale Price <input type="radio"/> Published National Average Wholesale Price (AWP) <input type="radio"/> Published National AWP plus Dispensing Fee (\$___) <input type="radio"/> Discount (___%) of Published National AWP <input type="radio"/> Medicare Fee Schedule <input type="radio"/> MA Organization Acquisition Cost Plus (\$___) <input type="radio"/> Published MA Organization Fee/Charge Schedule <input type="radio"/> Other, describe | Indicate Maximum Dispensing Fee amount for Coinsurance for other Medicare Part B Drugs: <input type="text"/> |
| | Indicate percentage Discount of AWP for Coinsurance for other Medicare Part B Drugs: <input type="text"/> |
| | Indicate amount over MA Organization Acquisition Cost for Coinsurance for other Medicare Part B Drugs: <input type="text"/> |

SECTION B – 15 – MEDICARE PART B PRESCRIPTION DRUGS – BASE 3 SCREEN

PBP 2010 Data Entry System - #15 Medicare Part B Rx Drugs - Base 2

File

| | |
|--|---|
| Is there an enrollee Deductible? <input type="radio"/> Yes <input type="radio"/> No | Is Authorization Required? <input type="radio"/> Yes <input type="radio"/> No |
| Indicate Deductible Amount: <input type="text"/> | |
| Is there an enrollee Copayment? <input type="radio"/> Yes <input type="radio"/> No | |
| Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy Drugs: <input type="text"/> | |
| Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy Drugs: <input type="text"/> | |
| Indicate Minimum Copayment Amount for other Medicare Part B Drugs: <input type="text"/> | |
| Indicate Maximum Copayment Amount for other Medicare Part B Drugs: <input type="text"/> | |

B – 15 – MEDICARE PART B PRESCRIPTION DRUGS – NOTES (OPTIONAL)

The screenshot shows a software window with a blue title bar containing the text "PBP 2010 Data Entry System - #15 Medicare Part B Rx Drugs - Notes (Optional)". Below the title bar is a menu bar with the word "File". The main area of the window is a large, empty text box with a light gray background, labeled "Notes (Optional)" in the top left corner. In the bottom right corner of this text box, there is a button labeled "Import Text".

B – 15 – PART C HOME INFUSION DRUGS

File

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit under Part C?

Yes
 No

If you select 'Yes' you must indicate these specific medications in a flat file which will be uploaded through the Formulary Submission Module on June 09, 2008.

Also if you select 'Yes' you must ensure that your benefit includes not only the home infusion drug, but also any services and supplies associated with the home infusion drug's administration.

Is there an enrollee Copayment for Home Infusion bundled services?

Yes
 No

Indicate Minimum Copayment amount for Home Infusion bundled services:

Indicate Maximum Copayment amount for Home Infusion bundled services:

Is there an enrollee Coinsurance for Home Infusion bundled services?

Yes
 No

Indicate Minimum Coinsurance percentage for Home Infusion bundled

Indicate Maximum Coinsurance percentage for Home Infusion bundled

SECTION B – 16A – PREVENTIVE DENTAL – BASE 1 SCREEN

PBP 2010 Data Entry System - #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 B – 16A – PREVENTIVE DENTAL – BASE 2 SCREEN

The screenshot shows a web browser window titled "PBP 2010 Data Entry System - (repaint)#16a Preventive Dental - Base 2". The window contains a "File" menu and several form sections:

- Select type of benefit for Dental X-Rays:**
 - Mandatory
 - Optional
- 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
- 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

SECTION B – 16A – PREVENTIVE DENTAL – BASE 3 SCREEN

PBP 2010 Data Entry System - (repaint)#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:

SECTION B – 16A – PREVENTIVE DENTAL – BASE 4 SCREEN

The screenshot shows a web browser window with the following content:

- Browser title bar: PBP 2010 Data Entry System - (repaint)#16a Preventive Dental - Base 4
- Menu bar: File
- Form fields:
 - Indicate Minimum Coinsurance percentage for Oral Exams:
 - Indicate Maximum Coinsurance percentage for Oral Exams:
 - Indicate Minimum Coinsurance percentage for Prophylaxis (Cleaning):
 - Indicate Maximum Coinsurance percentage for Prophylaxis (Cleaning):
 - Indicate Minimum Coinsurance percentage for Fluoride Treatment:
 - Indicate Maximum Coinsurance percentage for Fluoride Treatment:

SECTION B – 16A – PREVENTIVE DENTAL – BASE 5 SCREEN

PBP 2010 Data Entry System - #16a Preventive Dental - Base 5

File

Indicate Minimum Coinsurance percentage for Dental X-Rays:

Indicate Maximum Coinsurance percentage for Dental X-Rays:

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

Is there an enrollee Deductible?
 Yes
 No

Indicate Deductible Amount:

SECTION B – 16A – PREVENTIVE DENTAL – BASE 6 SCREEN

PBP 2010 Data Entry System - #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 B – 16A – PREVENTIVE DENTAL – BASE 7 SCREEN

PBP 2010 Data Entry System - #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 B – 16B – COMPREHENSIVE DENTAL – BASE 1 SCREEN

PBP 2010 Data Entry System - #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.

Select type of benefit for Emergency Services:
 Mandatory
 Optional

Select type of benefit for Diagnostic Services:
 Mandatory
 Optional

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

Is this benefit unlimited for Emergency Services?
 Yes
 No, indicate number

Is this benefit unlimited for Diagnostic Services?
 Yes
 No, indicate number

Select enhanced benefits:
 Emergency Services
 Diagnostic Services
 Restorative Services
 Endodontics/Periodontics/Extractions
 Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

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 B – 16B – COMPREHENSIVE DENTAL – BASE 2 SCREEN

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

File

| | | |
|--|--|--|
| <p>Select type of benefit for Restorative Services:</p> <p><input type="radio"/> Mandatory</p> <p><input type="radio"/> Optional</p> | <p>Select type of benefit for Endodontics/Periodontics/Extractions:</p> <p><input type="radio"/> Mandatory</p> <p><input type="radio"/> Optional</p> | <p>Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:</p> <p><input type="radio"/> Mandatory</p> <p><input type="radio"/> Optional</p> |
| <p>Is this benefit unlimited for Restorative Services?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No, indicate number</p> | <p>Is this benefit unlimited for Endodontics/Periodontics/Extractions?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No, indicate number</p> | <p>Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No, indicate number</p> |
| <p>Indicate number of visits for Restorative Services:</p> <input type="text"/> | <p>Indicate number of visits for Endodontics/Periodontics/Extractions:</p> <input type="text"/> | <p>Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:</p> <input type="text"/> |
| <p>Select the Restorative Services 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 Endodontics/Periodontics/Extractions 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 Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services 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 B – 16B – COMPREHENSIVE DENTAL – BASE 3 SCREEN

PBP 2010 Data Entry System - (repaint)#16b Comp Dental - Base 3

File

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

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

Select the Maximum Plan Benefit Coverage type:
 Covered under Preventive Dental Category 16a
 Plan-specified amount per period

Select the Maximum Enrollee Out-of-Pocket Cost type:
 Covered under Preventive Dental Category 16a
 Plan-specified amount per period

Indicate Maximum Plan Benefit Coverage amount:

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

SECTION B – 16B – COMPREHENSIVE DENTAL – BASE 4 SCREEN

PBP 2010 Data Entry System - (repaint)#16b Comp Dental - Base 4

File

| | |
|--|---|
| Is there an enrollee Coinsurance? <input type="radio"/> Yes <input type="radio"/> No | Indicate Minimum Coinsurance percentage for Endodontics/Periodontics/Extractions: <input type="text"/> |
| Indicate the Minimum Coinsurance percentage for Medicare Covered Benefits: <input type="text"/> | Indicate Maximum Coinsurance percentage for Endodontics/Periodontics/Extractions: <input type="text"/> |
| Indicate the Maximum Coinsurance percentage for Medicare Covered Benefits: <input type="text"/> | Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: <input type="text"/> |
| Indicate Minimum Coinsurance percentage for Emergency Services: <input type="text"/> | Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: <input type="text"/> |
| Indicate Maximum Coinsurance percentage for Emergency Services: <input type="text"/> | Is there an enrollee Deductible? <input type="radio"/> Yes <input type="radio"/> No |
| | Indicate Deductible Amount: <input type="text"/> |

SECTION B – 16B – COMPREHENSIVE DENTAL – BASE 5 SCREEN

File

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

SECTION B – 16B – COMPREHENSIVE DENTAL – BASE 6 SCREEN

PBP 2010 Data Entry System - (repaint)#16b Comp Dental - Base 6

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 B – 17A – EYE EXAMS – BASE 1 SCREEN

PBP 2010 Data Entry System - (repaint)#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 Enrollee Out-of-Pocket Cost?

Yes
 No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

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 Maximum Enrollee Out-of-Pocket Cost periodicity:

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

SECTION B – 17A – EYE EXAMS – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)#17a Eye Exams - Base 2

File

| | |
|--|--|
| Is there an enrollee Coinsurance? <input type="radio"/> Yes <input type="radio"/> No | 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 Minimum Copayment amount for Medicare Covered Benefits: <input type="text"/> |
| Indicate Maximum Coinsurance percentage for Medicare Covered Benefits: <input type="text"/> | Indicate Maximum Copayment amount for Medicare Covered Benefits: <input type="text"/> |
| Indicate Minimum Coinsurance percentage for Routine Eye Exams: <input type="text"/> | Indicate Minimum Copayment amount per Routine Eye Exam: <input type="text"/> |
| Indicate Maximum Coinsurance percentage for Routine Eye Exams: <input type="text"/> | Indicate Maximum Copayment amount per Routine Eye Exam: <input type="text"/> |
| Is there an enrollee Deductible? <input type="radio"/> Yes <input type="radio"/> No | |
| Indicate Deductible Amount: <input type="text"/> | |

SECTION B – 17A – EYE EXAMS – BASE 3 SCREEN

PBP 2010 Data Entry System - #17a Eye Exams - Base 3

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 B – 17B – EYE WEAR – BASE 1 SCREEN

PBP 2010 Data Entry System - #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 B – 17B – EYE WEAR – BASE 2 SCREEN

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

File

| | |
|---|---|
| Select type of benefit for Eye Glass Lenses: <input type="radio"/> Mandatory <input type="radio"/> Optional | Select type of benefit for Eye Glass Frames: <input type="radio"/> Mandatory <input type="radio"/> Optional |
| Is this benefit unlimited for Eye Glass Lenses? <input type="radio"/> Yes <input type="radio"/> No, indicate number | Is this benefit unlimited for Eye Glass Frames? <input type="radio"/> Yes <input type="radio"/> No, indicate number |
| Indicate quantity (number of pairs) for Eye Glass Lenses: <input type="text"/> | Indicate quantity for Eye Glass Frames: <input type="text"/> |
| Select Eye Glass Lenses 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 Eye Glass Frames 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 type of benefit for Upgrades: <input type="radio"/> Mandatory <input type="radio"/> Optional | |

SECTION B – 17B – EYE WEAR – BASE 3 SCREEN

PBP 2010 Data Entry System - (repaint)#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 type of eye wear with Individual Max Plan Benefit Coverage amount:</p> <p><input type="checkbox"/> Contact Lenses</p> <p><input type="checkbox"/> Eye Glasses (Lenses and Frames)</p> <p><input type="checkbox"/> Eye Glass Lenses</p> <p><input type="checkbox"/> Eye Glass Frames</p> <p><input type="checkbox"/> Upgrades</p> | <p>Select the Individual Maximum Plan Benefit Coverage periodicity for Eye Glasses (Lenses and Frames):</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 Individual Maximum Plan Benefit Coverage periodicity for Eye Glasses Upgrades:</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 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>Indicate Max Plan Benefit Coverage amount for Contact Lenses:</p> <p><input type="text"/></p> | <p>Indicate Max Plan Benefit Coverage amount for Eye Glass Lenses:</p> <p><input type="text"/></p> | <p>Indicate Max Plan Benefit Coverage amount for Upgrades:</p> <p><input type="text"/></p> |
| <p>Do you offer a Combined Max Plan Benefit Coverage Amount for all Eye Wear?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> | <p>Select the Individual Maximum Plan Benefit Coverage periodicity for Contact Lenses:</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 Individual Maximum Plan Benefit Coverage periodicity for Eye Glasses Frames:</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 Individual Maximum Plan Benefit Coverage periodicity for Eye Glasses Lenses:</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 Combined Maximum Plan Benefit Coverage amount:</p> <p><input type="text"/></p> | <p>Indicate Max Plan Benefit Coverage amount for Eye Glasses (Lenses and Frames):</p> <p><input type="text"/></p> | <p>Indicate Max Plan Benefit Coverage amount for Eye Glass Frames:</p> <p><input type="text"/></p> | |
| <p>Select the Combined 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> | | | |

SECTION B – 17B – EYE WEAR – BASE 4 SCREEN

PBP 2010 Data Entry System - (repaint)#17b Eye Wear - Base 4

File

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

Yes
 No

Select the Maximum Enrollee Out-of-Pocket Cost type:

Covered under Eye Exams Category 17a
 Plan-specified amount per period

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 for Medicare Covered Benefits:

Indicate Coinsurance percentage for Contact Lenses:

Indicate Coinsurance percentage for Eye Glasses (Lenses and Frames):

Indicate Coinsurance percentage for Eye Glass Lenses:

Indicate Coinsurance percentage for Eye Glass Frames:

Indicate Coinsurance percentage for Upgrades:

SECTION B – 17B – EYE WEAR – BASE 5 SCREEN

PBP 2010 Data Entry System - #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 B – 17B – EYE WEAR – BASE 6 SCREEN

The screenshot shows a software window titled "PBP 2010 Data Entry System - #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 "Eye Wear Notes" field at the top, followed by a "Notes (Optional):" label and a large, empty text input area. At the bottom right of the text area, there is a button labeled "Import Text".

SECTION B – 18A – HEARING EXAMS – BASE 1 SCREEN

PBP 2010 Data Entry System - #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 B – 18A – HEARING EXAMS – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)#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>Is there an enrollee Deductible?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> | | <p>Indicate Minimum Coinsurance percentage for Routine Hearing Tests:</p> <input type="text"/> |
| <p>Indicate Deductible Amount:</p> <input type="text"/> | | <p>Indicate Maximum Coinsurance percentage for Routine Hearing Tests:</p> <input type="text"/> |
| | | <p>Indicate Minimum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:</p> <input type="text"/> |
| | | <p>Indicate Maximum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:</p> <input type="text"/> |

SECTION B – 18A – HEARING EXAMS – BASE 3 SCREEN

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 B – 18A – HEARING EXAMS – BASE 4 SCREEN

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

File

Hearing Exams Notes

Notes (Optional):

Import Text

SECTION B – 18B – HEARING AIDS – BASE 1 SCREEN

PBP 2010 Data Entry System - #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 B – 18B – HEARING AIDS – BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)#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

Is this benefit unlimited for Hearing Aids - Over the Ear?

Yes

No, indicate number

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 amount:

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

SECTION B – 18B – HEARING AIDS – BASE 3 SCREEN

PBP 2010 Data Entry System - (repaint)#18b Hearing Aids - Base 3

File

| | |
|--|--|
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? <input type="radio"/> Yes <input type="radio"/> No | Is there an enrollee Coinsurance? <input type="radio"/> Yes <input type="radio"/> No |
| Select the Maximum Enrollee Out-of-Pocket Cost type: <input type="radio"/> Covered under Hearing Exams Category - 18a <input type="radio"/> Plan-specified amount per period | Indicate Coinsurance percentage for Hearing Aids (all types): <input type="text"/> |
| Indicate Maximum Enrollee Out-of-Pocket Cost amount: <input type="text"/> | Indicate Coinsurance percentage for Hearing Aids - Inner Ear: <input type="text"/> |
| Select Maximum Enrollee Out-of-Pocket Cost 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 | Indicate Coinsurance percentage for Hearing Aids - Outer Ear: <input type="text"/> |
| | Indicate Coinsurance percentage for Hearing Aids - Over the Ear: <input type="text"/> |

SECTION B – 18B – HEARING AIDS – BASE 4 SCREEN

PBP 2010 Data Entry System - (repaint)#18b Hearing Aids - Base 4

File

| | |
|--|---|
| Is there an enrollee Copayment? <input type="radio"/> Yes <input type="radio"/> No | Indicate Copayment amount per Hearing Aid - Over the Ear: <input type="text"/> |
| Indicate Minimum Copayment amount per Hearing Aid (all types): <input type="text"/> | Indicate Copayment amount per two Hearing Aids - Over the Ear: <input type="text"/> |
| Indicate Maximum Copayment amount per Hearing Aid (all types): <input type="text"/> | Is there an enrollee Deductible? <input type="radio"/> Yes <input type="radio"/> No |
| Indicate Copayment amount per Hearing Aid - Inner Ear: <input type="text"/> | Indicate Deductible Amount: <input type="text"/> |
| Indicate Copayment amount per two Hearing Aids - Inner Ear: <input type="text"/> | |
| Indicate Copayment amount per Hearing Aid - Outer Ear: <input type="text"/> | |
| Indicate Copayment amount per two Hearing Aids - Outer Ear: <input type="text"/> | |

SECTION B – 18B – HEARING AIDS – BASE 5 SCREEN

PBP 2010 Data Entry System - #18b Hearing Aids - Base 5

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 B – 20 – OUTPNT DRUGS – BASE 1 SCREEN

PBP 2010 Data Entry System - #20 Outpatient Drugs - Base 1

File

DESCRIPTION OF BENEFIT

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

Select type of benefit:
 Mandatory
 Optional

Indicate the number of drug groupings that are offered:
 1
 2
 3
 4
 5

Is there a Maximum Plan Benefit Coverage amount for drugs?
 Yes
 No

Indicate type of Maximum Plan Benefit Coverage:
 All drug groups covered by plan
 Combination of drug groups
 Individual drug groups

Is the Maximum Plan Benefit Coverage net of the enrollee copay?
 Yes
 No

Indicate Maximum Plan Benefit Coverage periodicity for drugs:
 Annually
 Semi-annually
 Quarterly
 Monthly
 Other, describe

Indicate Max Plan Benefit Cov amount annually for drugs:

Indicate Max Plan Benefit Cov amount semi-annually for drugs:

Indicate Max Plan Benefit Cov amount quarterly for drugs:

Indicate Max Plan Benefit Cov amount monthly for drugs:

Indicate Max Plan Benefit Cov amount for Other for drugs:

SECTION B – 20 – OUTPNT DRUGS – BASE 2 SCREEN

PBP 2010 Data Entry System - #20 Outpatient Drugs - Base 2

File

Can any unused amounts be carried forward to the next period within the contract period?

Yes
 No

Select what combination of drug groups are included in the Maximum Plan Benefit:

Group 1
 Group 2
 Group 3
 Group 4
 Group 5

Indicate Maximum Plan Benefit Coverage periodicity for combination of drug groups:

Annually
 Semi-annually
 Quarterly
 Monthly
 Other, describe

Indicate Max Plan Benefit Cov amount annually for combination of drug groups:

Indicate Max Plan Benefit Cov amount semi-annually for combination of drug groups:

Indicate Max Plan Benefit Cov amount quarterly for combination of drug groups:

Indicate Max Plan Benefit Cov amount monthly for combination of drug groups:

Indicate Max Plan Benefit Cov amount for Other for combination of drug groups:

SECTION B – 20 – OUTPAT DRUGS – BASE 3 SCREEN

PBP 2010 Data Entry System - (repaint)#20 Outpatient Drugs - Base 3

File

Is a selected group unlimited after the combination Maximum Plan Benefit Coverage amount has been reached?

Yes
 No

Indicate the selected group(s) for which the Maximum Plan Benefit Coverage is waived:

Group 1
 Group 2
 Group 3
 Group 4
 Group 5

Does the enrollee incur a cost in addition to the Coinsurance or Copay for selecting a higher priced drug when a less expensive drug is available?

Yes
 No

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

Yes
 No

Select what combination of drug groups applies for Maximum Enrollee Out-of-Pocket Cost:

Group 1
 Group 2
 Group 3
 Group 4
 Group 5
 Medicare Covered Benefits

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
 Every month
 Other, describe

Is there an enrollee Coinsurance for Medicare Covered Benefits?

Yes
 No

Indicate Minimum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:

Indicate Maximum Coinsurance percentage for Medicare Part B Chemotherapy Drugs:

Indicate Maximum Coinsurance percentage for other Medicare Part B Drugs:

Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:

SECTION B – 20 – OUTPNT DRUGS – BASE 4 SCREEN

PBP 2010 Data Entry System - (repaint)#20 Outpatient Drugs - Base 4

File

Is there an enrollee Deductible?
 Yes
 No

Select what combination of drug groups applies for Deductible:
 Group 1
 Group 2
 Group 3
 Group 4
 Group 5
 Medicare Covered Benefits

Indicate Deductible amount:

Is there an enrollee Copayment for Medicare Covered Benefits?
 Yes
 No

Indicate Minimum Copayment amount for Medicare Part B
Chemotherapy Drugs:

Indicate Maximum Copayment amount for Medicare Part B
Chemotherapy Drugs:

Indicate Maximum Copayment for other Medicare Part B Drugs:

Indicate Minimum Copayment for other Medicare Part B Drugs:

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

SECTION B – 20 – OUTPAT DRUGS – NOTES (OPTIONAL)

PBP 2010 Data Entry System - #20 Outpatient Drugs - Notes (Optional)

File

Outpatient Drugs Notes

Notes (Optional):

Import Text

SECTION B – 20 – OUTPAT DRUGS – GROUP 1- BASE 1 SCREEN

PBP 2010 Data Entry System - #20 Outpatient Drugs - Group 1 - Base 1

File

Select a label for Group 1:

- Formulary Generic
- Formulary Preferred Brand
- Formulary Brand
- Non-formulary Generic
- Non-formulary Brand
- Generic
- Preferred Brand
- Brand
- Tier 1
- Tier 2

Select the drug type(s) covered for Group 1:

- Generic
- Preferred Brand
- Brand

Is there a Maximum Plan Benefit Coverage amount for Group 1?

- Yes
- No

Indicate Maximum Plan Benefit Coverage for Group 1 periodicity:

- Annually
- Semi-annually
- Quarterly
- Monthly
- Per Prescription
- Other, describe

Indicate Maximum Plan Benefit Coverage annual amount for Group 1:

Indicate Maximum Plan Benefit Coverage monthly amount for Group 1:

Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 1:

Indicate Maximum Plan Benefit Coverage amount per prescription for Group 1:

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 1:

Indicate Maximum Plan Benefit Coverage amount for Other for Group 1:

SECTION B – 20 – OUTPNT DRUGS – GROUP 1- BASE 2 SCREEN

The screenshot shows a web browser window with the title "PBP 2010 Data Entry System - (repaint)#20 Outpatient Drugs - Group 1 - Base 2". The browser's address bar and window controls are visible at the top. Below the browser window, the main content area contains a "File" menu and a series of form fields:

- Select from where Group 1 Drugs can be acquired:**
 - Designated Retail Pharmacy
 - HMO-Owned Pharmacy
 - Mail Order
 - Other, describe
- Is there an enrollee Coinsurance for Group 1?**
 - Yes
 - No
- Indicate Coinsurance percentage for Group 1 Designated Retail Pharmacy:**
- Indicate Coinsurance percentage for Group 1 HMO-Owned Pharmacy:**
- Indicate Coinsurance percentage for Group 1 Mail Order:**
- Indicate Coinsurance percentage for Group 1 Other:**

SECTION B – 20 – OUTPAT DRUGS – GROUP 2- BASE 1 SCREEN

File

Select a label for Group 2:

- Formulary Generic
- Formulary Preferred Brand
- Formulary Brand
- Non-formulary Generic
- Non-formulary Brand
- Generic
- Preferred Brand
- Brand

Select the drug type(s) covered for Group 2:

- Generic
- Preferred Brand
- Brand

Is there a Maximum Plan Benefit Coverage amount for Group 2?

- Yes
- No

Indicate Maximum Plan Benefit Coverage for Group 2 periodicity:

- Annually
- Semi-annually
- Quarterly
- Monthly
- Per Prescription
- Other, describe

Indicate Maximum Plan Benefit Coverage annual amount for Group 2:

Indicate Maximum Plan Benefit Coverage monthly amount for Group 2:

Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 2:

Indicate Maximum Plan Benefit Coverage amount per prescription for Group 2:

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 2:

Indicate Maximum Plan Benefit Coverage amount for Other for Group 2:

SECTION B – 20 – OUTPNT DRUGS – GROUP 2- BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)#20 Outpatient Drugs - Group 2 - Base 2

File

Select from where Group 2 Drugs can be acquired:

- Designated Retail Pharmacy
- HMO-Owned Pharmacy
- Mail Order
- Other, describe

Is there an enrollee Coinsurance for Group 2?

Yes

No

Indicate Coinsurance percentage for Group 2 for Designated Retail Pharmacy:

Indicate Coinsurance percentage for Group 2 for HMO-Owned Pharmacy:

Indicate Coinsurance percentage for Group 2 for Mail Order:

Indicate Coinsurance percentage for Group 2 for Other:

SECTION B – 20 – OUTPNT DRUGS – GROUP 3- BASE 1 SCREEN

PBP 2010 Data Entry System - #20 Outpatient Drugs - Group 3 - Base 1

File

Select a label for Group 3:

- Formulary Generic
- Formulary Preferred Brand
- Formulary Brand
- Non-formulary Generic
- Non-formulary Brand
- Generic
- Preferred Brand

Select the drug type(s) covered for Group 3:

- Generic
- Preferred Brand
- Brand

Is there a Maximum Plan Benefit Coverage amount for Group 3?

- Yes
- No

Indicate Maximum Plan Benefit Coverage Group 3 periodicity:

- Annually
- Semi-annually
- Quarterly
- Monthly
- Per Prescription
- Other, describe

Indicate Maximum Plan Benefit Coverage annual amount for Group 3:

Indicate Maximum Plan Benefit Coverage monthly amount for Group 3:

Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 3:

Indicate Maximum Plan Benefit Coverage amount per prescription for Group 3:

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 3:

Indicate Maximum Plan Benefit Coverage amount for Other for Group 3:

SECTION B – 20 – OUTPNT DRUGS – GROUP 3- BASE 2 SCREEN

File

Select from where Group 3 Drugs can be acquired:

- Designated Retail Pharmacy
- HMO-Owned Pharmacy
- Mail Order
- Other, describe

Is there an enrollee Coinsurance for Group 3?

Yes

No

Indicate Coinsurance percentage for Group 3 Designated Retail Pharmacy:

Indicate Coinsurance percentage for Group 3 HMO-Owned Pharmacy:

Indicate Coinsurance percentage for Group 3 Mail Order:

Indicate Coinsurance percentage for Group 3 Other:

SECTION B – 20 – OUTPAT DRUGS – GROUP 4- BASE 1 SCREEN

File

Select a label for Group 4:

- Formulary Generic
- Formulary Preferred Brand
- Formulary Brand
- Non-formulary Generic
- Non-formulary Brand
- Generic
- Preferred Brand

Select the drug type(s) covered for Group 4:

- Generic
- Preferred Brand
- Brand

Is there a Maximum Plan Benefit Coverage amount for Group 4?

- Yes
- No

Indicate Maximum Plan Benefit Coverage Group 4:

- Annually
- Semi-annually
- Quarterly
- Monthly
- Per Prescription
- Other, describe

Indicate Maximum Plan Benefit Coverage annual amount for Group 4:

Indicate Maximum Plan Benefit Coverage monthly amount for Group 4:

Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 4:

Indicate Maximum Plan Benefit Coverage amount per prescription for Group 4:

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 4:

Indicate Maximum Plan Benefit Coverage amount for Other for Group 4:

SECTION B – 20 – OUTPNT DRUGS – GROUP 4- BASE 2 SCREEN

The screenshot shows a software window with the following content:

- Window Title: PBP 2010 Data Entry System - (repaint)#20 Outpatient Drugs - Group 4 - Base 2
- Menu: File
- Form 1: Select from where Group 4 Drugs can be acquired:
 - Designated Retail Pharmacy
 - HMO-Owned Pharmacy
 - Mail Order
 - Other, describe
- Form 2: Is there an enrollee Coinsurance for Group 4?
 - Yes
 - No
- Form 3: Indicate Coinsurance percentage for Group 4 Designated Retail Pharmacy:
 -
- Form 4: Indicate Coinsurance percentage for Group 4 HMO-Owned Pharmacy:
 -
- Form 5: Indicate Coinsurance percentage for Group 4 Mail Order:
 -
- Form 6: Indicate Coinsurance percentage for Group 4 Other:
 -

SECTION B – 20 – OUTPAT DRUGS – GROUP 5- BASE 1 SCREEN

File

Select a label for Group 5:

- Formulary Generic
- Formulary Preferred Brand
- Formulary Brand
- Non-formulary Generic
- Non-formulary Brand
- Generic
- Preferred Brand
- Brand

Select the drug type(s) covered for Group 5:

- Generic
- Preferred Brand
- Brand

Is there a Maximum Plan Benefit Coverage amount for Group 5?

- Yes
- No

Indicate Maximum Plan Benefit Coverage for Group 5 periodicity:

- Annually
- Semi-annually
- Quarterly
- Monthly
- Per Prescription
- Other, describe

Indicate Maximum Plan Benefit Coverage annual amount for Group 5:

Indicate Maximum Plan Benefit Coverage monthly amount for Group 5:

Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 5:

Indicate Maximum Plan Benefit Coverage amount per prescription for Group 5:

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 5:

Indicate Maximum Plan Benefit Coverage amount for Other for Group 5:

SECTION B – 20 – OUTPAT DRUGS – GROUP 5- BASE 2 SCREEN

PBP 2010 Data Entry System - (repaint)#20 Outpatient Drugs - Group 5 - Base 2

File

Select from where Group 5 Drugs can be acquired:

Designated Retail Pharmacy

HMO-Owned Pharmacy

Mail Order

Other, describe

Is there an enrollee Coinsurance for Group 5?

Yes

No

Indicate Coinsurance percentage for Group 5 Designated Retail Pharmacy:

Indicate Coinsurance percentage for Group 5 HMO-Owned Pharmacy:

Indicate Coinsurance percentage for Group 5 Mail Order:

Indicate Coinsurance percentage for Group 5 Other:

SECTION B – 20 – HOME INFUSION DRUGS

PBP 2010 Data Entry System - #20 Part C Home Infusion Drugs

File

| | |
|---|--|
| Does the plan provide Part D home infusion drugs as a supplemental benefit under Part C? <input type="radio"/> Yes <input type="radio"/> No | Is there an enrollee Copayment for Home Infusion drugs? <input type="radio"/> Yes <input type="radio"/> No |
| If you select 'Yes' to 'Does the plan provide Part D home infusion drugs as a supplemental benefit under Part C?', you must indicate these specific medications in a flat file which will be uploaded through the Formulary Submission Module on June 09, 2008. | Indicate Minimum Copayment amount for Home Infusion drugs: <input type="text"/> |
| Is there an enrollee Coinsurance for Home Infusion drugs? <input type="radio"/> Yes <input type="radio"/> No | Indicate Maximum Copayment amount for Home Infusion drugs: <input type="text"/> |
| Indicate Minimum Coinsurance percentage for Home Infusion drugs: <input type="text"/> | |
| Indicate Maximum Coinsurance percentage for Home Infusion drugs: <input type="text"/> | |