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

PBP Data Entry System - Section B-1, Contract Z0001, Plan 001, Segment 000

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CLICK FOR 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 Data Entry System - Section B-1, Contract Z0001, Plan 001, Segment 000

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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 Data Entry System - Section B-1, Contract Z0001, Plan 001, Segment 000

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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: Lifetime Reserve Begin Day Interval 1: Lifetime Reserve End Day Interval 1:

Coinsurance % Interval 2: Lifetime Reserve Begin Day Interval 2: Lifetime Reserve End Day Interval 2:

Coinsurance % Interval 3: Lifetime Reserve Begin Day Interval 3: Lifetime Reserve End Day Interval 3:

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

PBP Data Entry System - Section B-1, Contract Z0001, Plan 001, Segment 000

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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: 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 5 SCREEN

PBP Data Entry System - Section B-1, Contract Z0001, Plan 001, Segment 000

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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: 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:

Indicate Coinsurance percentage for Upgrades:

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

PBP Data Entry System - Section B-1, Contract Z0001, Plan 001, Segment 000

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Go To: #1a Inpatient Hospital-Acute - Base 6

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: 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:

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

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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: | Lifetime Reserve Begin Day Interval 1: | Lifetime Reserve End Day Interval 1:

Copayment Amt Interval 2: | Lifetime Reserve Begin Day Interval 2: | Lifetime Reserve End Day Interval 2:

Copayment Amt Interval 3: | Lifetime Reserve Begin Day Interval 3: | Lifetime Reserve End Day Interval 3:

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

PBP Data Entry System - Section B-1, Contract Z0001, Plan 001, Segment 000

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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: 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:

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

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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

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Is a referral required for Inpatient Hospital - Acute Services?

- Yes
- No

Inpatient Hospital - Acute Notes

Notes (Optional):

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

PBP Data Entry System - Section B-1, Contract Z0001, Plan 001, Segment 000

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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

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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: 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 (B ONLY) – BASE 3 SCREEN

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Go To: #1a Inpatient Hospital-Acute (B Only) - Base 3

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: 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:

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

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Inpatient Hospital - Acute Notes

Notes (Optional):

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

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CLICK FOR 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

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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 – 1B – INPATIENT PSYCHIATRIC HOSPITAL – BASE 3 SCREEN

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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: Lifetime Reserve Begin Day Interval 1: Lifetime Reserve End Day Interval 1:

Coinsurance % Interval 2: Lifetime Reserve Begin Day Interval 2: Lifetime Reserve End Day Interval 2:

Coinsurance % Interval 3: Lifetime Reserve Begin Day Interval 3: Lifetime Reserve End Day Interval 3:

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

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

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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: 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:

Is there an enrollee Deductible?

- Yes
- No

Indicate Deductible Amount:

Section B – 1b – Inpatient Psychiatric Hospital – Base 6 Screen

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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: | 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:

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

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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: | Lifetime Reserve Begin Day Interval 1: | Lifetime Reserve End Day Interval 1:

Copayment Amt Interval 2: | Lifetime Reserve Begin Day Interval 2: | Lifetime Reserve End Day Interval 2:

Copayment Amt Interval 3: | Lifetime Reserve Begin Day Interval 3: | Lifetime Reserve End Day Interval 3:

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

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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: 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:

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

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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:

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

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Inpatient Psychiatric Hospital Notes

Notes (Optional):

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

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Do you offer Inpatient Psychiatric Hospital Services as a benefit?

- Yes
- No

Select type of benefit for Inpatient Psychiatric Hospital 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

Select the Maximum Plan Benefit Coverage type:

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

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

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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

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Go To: #1b Inpatient Psychiatric Hosp (B Only) - Base 3

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

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Go To: #1b Inpatient Psychiatric Hosp (B Only) - Base 4

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: 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:

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

PBP Data Entry System - Section B-1, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate) **Go To:** #1b Inpatient Psychiatric Hosp (B Only) - Base 5

Inpatient Psychiatric Hospital Notes

Notes (Optional):

SECTION B – 2 – SNF – BASE 1 SCREEN

PBP Data Entry System - Section B-2, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #2 SNF - Base 1

CLICK FOR 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 Data Entry System - Section B-2, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #2 SNF - Base 2

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: | 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 – 2 – SNF – BASE 3 SCREEN

PBP Data Entry System - Section B-2, Contract Z0001, Plan 001, Segment 000

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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: 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 – 2 – SNF – BASE 4 SCREEN

PBP Data Entry System - Section B-2, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #2 SNF - Base 4

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: | 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:

Is there an enrollee Deductible?

- Yes
- No

Indicate Deductible Amount:

SECTION B – 2 – SNF – BASE 5 SCREEN

PBP Data Entry System - Section B-2, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #2 SNF - Base 5

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: 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 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: 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:

SECTION B – 2 – SNF – BASE 6 SCREEN

PBP Data Entry System - Section B-2, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #2 SNF - Base 6

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: 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:

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

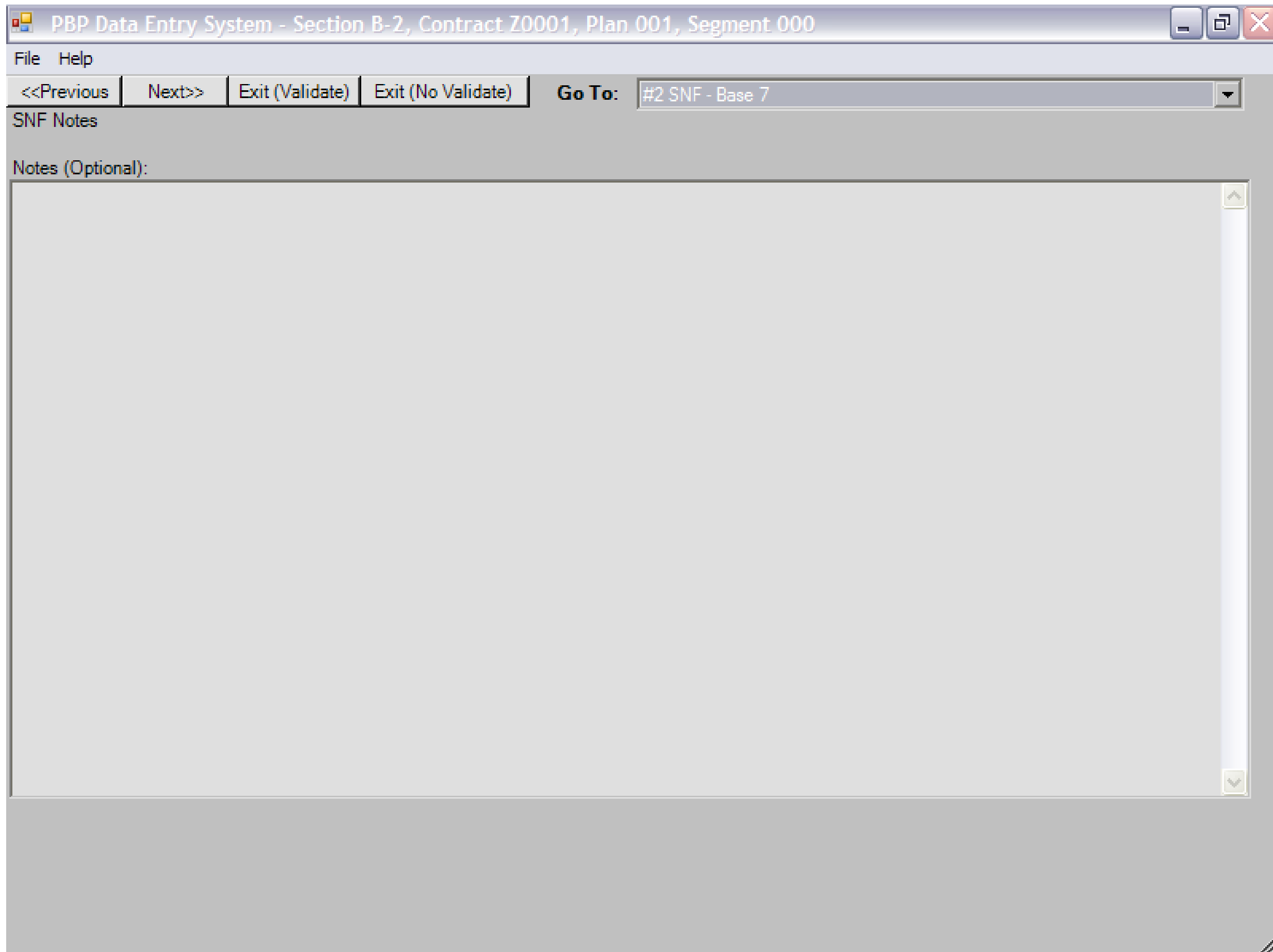
ESRD I Plans Only (Optional): If the beneficiary does not notify the plan of a planned inpatient admission, indicate the additional copayment amount per day:

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



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

PBP Data Entry System - Section B-2, Contract Z0001, Plan 001, Segment 000

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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 Data Entry System - Section B-2, Contract Z0001, Plan 001, Segment 000

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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: | 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 – 2 – SNF (B ONLY) – BASE 3 SCREEN

PBP Data Entry System - Section B-2, Contract Z0001, Plan 001, Segment 000

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Go To: #2 SNF (B Only) - Base 3

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: 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:

SECTION B – 2 – SNF (B ONLY) – BASE 4 SCREEN

PBP Data Entry System - Section B-2, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #2 SNF (B Only) - Base 4

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):

SECTION B – 3 – CORF – BASE 1 SCREEN

PBP Data Entry System - Section B-3, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #3 CORF - Base 1

CLICK FOR 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 Coinsurance percentage for Medicare-covered Benefits:

Is there an enrollee Deductible?

- Yes
- No

Indicate Deductible Amount:

Is there an enrollee Copayment?

- Yes
- No

Indicate Copayment amount per visit for Medicare -covered Benefits:

SECTION B – 3 – CORF – BASE 2 SCREEN

PBP Data Entry System - Section B-3, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #3 CORF - Base 2

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):

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

PBP Data Entry System - Section B-4, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #4a Emergency Care - Base 1

CLICK FOR 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:

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

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 – 4A – EMERGENCY CARE – BASE 2 SCREEN

PBP Data Entry System - Section B-4, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #4a Emergency Care - Base 2

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 Data Entry System - Section B-4, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #4a Emergency Care - Base 3

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:

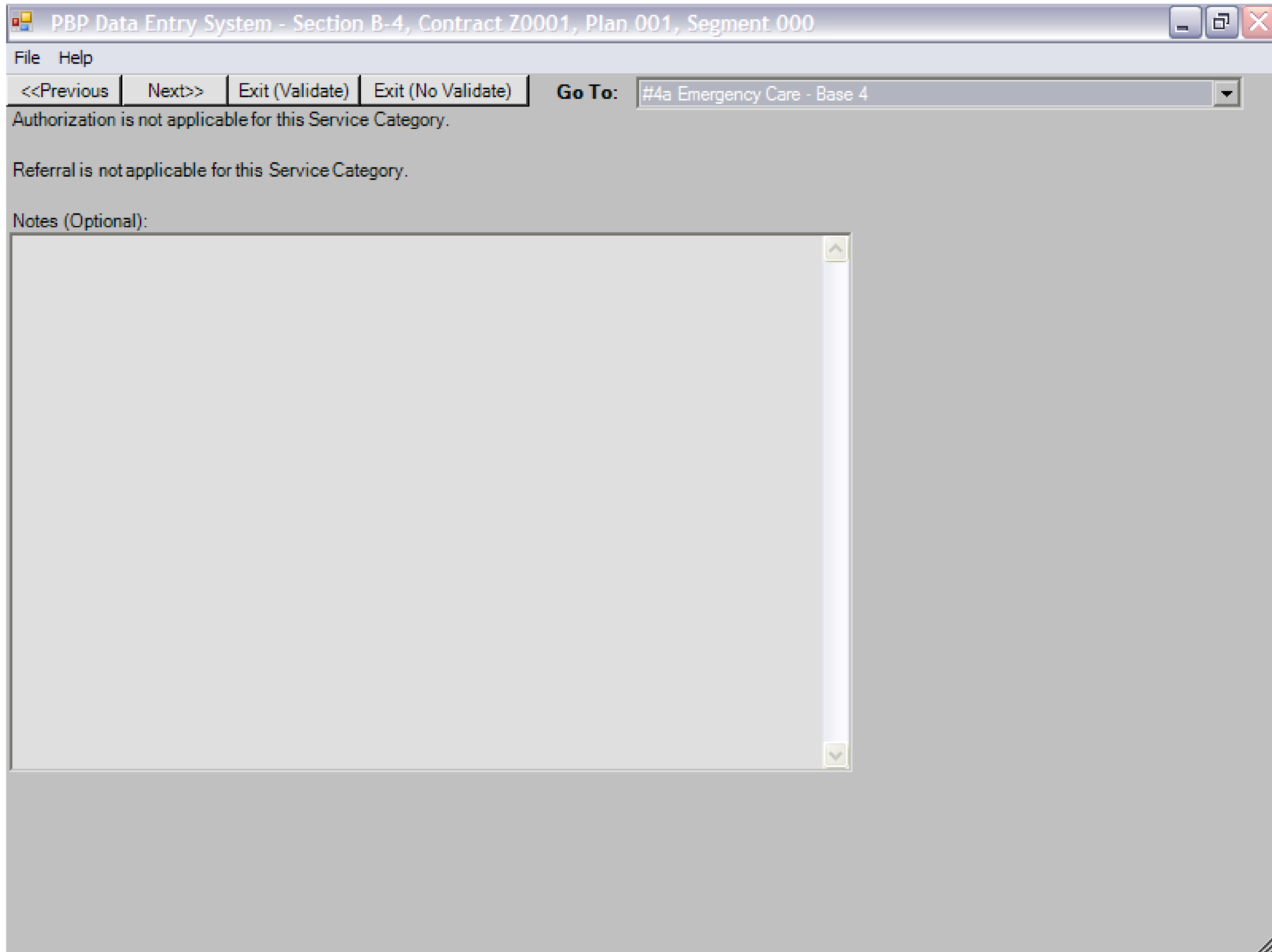
Indicate Copayment amount for Worldwide Coverage:

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

Does ER cost sharing count towards any plan-level deductibles?
- Yes
- No

Indicate the plan-level deductibles where ER cost sharing counts:
- In-Network only
- Out-of-Network only
- Combined (In-Network and Out-of-Network)

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



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

PBP Data Entry System - Section B-4, Contract Z0001, Plan 001, Segment 000

File Help

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CLICK FOR 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 when the enrollee is in the service or continuation area but the organization's provider network is temporarily unavailable or inaccessible) when the services are 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 Data Entry System - Section B-4, Contract Z0001, Plan 001, Segment 000

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<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #4b Urgently Needed Services - Base 2

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?

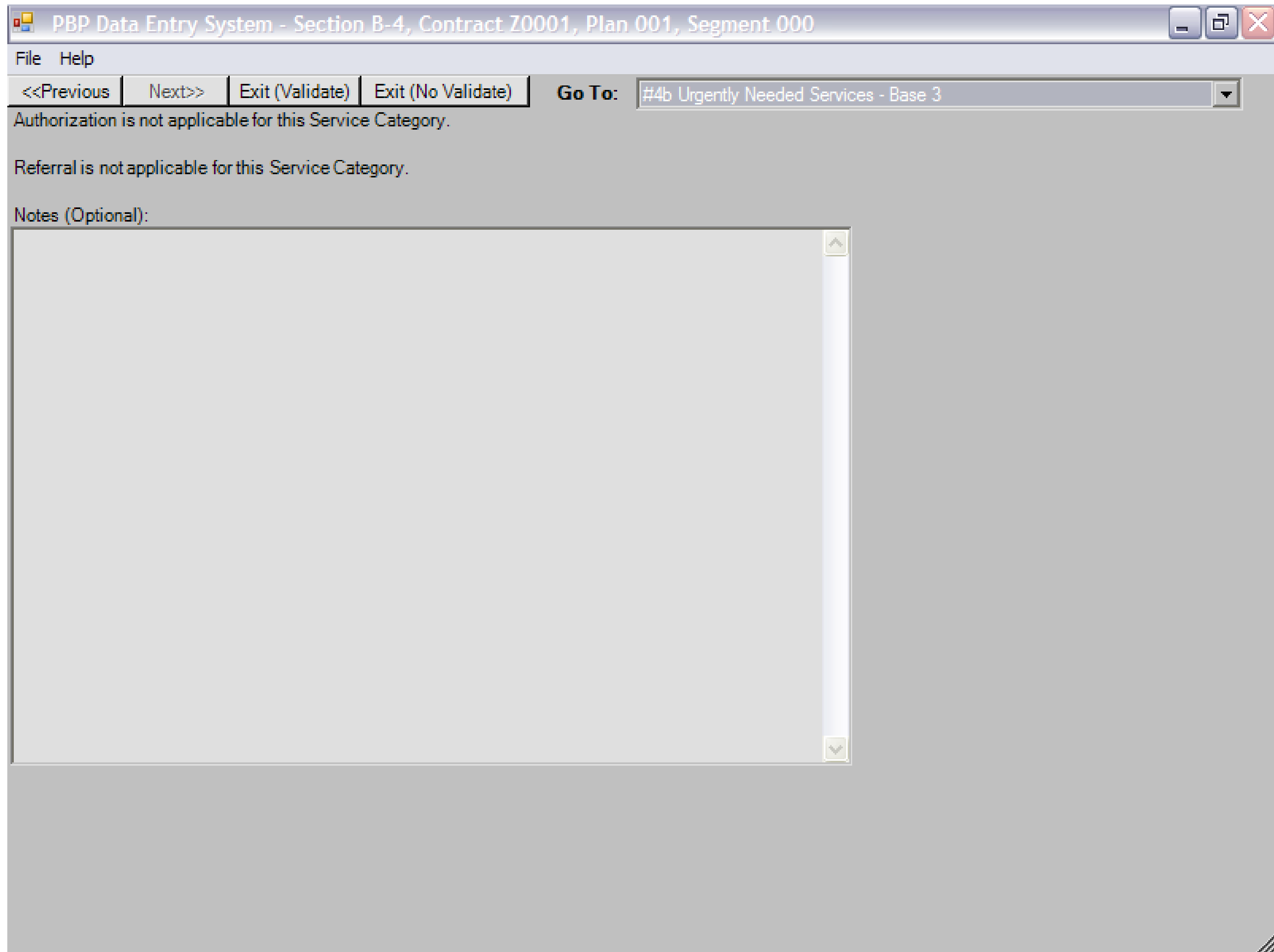
- Yes
- No

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



SECTION B – 5 – PARTIAL HOSPITALIZATION – BASE 1 SCREEN

PBP Data Entry System - Section B-5, Contract Z0001, Plan 001, Segment 000

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CLICK FOR 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 Data Entry System - Section B-5, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #5 Partial Hosp - Base 2

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):

SECTION B – 6 –HOME HEALTH – BASE 1 SCREEN

PBP Data Entry System - Section B-6, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #6 Home Health - Base 1

CLICK FOR 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 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:

Indicate Minimum Coinsurance percentage for Respite Care:

Indicate Maximum Coinsurance percentage for Respite Care:

SECTION B – 6 –HOME HEALTH – BASE 2 SCREEN

PBP Data Entry System - Section B-6, Contract Z0001, Plan 001, Segment 000

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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 3 SCREEN

PBP Data Entry System - Section B-6, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #6 Home Health - Base 3

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):

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

PBP Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

File Help

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Go To: #7a Primary Care - Base 1

CLICK FOR 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 Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

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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

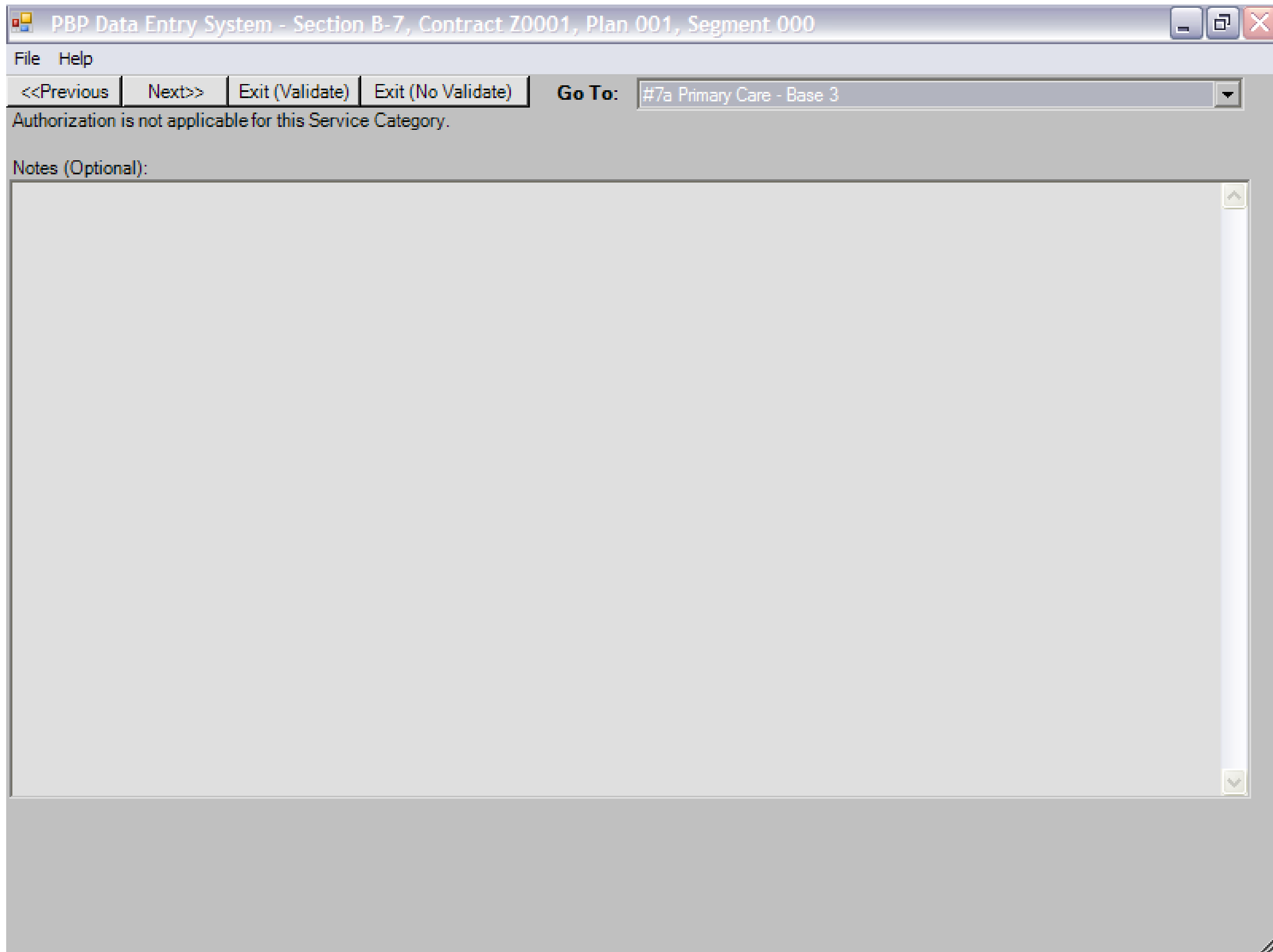
Indicate the Minimum Coinsurance percentage for In-Area, Network Urgent Care services:

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 – 7A – PRIMARY CARE PHYSICIAN – BASE 3 SCREEN



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

PBP Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #7b Chiropractic Services - Base 1

CLICK FOR 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

PBP Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #7b Chiropractic Services - Base 2

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 Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

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<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #7b Chiropractic Services - Base 3

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

PBP Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

File Help

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Chiropractic Services Notes

Notes (Optional):

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

PBP Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

File Help

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CLICK FOR 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

PBP Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

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<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #7c Occupational Therapy - Base 2

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):

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

PBP Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

File Help

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CLICK FOR 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

PBP Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

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<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #7d Physician Specialist - Base 2

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):

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

PBP Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

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CLICK FOR 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

PBP Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #7e Mental Health - Base 2

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 Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #7e Mental Health - Base 3

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: | 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:

Is there an enrollee Deductible?

- Yes
- No

Indicate Deductible Amount:

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

PBP Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

File Help

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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 – 7E – MENTAL HEALTH SERVICES – BASE 5 SCREEN

PBP Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #7e Mental Health - Base 5

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):

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

PBP Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

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CLICK FOR 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 Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #7f Podiatry Services - Base 2

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 Routine Footcare:

Indicate Maximum Coinsurance percentage for Routine Footcare:

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 Routine Footcare:

Indicate Maximum Copayment amount per visit for Routine Footcare:

SECTION B – 7F – PODIATRY SERVICES – BASE 3 SCREEN

PBP Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #7f Podiatry Services - Base 3

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):

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

PBP Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

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CLICK FOR 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 Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

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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):

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

PBP Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

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CLICK FOR 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 Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

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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 – 7H – PSYCHIATRIC SERVICES – BASE 3 SCREEN

PBP Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

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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: | 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:

Is there an enrollee Deductible?

- Yes
- No

Indicate Deductible Amount:

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

PBP Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

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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 Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

File Help

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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):

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

PBP Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #7i PT and SP Services - Base 1

CLICK FOR 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:

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 – 7I – PHYSICAL THERAPY AND SPEECH-LANGUAGE SERVICES – BASE 2 SCREEN

PBP Data Entry System - Section B-7, Contract Z0001, Plan 001, Segment 000

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<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #7i PT and SP Services - Base 2

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):

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

PBP Data Entry System - Section B-8, Contract Z0001, Plan 001, Segment 000

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CLICK FOR 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 Data Entry System - Section B-8, Contract Z0001, Plan 001, Segment 000

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<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #8a Outpatient Diag Procs/Tests/Lab Services - Base 2

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 Data Entry System - Section B-8, Contract Z0001, Plan 001, Segment 000

File Help

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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:

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

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 an enrollee Coinsurance for a separate office visit?
- Yes
- No

Indicate Minimum Coinsurance for a separate office visit:

Indicate Maximum Coinsurance for a separate office visit:

Is there an enrollee Copayment for a separate office visit?
- Yes
- No

Indicate Minimum Copayment for a separate office visit:

Indicate Maximum Copayment for a separate office visit:

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

PBP Data Entry System - Section B-8, Contract Z0001, Plan 001, Segment 000

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<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #8a Outpatient Diag Procs/Tests/Lab Services - Base 4

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):

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

PBP Data Entry System - Section B-8, Contract Z0001, Plan 001, Segment 000

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CLICK FOR 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:

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 2 SCREEN

PBP Data Entry System - Section B-8, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #8b Outpatient Diag/Therapeutic Rad Services - Base 2

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

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 an enrollee Coinsurance for a separate office visit?
- Yes
- No

Indicate Minimum Coinsurance for a separate office visit:

Indicate Maximum Coinsurance for a separate office visit:

Is there an enrollee Copayment for a separate office visit?
- Yes
- No

Indicate Minimum Copayment for a separate office visit:

Indicate Maximum Copayment for a separate office visit:

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

PBP Data Entry System - Section B-8, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #8b Outpatient Diag/Therapeutic Rad Services - Base 3

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

Outpatient Diagnostic and Therapeutic Radiological Services Notes

Notes (Optional):

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

PBP Data Entry System - Section B-9, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #9a Outpatient Hospital - Base 1

CLICK FOR 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

PBP Data Entry System - Section B-9, Contract Z0001, Plan 001, Segment 000

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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.

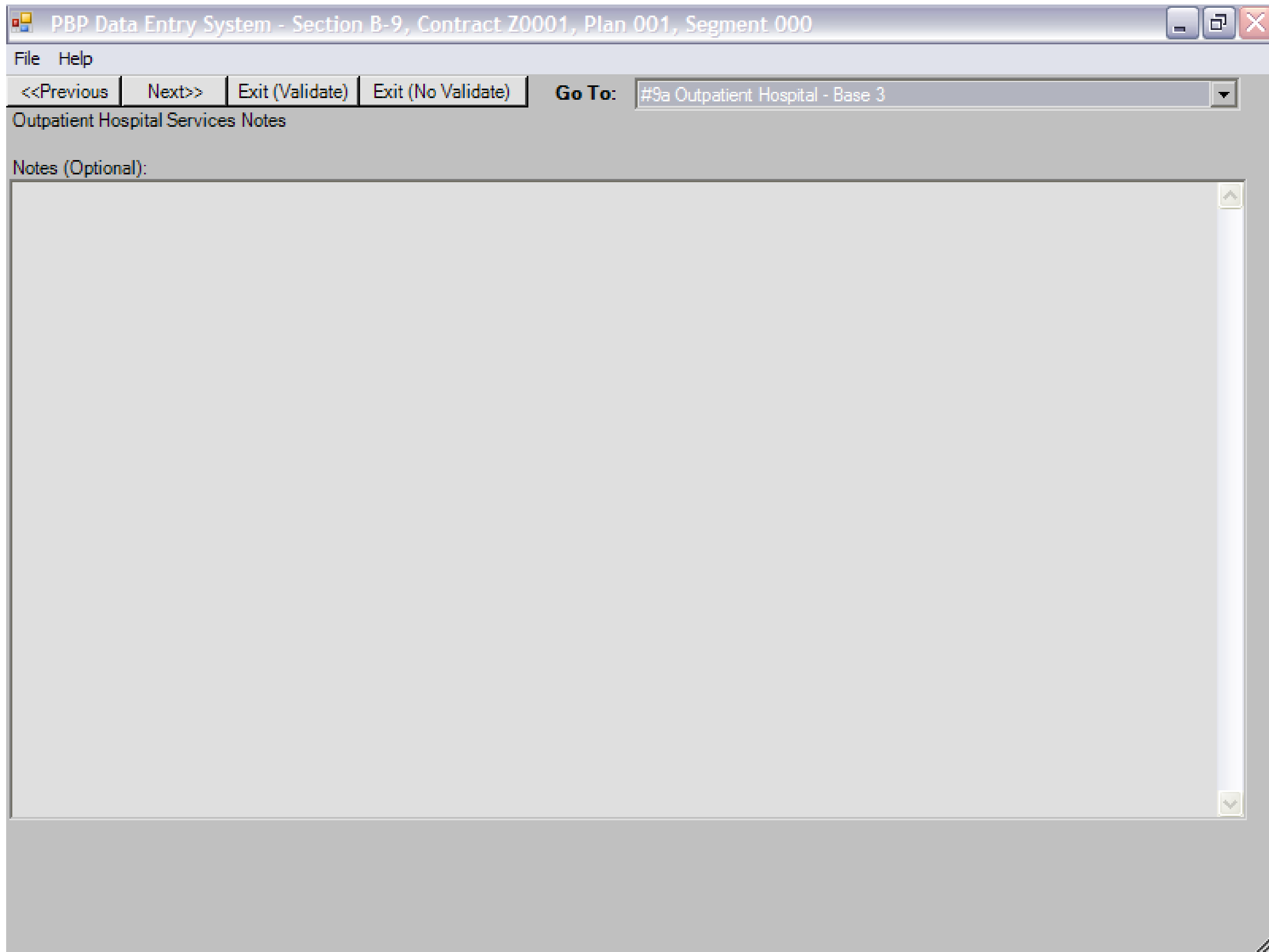
Enrollee must receive Authorization from one or more of the following:

- 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



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

PBP Data Entry System - Section B-9, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #9b ASC Services - Base 1

CLICK FOR 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

PBP Data Entry System - Section B-9, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #9b ASC Services - Base 2

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.

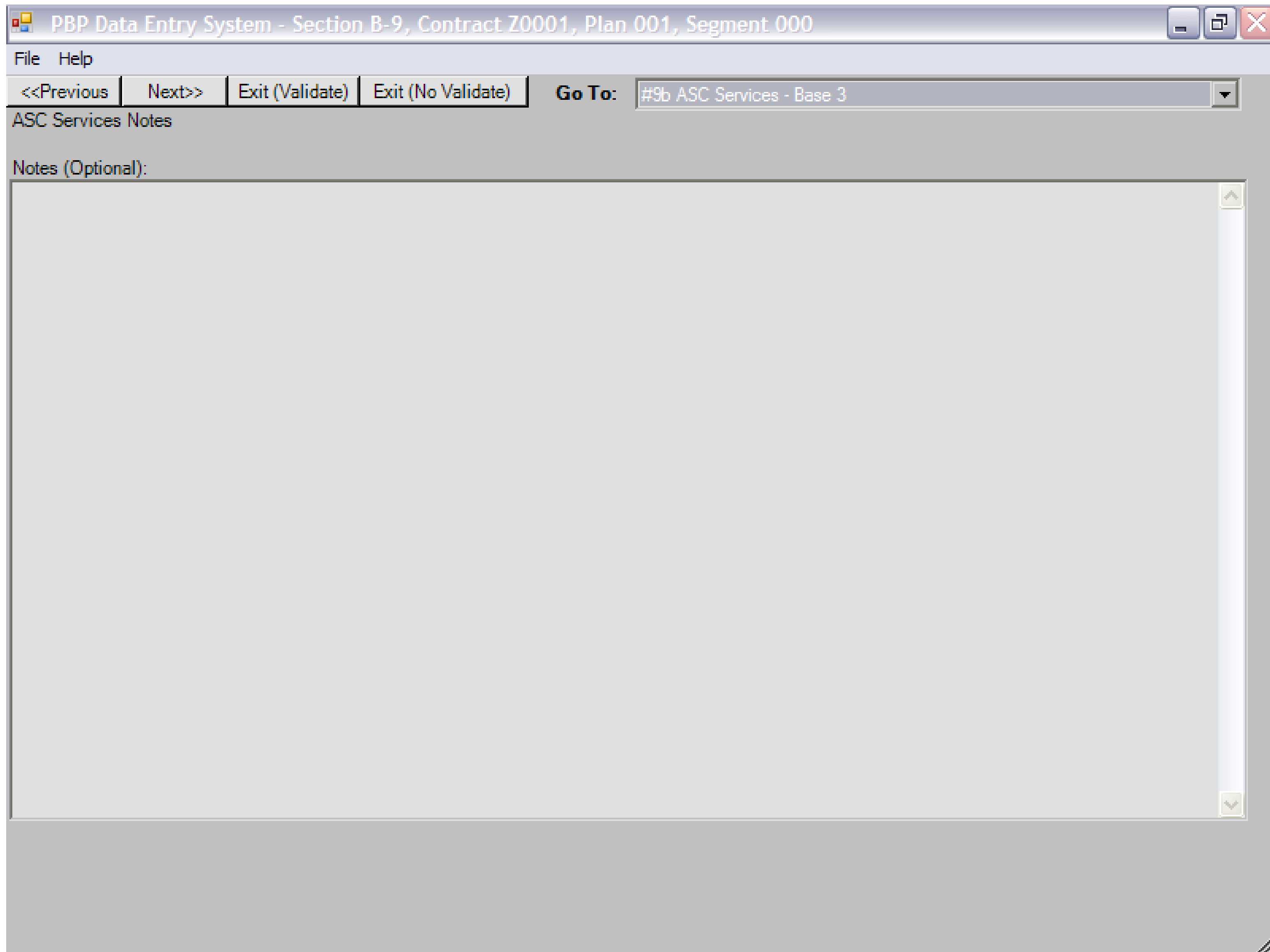
Enrollee must receive Authorization from one or more of the following:

- 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



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

PBP Data Entry System - Section B-9, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #9c Outpatient Sub Abuse - Base 1

CLICK FOR 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

PBP Data Entry System - Section B-9, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #9c Outpatient Sub Abuse - Base 2

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

PBP Data Entry System - Section B-9, Contract Z0001, Plan 001, Segment 000

File Help

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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: | 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:

Is there an enrollee Deductible?

- Yes
- No

Indicate Deductible Amount:

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

PBP Data Entry System - Section B-9, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #9c Outpatient Sub Abuse - Base 4

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

PBP Data Entry System - Section B-9, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #9c Outpatient Sub Abuse - Base 5

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):

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

PBP Data Entry System - Section B-9, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #9d Cardiac Rehab Services - Base 1

CLICK FOR 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 Data Entry System - Section B-9, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #9d Cardiac Rehab Services - Base 2

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:

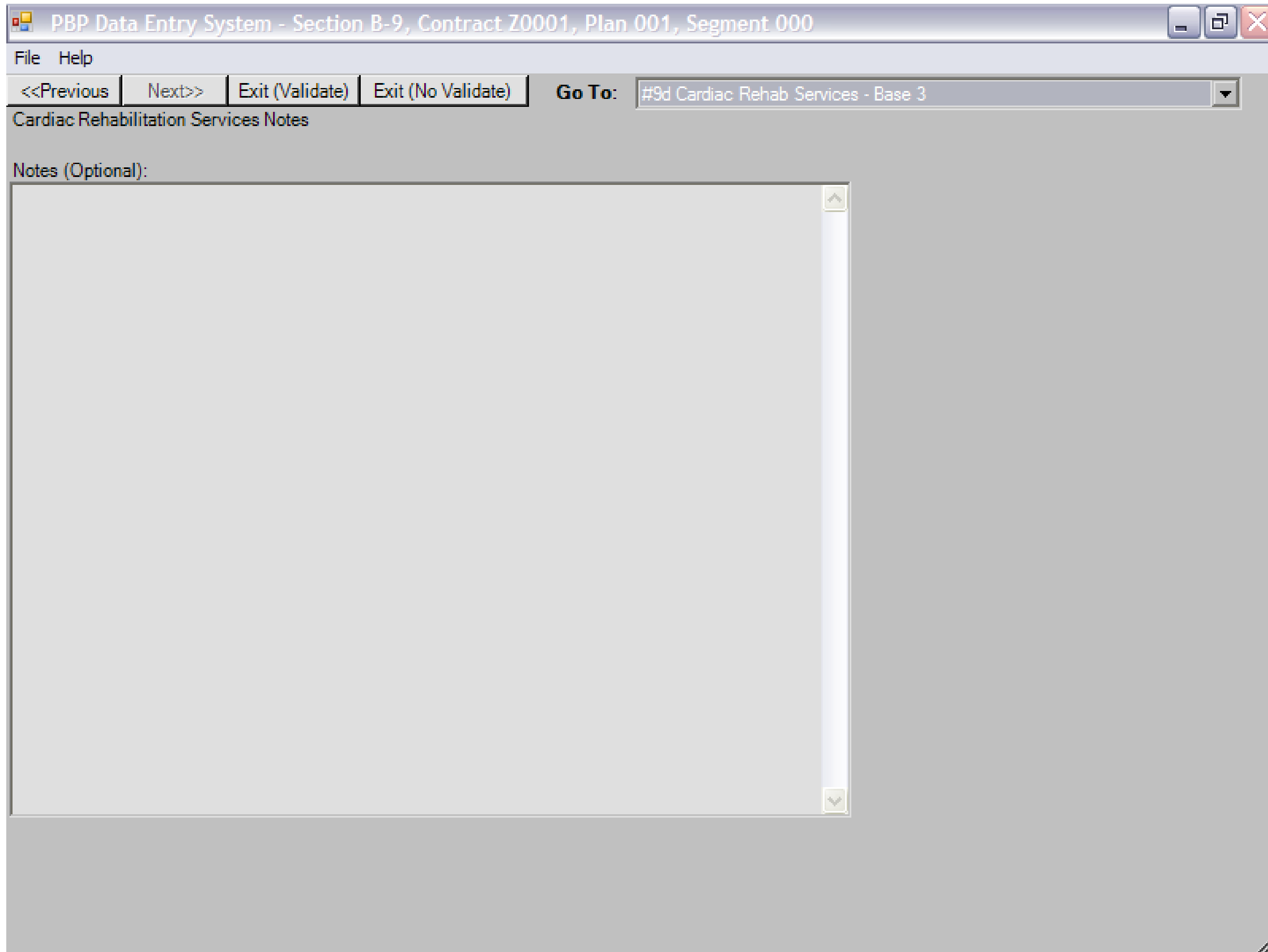
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:

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

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



SECTION B – 10A – AMBULANCE – BASE 1 SCREEN

PBP Data Entry System - Section B-10, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #10a Ambulance - Base 1

CLICK FOR 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 the Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:

Is this Coinsurance waived if admitted to hospital?

- Yes
- No

Is there an enrollee Deductible?

- Yes
- No

Indicate Deductible Amount:

Is there an enrollee Copayment?

- Yes
- No

Indicate the Minimum Copayment amount for Medicare-covered Benefits:

Indicate the Maximum Copayment amount for Medicare-covered Benefits:

Is this Copayment waived if admitted to hospital?

- Yes
- No

SECTION B – 10A – AMBULANCE – BASE 2 SCREEN

PBP Data Entry System - Section B-10, Contract Z0001, Plan 001, Segment 000

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<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #10a Ambulance - Base 2

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):

SECTION B – 10B – TRANSPORTATION – BASE 1 SCREEN

PBP Data Entry System - Section B-10, Contract Z0001, Plan 001, Segment 000

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<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #10b Transportation - Base 1

CLICK FOR 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 Data Entry System - Section B-10, Contract Z0001, Plan 001, Segment 000

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<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #10b Transportation - Base 2

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 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:

Is there an enrollee Deductible?
- Yes
- No

Indicate Deductible Amount:

SECTION B – 10B – TRANSPORTATION – BASE 3 SCREEN

PBP Data Entry System - Section B-10, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #10b Transportation - Base 3

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):

SECTION B – 11A – DME – BASE 1 SCREEN

PBP Data Entry System - Section B-11, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #11a DME - Base 1

CLICK FOR 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 item for Medicare-covered Benefits:

Indicate Maximum Copayment amount per item for Medicare-covered Benefits:

SECTION B – 11A – DME – BASE 2 SCREEN

PBP Data Entry System - Section B-11, Contract Z0001, Plan 001, Segment 000

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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):

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

PBP Data Entry System - Section B-11, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #11b Pros./Med. Supp. - Base 1

CLICK FOR 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

PBP Data Entry System - Section B-11, Contract Z0001, Plan 001, Segment 000

File Help

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Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:

Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:

Is there an enrollee Deductible?
- Yes
- No

Indicate Deductible Amount:

Is there an enrollee Copayment?
- Yes
- No

Indicate Minimum Copayment amount per item for Medicare-covered Prosthetic Devices:

Indicate Maximum Copayment amount per item for Medicare-covered Prosthetic Devices:

Indicate Minimum Copayment amount per item for Medicare-covered Medical Supplies:

Indicate Maximum Copayment amount per item for Medicare-covered Medical Supplies:

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

PBP Data Entry System - Section B-11, Contract Z0001, Plan 001, Segment 000

File Help

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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):

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

PBP Data Entry System - Section B-11, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #11c Diabetes Mon Supplies - Base 1

CLICK FOR 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 – 11C – DIABETES MONITORING SUPPLIES – BASE 2 SCREEN

PBP Data Entry System - Section B-11, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #11c Diabetes Mon Supplies - Base 2

Is there an enrollee Deductible?
- Yes
- No

Indicate Deductible Amount:

Is there an enrollee Copayment?
- Yes
- No

Indicate Minimum Copayment amount per item for Medicare-covered Benefits:

Indicate Maximum Copayment amount per item 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

Referral is not applicable for this Service Category.

Notes (Optional):

SECTION B – 12 – RENAL DIALYSIS – BASE 1 SCREEN

PBP Data Entry System - Section B-12, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #12 End-Stage Renal Disease - Base 1

CLICK FOR 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:

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 – 12 – RENAL DIALYSIS – BASE 2 SCREEN

PBP Data Entry System - Section B-12, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #12 End-Stage Renal Disease - Base 2

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):

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

PBP Data Entry System - Section B-13, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #13a Blood - Base 1

CLICK FOR 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 Data Entry System - Section B-13, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #13a Blood - Base 2

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):

SECTION B – 13B – ACUPUNCTURE – BASE 1 SCREEN

PBP Data Entry System - Section B-13, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #13b Acupuncture - Base 1

CLICK FOR 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

PBP Data Entry System - Section B-13, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #13b Acupuncture - Base 2

Is there an enrollee Coinsurance?
- Yes
- No

Indicate Coinsurance percentage:

Is there an enrollee Copayment?
- Yes
- No

Indicate Copayment amount per treatment:

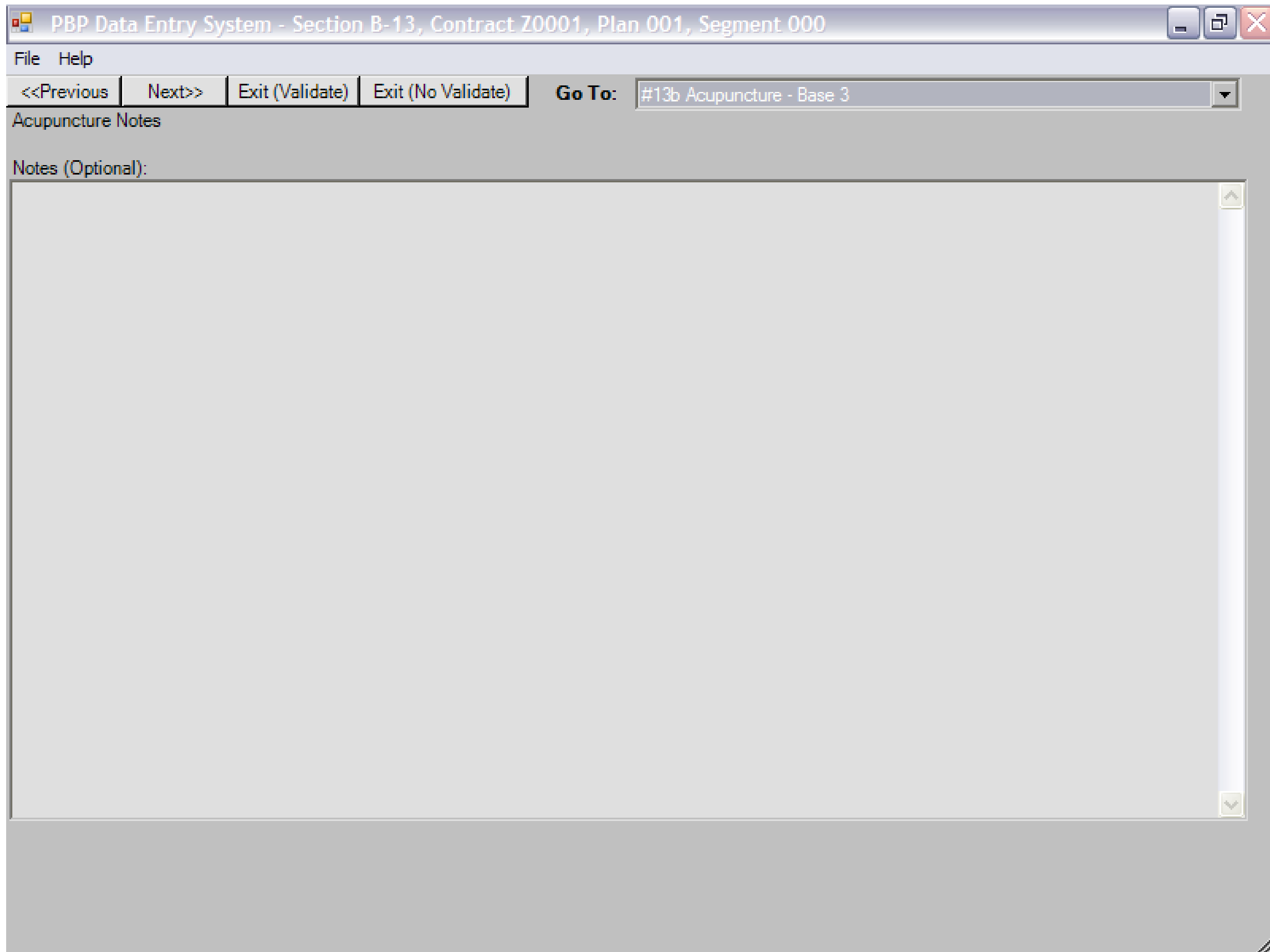
Is there an enrollee Deductible?
- Yes
- No

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



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

PBP Data Entry System - Section B-13, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #13c OTC - Base 1

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

PBP Data Entry System - Section B-13, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #13c OTC - Base 2

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?

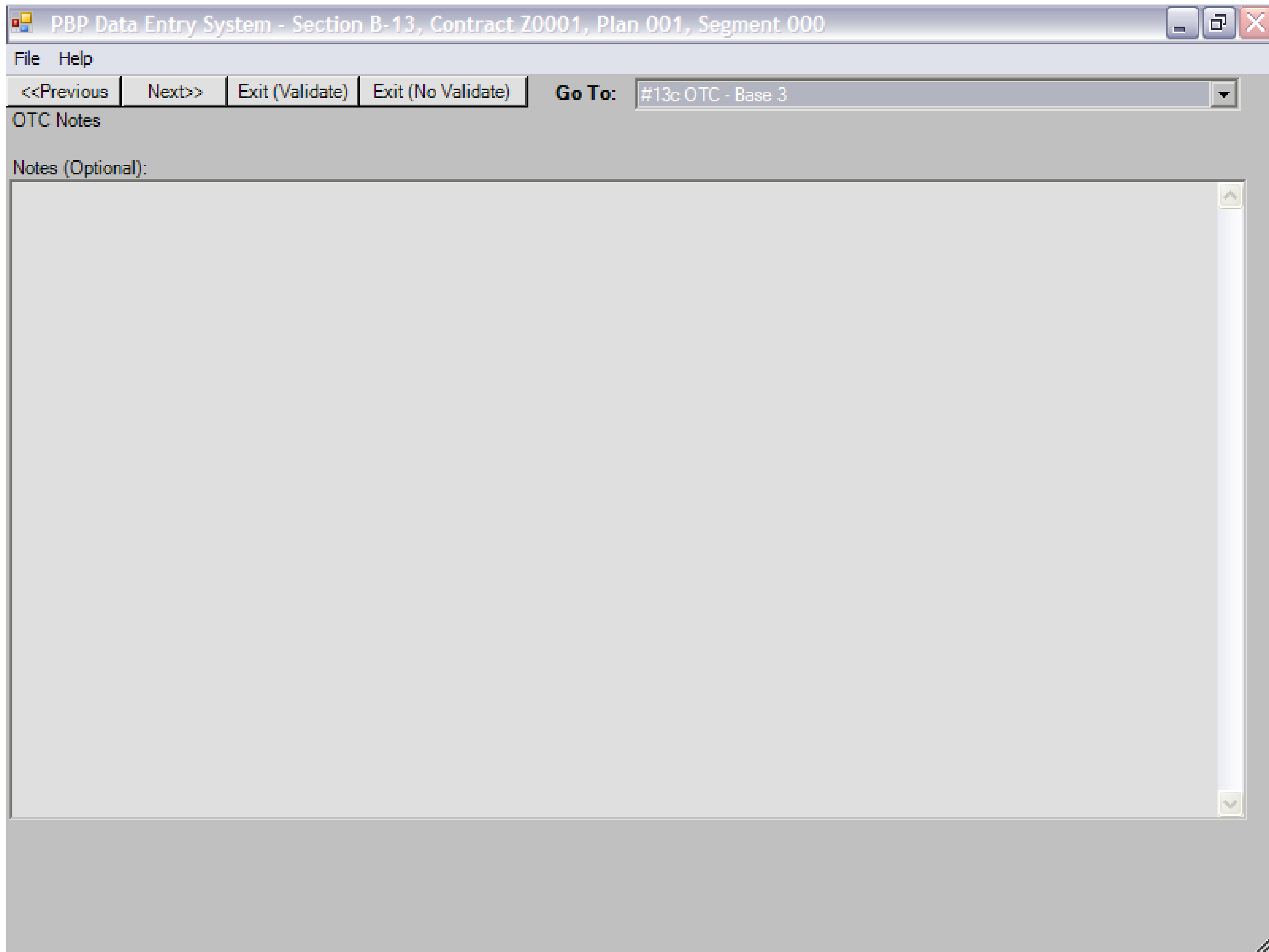
- Yes
- No

Indicate Copayment amount:

Does this cover all of the CMS OTC list?

- Yes
- No

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



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

PBP Data Entry System - Section B-13, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #13d Meal Benefit - Base 1

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 Data Entry System - Section B-13, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #13d Meal Benefit - Base 2

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

PBP Data Entry System - Section B-13, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #13d Meal Benefit - Base 3

Meal Benefit Notes

Notes (Optional):

SECTION B – 13E – OTHER 1 – BASE 1 SCREEN

PBP Data Entry System - Section B-13, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #13e Other 1 - Base 1

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 1 – BASE 2 SCREEN

PBP Data Entry System - Section B-13, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #13e Other 1 - Base 2

Is there an enrollee Coinsurance?
- Yes
- No

Indicate Coinsurance percentage:

Is there an enrollee Deductible?
- Yes
- No

Indicate Deductible Amount:

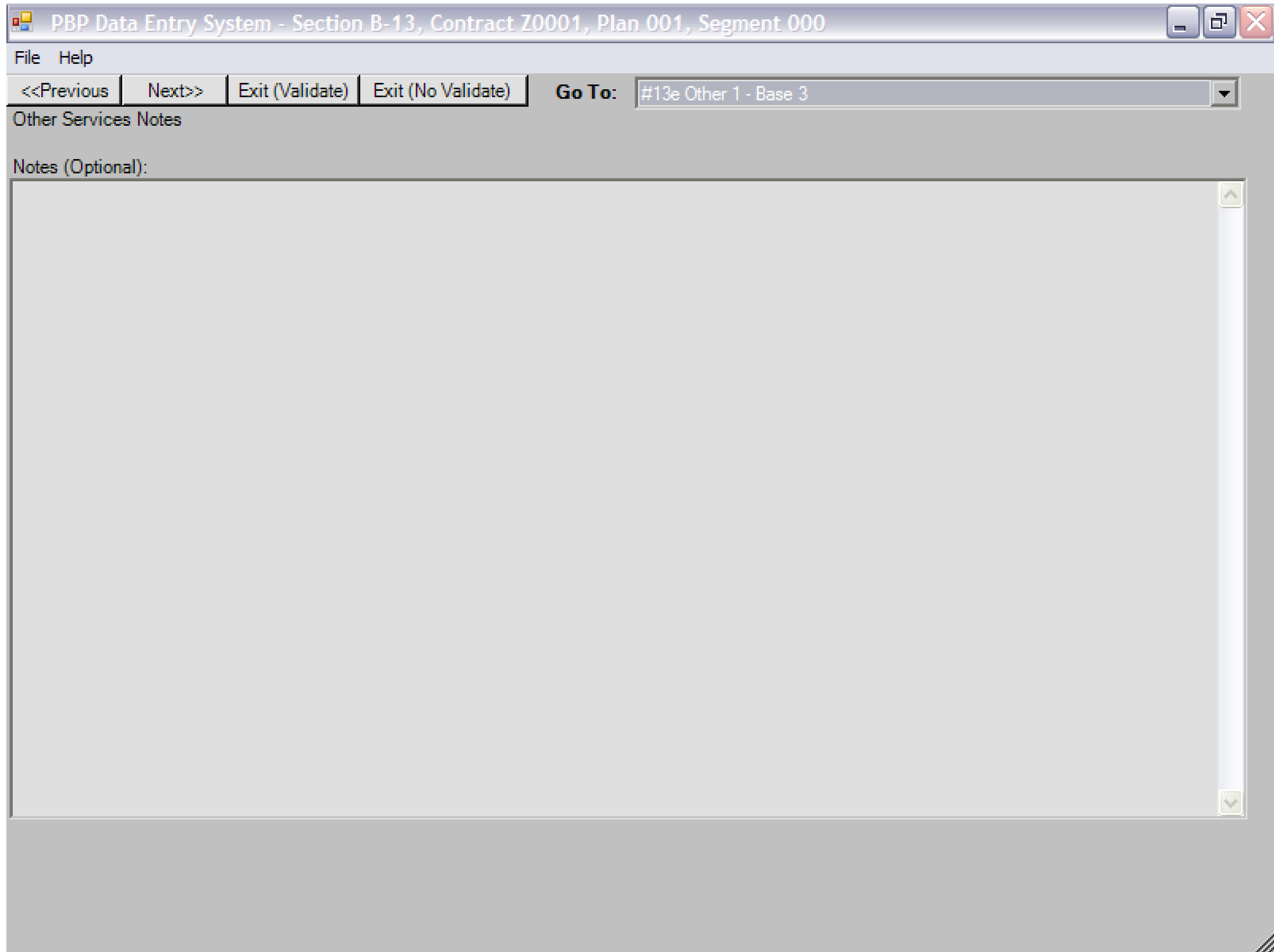
Is there an enrollee Copayment?
- Yes
- No

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 1 – BASE 3 SCREEN



SECTION B – 13F – OTHER 2 – BASE 1 SCREEN

PBP Data Entry System - Section B-13, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #13f Other 2 - Base 1

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 – 13F – OTHER 2 – BASE 2 SCREEN

PBP Data Entry System - Section B-13, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #13f Other 2 - Base 2

Is there an enrollee Coinsurance?
- Yes
- No

Indicate Coinsurance percentage:

Is there an enrollee Deductible?
- Yes
- No

Indicate Deductible Amount:

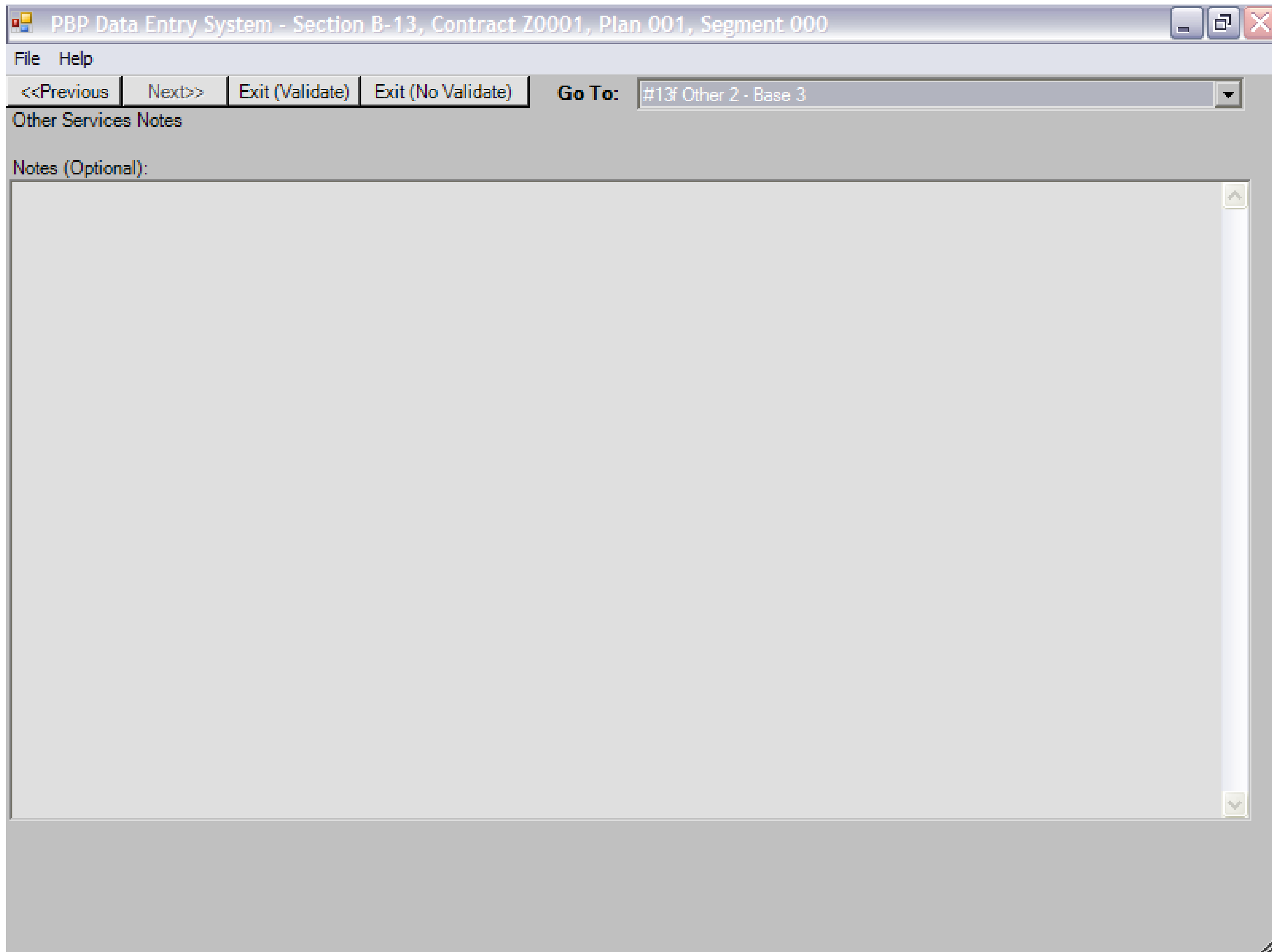
Is there an enrollee Copayment?
- Yes
- No

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 – 13F – OTHER 2 – BASE 3 SCREEN



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

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #14a Health Ed/Wellness - Base 1

CLICK FOR 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 Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #14a Health Ed/Wellness - Base 2

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 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 the Minimum Coinsurance percentage for the Medicare-covered Smoking Cessation benefit:

Indicate the Maximum Coinsurance percentage for the Medicare-covered Smoking Cessation benefit:

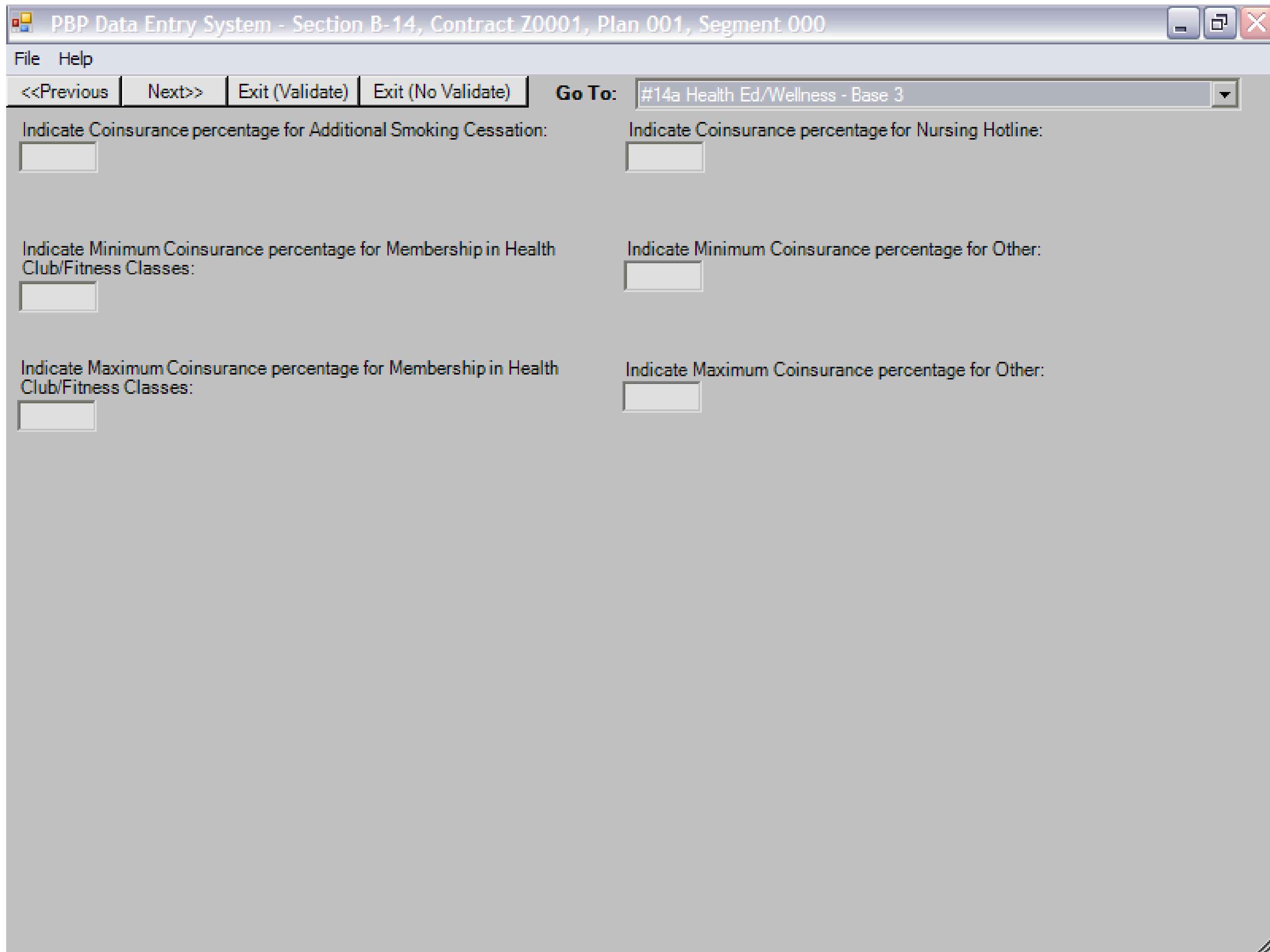
Indicate Minimum Coinsurance percentage for Written health education materials, incl. newsletters:

Indicate Maximum Coinsurance percentage for Written health education materials, incl. newsletters:

Indicate Coinsurance percentage for Nutritional Benefit:

Indicate Coinsurance percentage for Nutritional Training:

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



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

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #14a Health Ed/Wellness - Base 4

Is there an enrollee Deductible?

- Yes
- No

Indicate Deductible Amount:

Is there an enrollee Copayment?

- Yes
- No

Indicate the Minimum Copayment amount for the Medicare-covered Smoking Cessation benefit:

Indicate the Maximum Copayment amount for the Medicare-covered Smoking Cessation benefit:

Indicate Copayment amount for Written health education materials, incl. newsletters:

Indicate Copayment amount for Nutritional Training:

Indicate Copayment amount for Nutritional Benefit:

Indicate Copayment amount for Additional Smoking Cessation:

Indicate Minimum Copayment amount for Membership in Health Club/Fitness Classes:

Indicate Maximum Copayment amount for Membership in Health Club/Fitness Classes:

Indicate Copayment amount for Nursing Hotline:

Indicate Minimum Copayment amount for Other:

Indicate Maximum Copayment amount for Other:

SECTION B – 14A – HEALTH EDUCATION AND WELLNESS – BASE 5 SCREEN

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #14a Health Ed/Wellness - Base 5

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):

SECTION B – 14B – IMMUNIZATIONS – BASE 1 SCREEN

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #14b Immunizations - Base 1

CLICK FOR 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

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #14b Immunizations - Base 2

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

Is there an enrollee Coinsurance for a separate office visit?

- Yes
- No

Indicate Minimum Coinsurance for a separate office visit:

Indicate Maximum Coinsurance for a separate office visit:

Is there an enrollee Copayment for a separate office visit?

- Yes
- No

Indicate Minimum Copayment for a separate office visit:

Indicate Maximum Copayment for a separate office visit:

SECTION B – 14B – IMMUNIZATIONS – BASE 3 SCREEN

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #14b Immunizations - Base 3

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):

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

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #14c Physical Exams - Base 1

CLICK FOR 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

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #14c Physical Exams - Base 2

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 – 14C – PHYSICAL EXAMS – BASE 3 SCREEN

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #14c Physical Exams - Base 3

Is there an enrollee Coinsurance?

- Yes
- No

Indicate Coinsurance percentage for Medicare-covered initial preventive physical exam:

Indicate Coinsurance percentage for Routine Exams:

Is there an enrollee Deductible?

- Yes
- No

Indicate Deductible Amount:

Is there an enrollee Copayment?

- Yes
- No

Indicate Copayment amount for Medicare-covered initial preventive physical exam:

Indicate Copayment amount per Routine Exam:

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

- Yes
- No
- Sometimes, describe

Is there an enrollee Coinsurance for a separate office visit?

- Yes
- No

Indicate Minimum Coinsurance for a separate office visit:

Indicate Maximum Coinsurance for a separate office visit:

Is there an enrollee Copayment for a separate office visit?

- Yes
- No

Indicate Minimum Copayment for a separate office visit:

Indicate Maximum Copayment for a separate office visit:

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

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #14c Physical Exams - Base 4

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 Routine Exams?

- ( ) Yes
- ( ) No

Routine Exam Notes

Notes (Optional):

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

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #14d Pap/Pelvic - Base 1

CLICK FOR DESCRIPTION OF BENEFIT

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

Indicate number of Additional Pap Smears:

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

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

Is this benefit unlimited for Additional Pelvic Exams?
- Yes
- No, indicate number

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

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #14d Pap/Pelvic - Base 2

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 Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #14d Pap/Pelvic - Base 3

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 Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #14d Pap/Pelvic - Base 4

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 Additional Pap Smear:

Indicate Copayment amount per Medicare-covered Pelvic Exam:

Indicate Copayment amount per Additional Pelvic Exam:

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

- Yes
- No
- Sometimes, describe

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 an enrollee Coinsurance for a separate office visit?

- Yes
- No

Indicate Minimum Coinsurance for a separate office visit:

Indicate Maximum Coinsurance for a separate office visit:

Is there an enrollee Copayment for a separate office visit?

- Yes
- No

Indicate Minimum Copayment for a separate office visit:

Indicate Maximum Copayment for a separate office visit:

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

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

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Pap Smear/Pelvic Exam Notes

Notes (Optional):

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

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

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CLICK FOR 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

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

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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 Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #14e Prostate Screening - Base 3

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:

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

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 an enrollee Coinsurance for a separate office visit?
- Yes
- No

Indicate Minimum Coinsurance for a separate office visit:

Indicate Maximum Coinsurance for a separate office visit:

Is there an enrollee Copayment for a separate office visit?
- Yes
- No

Indicate Minimum Copayment for a separate office visit:

Indicate Maximum Copayment for a separate office visit:

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

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

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Prostate Cancer Screening Notes

Notes (Optional):

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

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #14f Colorectal Screening - Base 1

CLICK FOR 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

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #14f Colorectal Screening - Base 2

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 – 14F – COLORECTAL SCREENING – BASE 3 SCREEN

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #14f Colorectal Screening - Base 3

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 Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #14f Colorectal Screening - Base 4

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:

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

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 an enrollee Coinsurance for a separate office visit?
- Yes
- No

Indicate Minimum Coinsurance for a separate office visit:

Indicate Maximum Coinsurance for a separate office visit:

Is there an enrollee Copayment for a separate office visit?
- Yes
- No

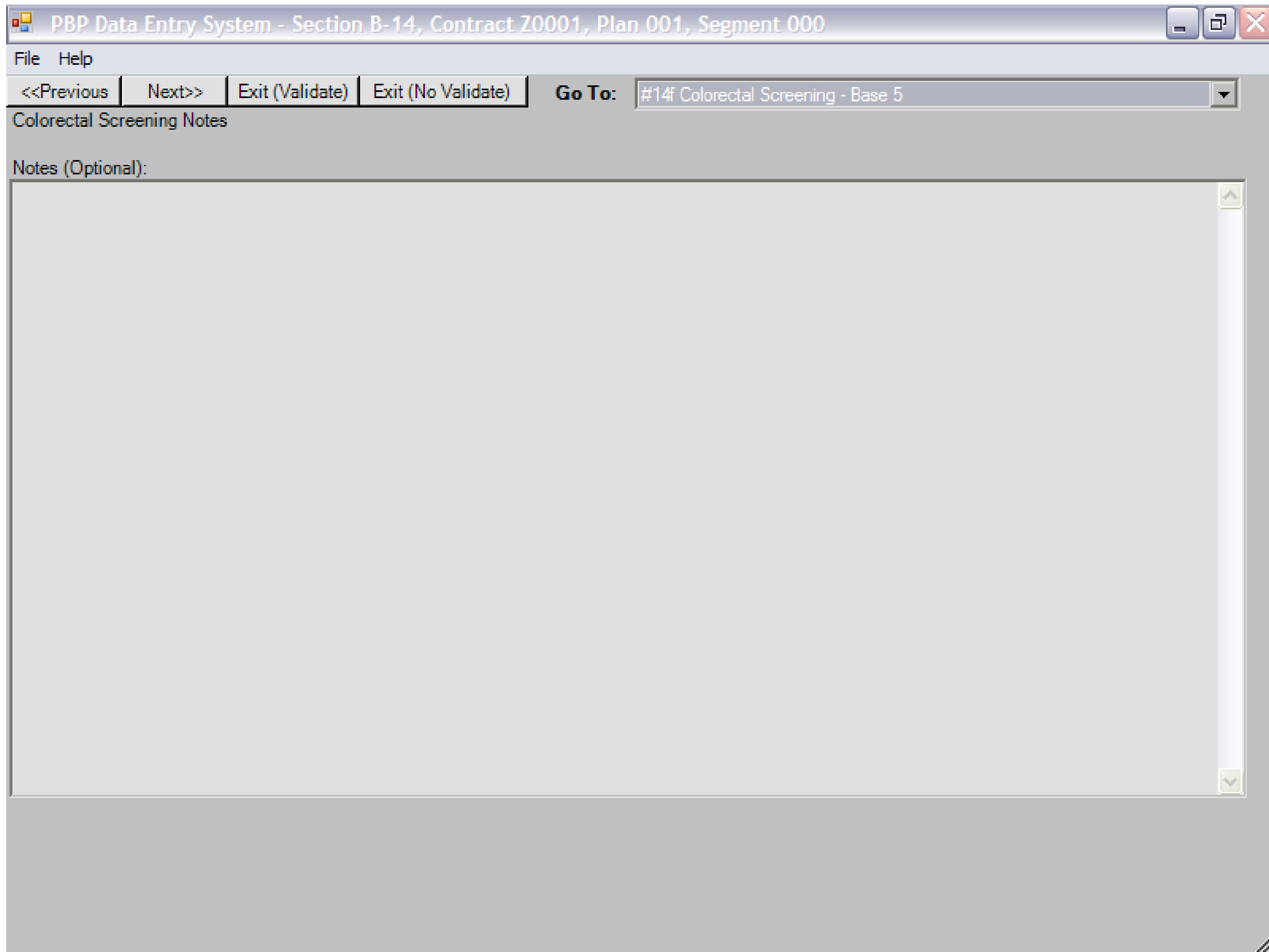
Indicate Minimum Copayment for a separate office visit:

Indicate Maximum Copayment for a separate office visit:

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



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

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

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CLICK FOR 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 Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

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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

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 an enrollee Coinsurance for a separate office visit?

- Yes
- No

Indicate Minimum Coinsurance for a separate office visit:

Indicate Maximum Coinsurance for a separate office visit:

Is there an enrollee Copayment for a separate office visit?

- Yes
- No

Indicate Minimum Copayment for a separate office visit:

Indicate Maximum Copayment for a separate office visit:

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

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #14g Bone Mass Meas. - Base 3

Bone Mass Measurement Screening Notes

Notes (Optional):

SECTION B – 14H – MAMMOGRAPHY – BASE 1 SCREEN

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

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CLICK FOR 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

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 – 14H – MAMMOGRAPHY – BASE 2 SCREEN

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

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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 – 14H – MAMMOGRAPHY – BASE 3 SCREEN

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #14h Mammography - Base 3

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:

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

- Yes
- No
- Sometimes, describe

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 an enrollee Coinsurance for a separate office visit?

- Yes
- No

Indicate Minimum Coinsurance for a separate office visit:

Indicate Maximum Coinsurance for a separate office visit:

Is there an enrollee Copayment for a separate office visit?

- Yes
- No

Indicate Minimum Copayment for a separate office visit:

Indicate Maximum Copayment for a separate office visit:

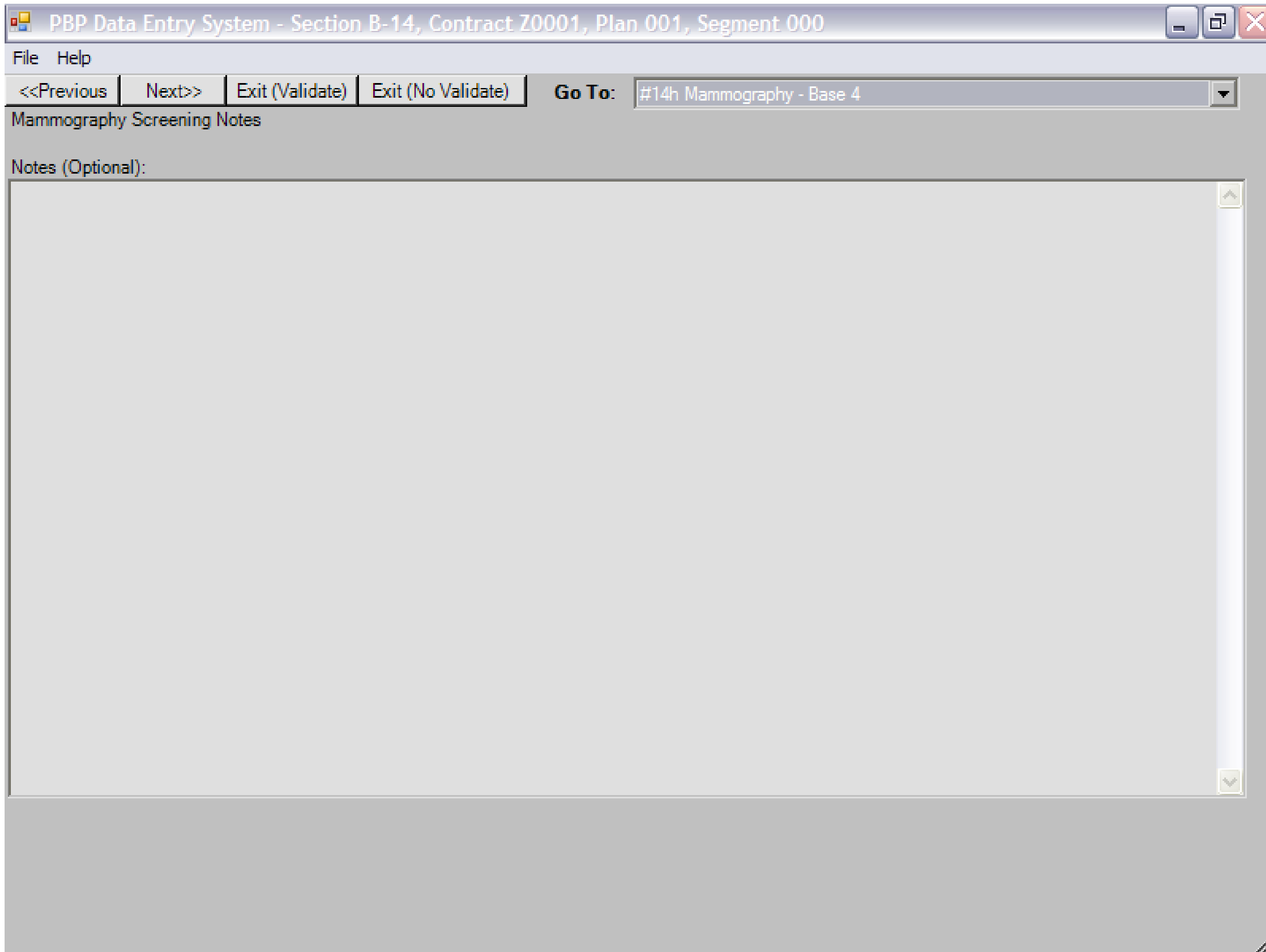
Enrollee must receive Authorization for Additional Screenings from one or more of the following:

- 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



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

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #14i Diabetes Monitoring - Base 1

CLICK FOR 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 Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #14i Diabetes Monitoring - Base 2

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

Is there an enrollee Coinsurance for a separate office visit?
- Yes
- No

Indicate Minimum Coinsurance for a separate office visit:

Indicate Maximum Coinsurance for a separate office visit:

Is there an enrollee Copayment for a separate office visit?
- Yes
- No

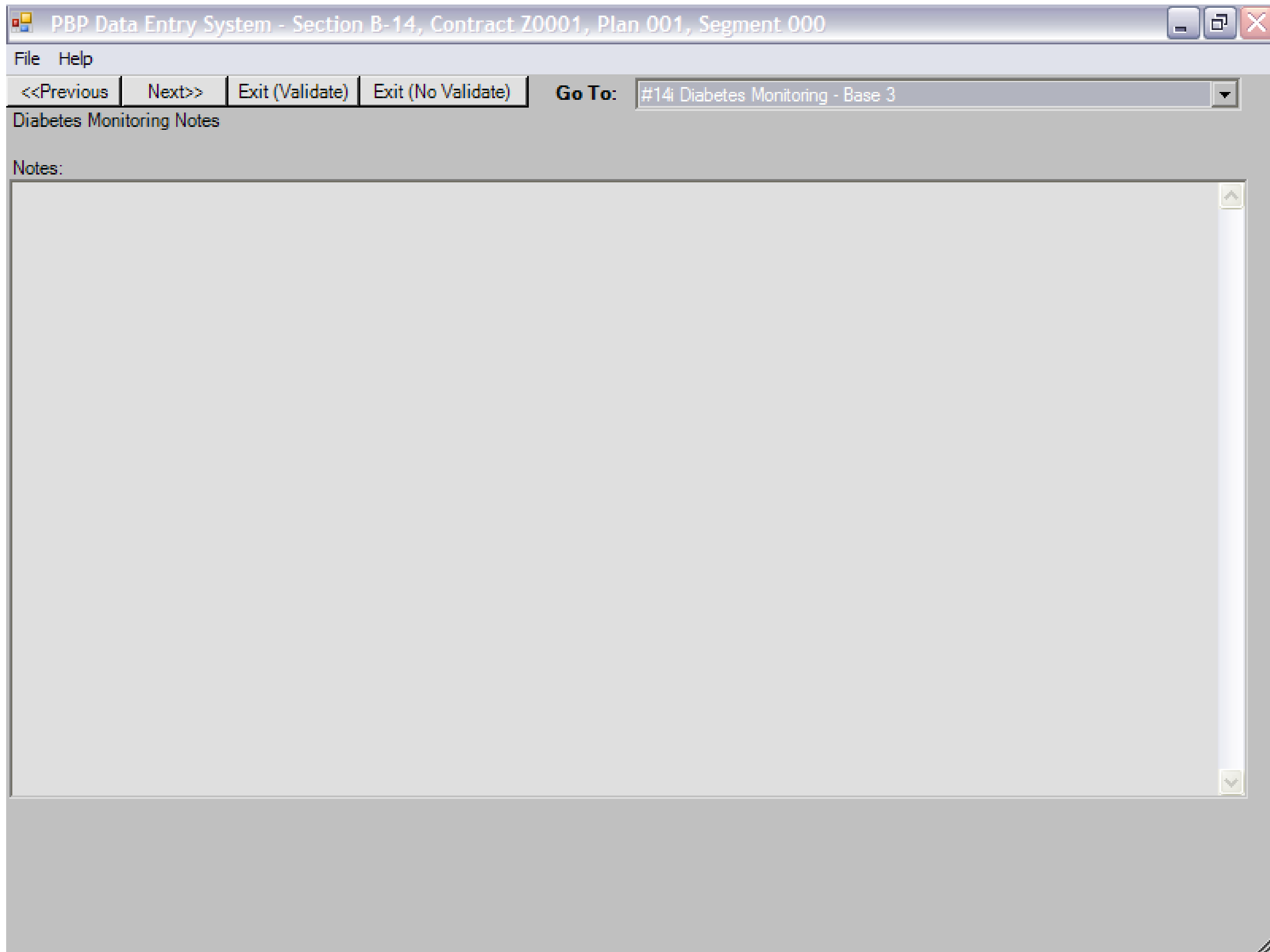
Indicate Minimum Copayment for a separate office visit:

Indicate Maximum Copayment for a separate office visit:

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



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

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

File Help

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CLICK FOR 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 Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

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<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #14j Nutrition Therapy - Base 2

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

PBP Data Entry System - Section B-14, Contract Z0001, Plan 001, Segment 000

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Nutrition Therapy for Diabetes and Renal Disease Notes

Notes:

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

PBP Data Entry System - Section B-15, Contract Z0001, Plan 001, Segment 000

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Go To: #15 Medicare Part B Rx Drugs - Base 1

CLICK FOR 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:

Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:

Indicate Maximum Coinsurance percentage for other Medicare Part B Drugs:

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

PBP Data Entry System - Section B-15, Contract Z0001, Plan 001, Segment 000

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Is there an enrollee Deductible?

- Yes
- No

Indicate Deductible Amount:

Is there an enrollee Copayment?

- Yes
- No

Indicate Minimum Copayment Amount for Medicare Part B Chemotherapy Drugs:

Indicate Maximum Copayment Amount for Medicare Part B Chemotherapy Drugs:

Indicate Minimum Copayment Amount for other Medicare Part B Drugs:

Indicate Maximum Copayment Amount for other Medicare Part B Drugs:

Is Authorization Required?

- Yes
- No

B – 15 – Medicare Part B Prescription Drugs – Notes (Optional)

PBP Data Entry System - Section B-15, Contract Z0001, Plan 001, Segment 000

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Notes (Optional):

B – 15 – Part C Home Infusion drugs

PBP Data Entry System - Section B-15, Contract Z0001, Plan 001, Segment 000

File Help

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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' to 'Does the plan provide Part D home infusion drugs as part of a bundled service 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 08, 2009.

You must also ensure that your benefit includes not only the Home Infusion drug, but any services and supplies associated with the home infusion drug's administration.

Is there an enrollee Coinsurance for Home Infusion bundled services?

- Yes
- No

Indicate Minimum Coinsurance percentage for Home Infusion bundled services:

Indicate Maximum Coinsurance percentage for Home Infusion bundled services:

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:

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

PBP Data Entry System - Section B-16, Contract Z0001, Plan 001, Segment 000

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CLICK FOR 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

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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

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Go To: #16a Preventive Dental - Base 3

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

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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:

Indicate Minimum Coinsurance percentage for Dental X-Rays:

Indicate Maximum Coinsurance percentage for Dental X-Rays:

Is there an enrollee Deductible?

- Yes
- No

Indicate Deductible Amount:

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

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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 6 SCREEN

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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):

SECTION B – 16B – COMPREHENSIVE DENTAL – BASE 1 SCREEN

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CLICK FOR 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:
- Non-routine Services
- Diagnostic Services
- Restorative Services
- Endodontics/Periodontics/Extractions
- Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

Select type of benefit for Non-routine Services:
- Mandatory
- Optional

Is this benefit unlimited for Non-routine Services?
- Yes
- No, indicate number

Indicate number of visits for Non-routine Services:

Select the Non-routine Services periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Select type of benefit for Diagnostic Services:
- Mandatory
- Optional

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

Indicate number of visits for Diagnostic Services:

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 Data Entry System - Section B-16, Contract Z0001, Plan 001, Segment 000

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Select type of benefit for Restorative Services:
- Mandatory
- Optional

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

Indicate number of visits for Restorative Services:

Select the Restorative Services periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Select type of benefit for Endodontics/Periodontics/Extractions:
- Mandatory
- Optional

Is this benefit unlimited for Endodontics/Periodontics/Extractions?
- Yes
- No, indicate number

Indicate number of visits for Endodontics/Peridontics/Extractions:

Select the Endodontics/Periodontics/Extractions periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:
- Mandatory
- Optional

Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?
- Yes
- No, indicate number

Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

SECTION B – 16B – COMPREHENSIVE DENTAL – BASE 3 SCREEN

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

- Yes
- No

Select the Maximum Plan Benefit Coverage type:

- Covered under Preventive Dental Category 16a
- 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 Dental Category 16a
- 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 – 16B – COMPREHENSIVE DENTAL – BASE 4 SCREEN

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Is there an enrollee Coinsurance?

- Yes
- No

Indicate the Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Non-routine Services:

Indicate Maximum Coinsurance percentage for Non-routine Services:

Indicate Minimum Coinsurance percentage for Diagnostic Services:

Indicate Maximum Coinsurance percentage for Diagnostic Services:

Indicate Minimum Coinsurance percentage for Restorative Services:

Indicate Maximum Coinsurance percentage for Restorative Services:

Indicate Minimum Coinsurance percentage for Endodontics/Periodontics/Extractions:

Indicate Maximum Coinsurance percentage for Endodontics/Periodontics/Extractions:

Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

Is there an enrollee Deductible?

- Yes
- No

Indicate Deductible Amount:

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

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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 Non-routine Services:

Indicate Maximum Copayment amount for Non-routine Services:

Indicate Minimum Copayment amount for Diagnostic Services:

Indicate Maximum Copayment amount for Diagnostic Services:

Indicate Minimum Copayment amount for Restorative Services:

Indicate Maximum Copayment amount for Restorative Services:

Indicate Minimum Copayment amount for Endodontics/Periodontics/Extractions:

Indicate Maximum Copayment amount for Endodontics/Periodontics/Extractions:

Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

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

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

- Yes
- No
- Sometimes, describe

Is there an enrollee Coinsurance for a separate office visit?

- Yes
- No

Indicate Minimum Coinsurance for a separate office visit:

Indicate Maximum Coinsurance for a separate office visit:

Is there an enrollee Copayment for a separate office visit?

- Yes
- No

Indicate Minimum Copayment for a separate office visit:

Indicate Maximum Copayment for a separate office visit:

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):

SECTION B – 17A – EYE EXAMS – BASE 1 SCREEN

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CLICK FOR DESCRIPTION OF BENEFIT

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

Select enhanced benefit:
- Routine Eye Exams

Select type of benefit for Routine Eye Exams:
- Mandatory
- Optional

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

Indicate number of exams for Routine Eye Exams:

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

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

Indicate Maximum Plan Benefit Coverage amount:

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

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 – 17A – EYE EXAMS – BASE 2 SCREEN

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Go To: #17a Eye Exams - Base 2

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 Routine Eye Exams:

Indicate Maximum Coinsurance percentage for Routine Eye Exams:

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 Routine Eye Exam:

Indicate Maximum Copayment amount per Routine Eye Exam:

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

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

- Yes
- No
- Sometimes, describe

Is there an enrollee Coinsurance for a separate office visit?

- Yes
- No

Indicate Minimum Coinsurance for a separate office visit:

Indicate Maximum Coinsurance for a separate office visit:

Is there an enrollee Copayment for a separate office visit?

- Yes
- No

Indicate Minimum Copayment for a separate office visit:

Indicate Maximum Copayment for a separate office visit:

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):

SECTION B – 17B – EYE WEAR – BASE 1 SCREEN

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CLICK FOR 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

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Select type of benefit for Eye Glass Lenses:
- Mandatory
- Optional

Is this benefit unlimited for Eye Glass Lenses?
- Yes
- No, indicate number

Indicate quantity (number of pairs) for Eye Glass Lenses:

Select Eye Glass Lenses periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Select type of benefit for Eye Glass Frames:
- Mandatory
- Optional

Is this benefit unlimited for Eye Glass Frames?
- Yes
- No, indicate number

Indicate quantity for Eye Glass Frames:

Select Eye Glass Frames periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Select type of benefit for Upgrades:
- Mandatory
- Optional

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

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

Select the Maximum Plan Benefit Coverage type:
- Covered under Eye Exams Category 17a
- Plan-specified amount per period

Do you offer a Combined Max Plan Benefit Coverage Amount for all Eye Wear?
- Yes
- No

Indicate Combined Maximum Plan Benefit Coverage amount:

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

Select the type of eye wear with Individual Max Plan Benefit Coverage amount:
- Contact Lenses
- Eye Glasses (Lenses and Frames)
- Eye Glass Lenses
- Eye Glass Frames
- Upgrades

Indicate Max Plan Benefit Coverage amount for Contact Lenses:

Select the Individual Maximum Plan Benefit Coverage periodicity for Contact Lenses:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Indicate Max Plan Benefit Coverage amount for Eye Glasses (Lenses and Frames):

Select the Individual Maximum Plan Benefit Coverage periodicity for Eye Glasses (Lenses and Frames):
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Indicate Max Plan Benefit Coverage amount for Eye Glass Lenses:

Select the Individual Maximum Plan Benefit Coverage periodicity for Eye Glasses Lenses:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Indicate Max Plan Benefit Coverage amount for Eye Glass Frames:

Select the Individual Maximum Plan Benefit Coverage periodicity for Eye Glasses Frames:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Indicate Max Plan Benefit Coverage amount for Upgrades:

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

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

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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:

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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

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Eye Wear Notes

Notes (Optional):

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

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Go To: #18a Hearing Exams - Base 1

CLICK FOR 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

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

- Yes
- No

Indicate Maximum Plan Benefit Coverage amount:

Select the Maximum Plan Benefit Coverage periodicity:

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

Is there an enrollee Deductible?

- Yes
- No

Indicate Deductible Amount:

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 the Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate the Maximum Coinsurance percentage for Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for Routine Hearing Tests:

Indicate Maximum Coinsurance percentage for Routine Hearing Tests:

Indicate Minimum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:

Indicate Maximum Coinsurance percentage for Fitting/Evaluation for Hearing Aid:

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

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Go To: #18a Hearing Exams - Base 3

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:

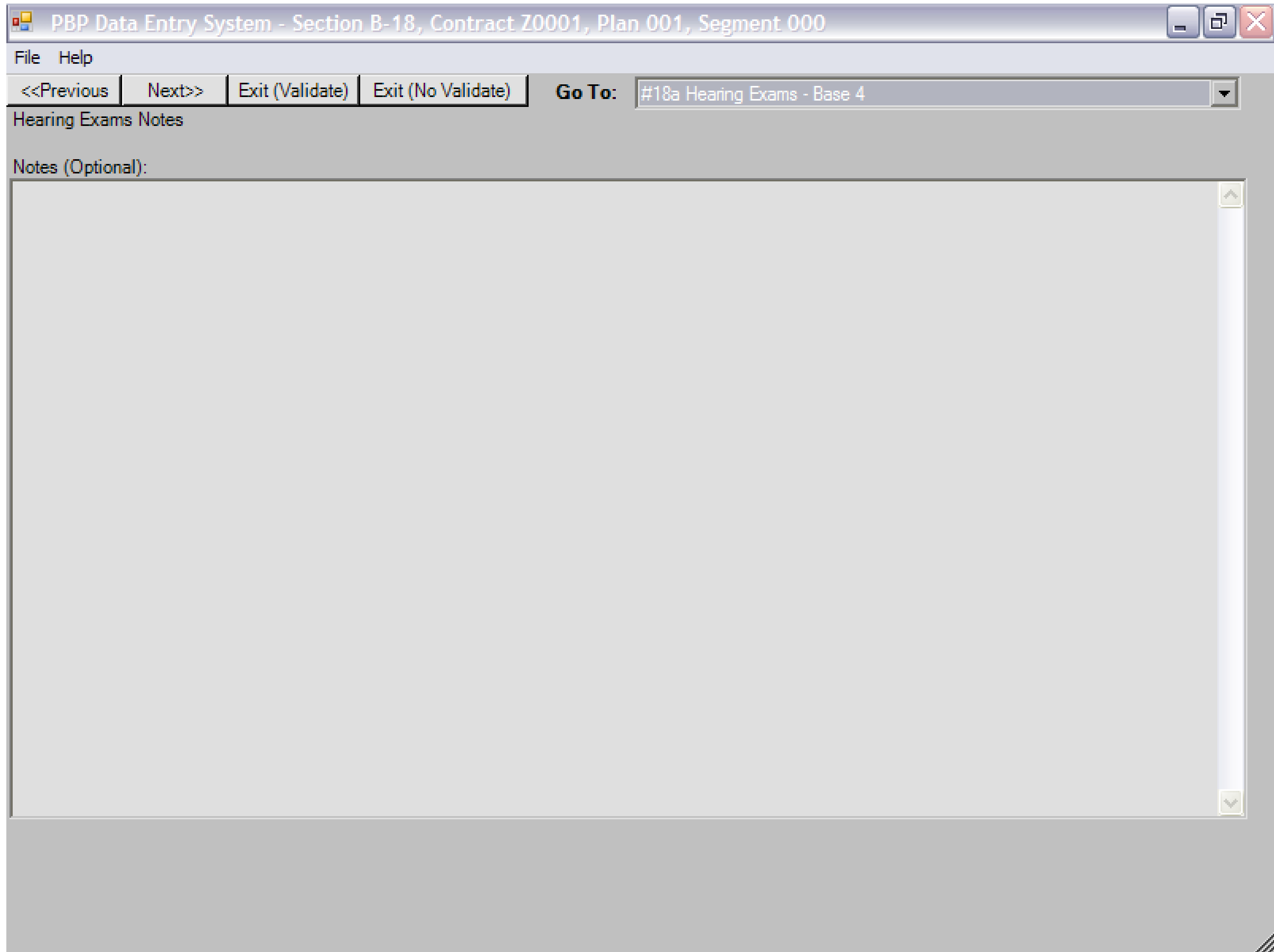
Enrollee must receive Authorization from one or more of the following:

- 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



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

PBP Data Entry System - Section B-18, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #18b Hearing Aids - Base 1

CLICK FOR 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 Data Entry System - Section B-18, Contract Z0001, Plan 001, Segment 000

File Help

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

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

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

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

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

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

PBP Data Entry System - Section B-18, Contract Z0001, Plan 001, Segment 000

File Help

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

- Yes
- No

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

- Covered under Hearing Exams Category - 18a
- 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 Hearing Aids (all types):

Indicate Coinsurance percentage for Hearing Aids - Inner Ear:

Indicate Coinsurance percentage for Hearing Aids - Outer Ear:

Indicate Coinsurance percentage for Hearing Aids - Over the Ear:

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

PBP Data Entry System - Section B-18, Contract Z0001, Plan 001, Segment 000

File Help

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Is there an enrollee Copayment?

- Yes
- No

Indicate Minimum Copayment amount per Hearing Aid (all types):

Indicate Maximum Copayment amount per Hearing Aid (all types):

Indicate Copayment amount per Hearing Aid - Inner Ear:

Indicate Copayment amount per two Hearing Aids - Inner Ear:

Indicate Copayment amount per Hearing Aid - Outer Ear:

Indicate Copayment amount per two Hearing Aids - Outer Ear:

Indicate Copayment amount per Hearing Aid - Over the Ear:

Indicate Copayment amount per two Hearing Aids - Over the Ear:

Is there an enrollee Deductible?

- Yes
- No

Indicate Deductible Amount:

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

PBP Data Entry System - Section B-18, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #18b Hearing Aids - Base 5

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):

SECTION B – 20 – OUTPNT DRUGS – BASE 1 SCREEN

PBP Data Entry System - Section B-20, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #20 Outpatient Drugs - Base 1

CLICK FOR 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 Data Entry System - Section B-20, Contract Z0001, Plan 001, Segment 000

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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 – OUTPNT DRUGS – BASE 3 SCREEN

PBP Data Entry System - Section B-20, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #20 Outpatient Drugs - Base 3

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 Minimum Coinsurance percentage for other Medicare Part B Drugs:

Indicate Maximum Coinsurance percentage for other Medicare Part B Drugs:

SECTION B – 20 – OUTPNT DRUGS – BASE 4 SCREEN

PBP Data Entry System - Section B-20, Contract Z0001, Plan 001, Segment 000

File Help

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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 Minimum Copayment for other Medicare Part B Drugs:

Indicate Maximum 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 – OUTPNT DRUGS – NOTES (OPTIONAL)

PBP Data Entry System - Section B-20, Contract Z0001, Plan 001, Segment 000

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Outpatient Drugs Notes

Notes (Optional):

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

PBP Data Entry System - Section B-20, Contract Z0001, Plan 001, Segment 000

File Help

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Go To: #20 Outpatient Drugs - Group 1 - Base 1

Select a label for Group 1:

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 semi-annual amount for Group 1:

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 1:

Indicate Maximum Plan Benefit Coverage monthly amount for Group 1:

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

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

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

PBP Data Entry System - Section B-20, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #20 Outpatient Drugs - Group 1 - Base 2

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

Is there an enrollee Copayment for Group 1?
- Yes
- No

Indicate Coinsurance percentage for Group 1 Designated Retail Pharmacy:

Indicate Copayment amount for Group 1 Designated Retail Pharmacy:

Up to a _____ day supply covered for Group 1 Designated Retail Pharmacy:

Indicate Coinsurance percentage for Group 1 HMO-Owned Pharmacy:

Indicate Copayment amount for Group 1 HMO-Owned Pharmacy:

Up to a _____ day supply covered for Group 1 HMO-Owned Pharmacy:

Indicate Coinsurance percentage for Group 1 Mail Order:

Indicate Copayment amount for Group 1 Mail Order:

Up to a _____ day supply covered for Group 1 Mail Order:

Indicate Coinsurance percentage for Group 1 Other:

Indicate Copayment amount for Group 1 Other:

Up to a _____ day supply covered for Group 1 Other:

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

PBP Data Entry System - Section B-20, Contract Z0001, Plan 001, Segment 000

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Select a label for Group 2:

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 semi-annual amount for Group 2:

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 2:

Indicate Maximum Plan Benefit Coverage monthly amount for Group 2:

Indicate Maximum Plan Benefit Coverage amount per prescription 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 Data Entry System - Section B-20, Contract Z0001, Plan 001, Segment 000

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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

Is there an enrollee Copayment for Group 2?

- Yes
- No

Indicate Coinsurance percentage for Group 2 for Designated Retail Pharmacy:

Indicate Copayment amount for Group 2 Designated Retail Pharmacy:

Up to a _____ day supply covered for Group 2 Designated Retail Pharmacy:

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

Indicate Copayment amount for Group 2 HMO-Owned Pharmacy:

Up to a _____ day supply covered for Group 2 HMO-Owned Pharmacy:

Indicate Coinsurance percentage for Group 2 for Mail Order:

Indicate Copayment amount for Group 2 Mail Order:

Up to a _____ day supply covered for Group 2 Mail Order:

Indicate Coinsurance percentage for Group 2 for Other:

Indicate Copayment amount for Group 2 Other:

Up to a _____ day supply covered for Group 2 Other:

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

PBP Data Entry System - Section B-20, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #20 Outpatient Drugs - Group 3 - Base 1

Select a label for Group 3:

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 semi-annual amount for Group 3:

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 3:

Indicate Maximum Plan Benefit Coverage monthly amount for Group 3:

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

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

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

PBP Data Entry System - Section B-20, Contract Z0001, Plan 001, Segment 000

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<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: #20 Outpatient Drugs - Group 3 - Base 2

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

Is there an enrollee Copayment for Group 3?

- Yes
- No

Indicate Coinsurance percentage for Group 3 Designated Retail Pharmacy:

Indicate Copayment amount for Group 3 Designated Retail Pharmacy:

Up to a _____ day supply covered for Group 3 Designated Retail Pharmacy:

Indicate Coinsurance percentage for Group 3 HMO-Owned Pharmacy:

Indicate Copayment amount for Group 3 HMO-Owned Pharmacy:

Up to a _____ day supply covered for Group 3 HMO-Owned Pharmacy:

Indicate Coinsurance percentage for Group 3 Mail Order:

Indicate Copayment amount for Group 3 Mail Order:

Up to a _____ day supply covered for Group 3 Mail Order:

Indicate Coinsurance percentage for Group 3 Other:

Indicate Copayment amount for Group 3 Other:

Up to a _____ day supply covered for Group 3 Other:

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

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

PBP Data Entry System - Section B-20, Contract Z0001, Plan 001, Segment 000

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Select from where Group 4 Drugs can be acquired:

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

Is there an enrollee Coinsurance for Group 4?
- Yes
- No

Is there an enrollee Copayment for Group 4?
- Yes
- No

Indicate Coinsurance percentage for Group 4 Designated Retail Pharmacy:

Indicate Copayment amount for Group 4 Designated Retail Pharmacy:

Up to a _____ day supply covered for Group 4 Designated Retail Pharmacy:

Indicate Coinsurance percentage for Group 4 HMO-Owned Pharmacy:

Indicate Copayment amount for Group 4 HMO-Owned Pharmacy:

Up to a _____ day supply covered for Group 4 HMO-Owned Pharmacy:

Indicate Coinsurance percentage for Group 4 Mail Order:

Indicate Copayment amount for Group 4 Mail Order:

Up to a _____ day supply covered for Group 4 Mail Order:

Indicate Coinsurance percentage for Group 4 Other:

Indicate Copayment amount for Group 4 Other:

Up to a _____ day supply covered for Group 4 Other:

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

PBP Data Entry System - Section B-20, Contract Z0001, Plan 001, Segment 000

File Help

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Go To: #20 Outpatient Drugs - Group 5 - Base 1

Select a label for Group 5:

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 semi-annual amount for Group 5:

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 5:

Indicate Maximum Plan Benefit Coverage monthly amount for Group 5:

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

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

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

PBP Data Entry System - Section B-20, Contract Z0001, Plan 001, Segment 000

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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

Is there an enrollee Copayment for Group 5?

- Yes
- No

Indicate Coinsurance percentage for Group 5 Designated Retail Pharmacy:

Indicate Copayment amount for Group 5 Designated Retail Pharmacy:

Up to a _____ day supply covered for Group 5 Designated Retail Pharmacy:

Indicate Coinsurance percentage for Group 5 HMO-Owned Pharmacy:

Indicate Copayment amount for Group 5 HMO-Owned Pharmacy:

Up to a _____ day supply covered for Group 5 HMO-Owned Pharmacy:

Indicate Coinsurance percentage for Group 5 Mail Order:

Indicate Copayment amount for Group 5 Mail Order:

Up to a _____ day supply covered for Group 5 Mail Order:

Indicate Coinsurance percentage for Group 5 Other:

Indicate Copayment amount for Group 5 Other:

Up to a _____ day supply covered for Group 5 Other:

SECTION B – 20 – HOME INFUSION DRUGS

PBP Data Entry System - Section B-20, Contract Z0001, Plan 001, Segment 000

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** #20 Part C Home Infusion Bundled Services

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

- Yes
- No

If you select 'Yes' to 'Does the plan provide Part D home infusion drugs as part of a bundled service 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 08, 2009.

You must also ensure that your benefit includes not only the Home Infusion drug, but any services and supplies associated with the home infusion drug's administration.

Is there an enrollee Coinsurance for Home Infusion bundled services?

- Yes
- No

Indicate Minimum Coinsurance percentage for Home Infusion bundled services:

Indicate Maximum Coinsurance percentage for Home Infusion bundled services:

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: