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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Plan Deductible (Combined) - Base 1

Is there a Combined (In-Network and Out-of-Network) Deductible amount?

- Yes
- No

Do you charge the Medicare-defined Part B Deductible amount?

- Yes
- No

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

Select the benefits that apply to the Combined Deductible:

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

Does the Combined Deductible apply to all In-Network Medicare-covered plan services?

- Yes
- No

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

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

Does the Combined Deductible apply to all In-Network Non-Medicare-covered plan services?

- Yes
- No

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

- 10b: Transportation:
- 13b: Acupuncture:
- 13c: Over The Counter (OTC) Items:
- 13d: Meal Benefit:
- 13e: Other 1:
- 13f: Other 2:
- 14a: Health Ed/Wellness:
- 16a: Preventive Dental:
- 16b: Comprehensive Dental:
- 17a: Eye Exams:
- 17b: Eye Wear:
- 18a: Hearing Exams:
- 18b: Hearing Aids:

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Plan Deductible (Combined) - Base 2

Does the Combined Deductible apply to all Out-Of-Network Medicare-covered plan services?

- Yes
- No

Does the Combined Deductible apply to all Out-Of-Network Non -Medicare-covered plan services?

- Yes
- No

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

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

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

10b: Transportation:
13b: Acupuncture:
13c: Over The Counter (OTC) Items:
13d: Meal Benefit:
13e: Other 1:
13f: Other 2:
14a: Health Ed/Wellness:
16a: Preventive Dental:
16b: Comprehensive Dental:
17a: Eye Exams:
17b: Eye Wear:
18a: Hearing Exams:
18b: Hearing Aids:

SECTION D – PLAN DEDUCTIBLE (IN-NETWORK) SCREEN

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate)

Go To: Plan Deductible (In-Network)

Is there an In-Network Plan Deductible?

- Yes
- No

Do you charge the Medicare-defined Part B Deductible amount?

- Yes
- No

Indicate In-Network Plan Deductible Amount:

Select the benefits that apply to the In-Network Deductible:

- In-Network Medicare-covered benefits
- In-Network Non-Medicare-covered benefits

Does the In-Network Deductible apply to all In-Network Medicare-covered plan services?

- Yes
- No

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

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

Does the In-Network Deductible apply to all In-Network Non-Medicare-covered plan services?

- Yes
- No

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

- 10b: Transportation:
- 13b: Acupuncture:
- 13c: Over The Counter (OTC) Items:
- 13d: Meal Benefit:
- 13e: Other 1:
- 13f: Other 2:
- 14a: Health Ed/Wellness:
- 16a: Preventive Dental:
- 16b: Comprehensive Dental:
- 17a: Eye Exams:
- 17b: Eye Wear:
- 18a: Hearing Exams:
- 18b: Hearing Aids:

SECTION D – PLAN DEDUCTIBLE (RPPO DIFFERENTIAL DEDUCTIBLE) – BASE 1

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Plan Deductible (RPPO-Differential Deductibles)-Base 1

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

- Yes
- No

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

- 1a: Inpatient Hospital Services Including Acute:
- 1b: Inpatient Hospital Psychiatric Services:
- 2: Skilled Nursing Facility (SNF):
- 3: Comprehensive Outpatient Rehabilitation Facility (CORF):
- 4a: Emergency Care:
- 4b:Urgently Needed Services:
- 5: Partial Hospitalization:
- 6: Home Health Services:
- 7a: Primary Care Physician Services:
- 7b: Chiropractic Services:
- 7c: Occupational Therapy Services:
- 7d: Physician Specialist Services:
- 7e: Mental Health Specialty Services - Non-Psychiatric:
- 7f: Podiatry Services:
- 7g: Other Health Care Professional Services:
- 7h: Psychiatric Services:
- 7i: Physical Therapy and Speech-Language Pathology Services:
- 8a: Diagnostic Procedures/Test/Lab Benefits:
- 8b: Diagnostic/ Therapeutic Radiological Services:
- 9a: Outpatient Hospital Services:
- 9b: Ambulatory Surgical Center (ASC) Services:
- 9c: Outpatient Substance Abuse Services:
- 9d: Cardiac Rehabilitation Services:
- 10a: Ambulance Services:
- 10b: Transportation Services:

Indicate Differential Deductible Amount for Inpatient Hospital Services including Acute:

Indicate Differential Deductible Amount for Partial Hospitalization:

Indicate Differential Deductible Amount for Inpatient Hospital Psychiatric Services:

Indicate Differential Deductible Amount for Home Health Services:

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

Indicate Differential Deductible Amount for Primary Care Physician Services:

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

Indicate Differential Deductible Amount for Chiropractic Services:

Indicate Differential Deductible Amount for Emergency Care:

Indicate Differential Deductible Amount for Occupational Therapy Services:

Indicate Differential Deductible Amount for Urgently Needed Services:

Indicate Differential Deductible Amount for Physician Specialist Services:

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Plan Deductible (RPPO-Differential Deductibles)-Base 2

Indicate Differential Deductible Amount for Mental Health Specialty Services - Non-Psychiatric:

Indicate Differential Deductible Amount for Podiatry Services:

Indicate Differential Deductible Amount for Other Health Care Professional Services:

Indicate Differential Deductible Amount for Psychiatric Services:

Indicate Differential Deductible Amount for Physical Therapy and Speech-Language Pathology Services

Indicate Differential Deductible Amount for Diagnostic Procedures/Test/Lab Benefits:

Indicate Differential Deductible Amount for Diagnostic/ Therapeutic Radiological Services:

Indicate Differential Deductible Amount for Outpatient Hospital Services:

Indicate Differential Deductible Amount for Ambulatory Surgical Center (ASC) Services:

Indicate Differential Deductible Amount for Outpatient Substance Abuse Services:

Indicate Differential Deductible Amount for Cardiac Rehabilitation Services:

Indicate Differential Deductible Amount for Ambulance Services:

Indicate Differential Deductible Amount for Transportation Services:

Indicate Differential Deductible Amount for DME:

Indicate Differential Deductible Amount for Prosthetics/Medical Supplies:

Indicate Differential Deductible Amount for Diabetes Monitoring Supplies:

Indicate Differential Deductible Amount for End-Stage Renal Disease:

Indicate Differential Deductible Amount for Outpatient Blood:

Indicate Differential Deductible Amount for Acupuncture:

Indicate Differential Deductible Amount for OTC:

Indicate Differential Deductible Amount for Meal Benefit:

Indicate Differential Deductible Amount for Other 1:

Indicate Differential Deductible Amount for Other 2:

Indicate Differential Deductible Amount for Health Education/Wellness Programs:

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Plan Deductible (RPPO-Differential Deductibles)-Base 3

Indicate Differential Deductible Amount for Immunizations:

Indicate Differential Deductible Amount for Physical Exams:

Indicate Differential Deductible Amount for Pap Smears and Pelvic Exams Screening:

Indicate Differential Deductible Amount for Prostate Cancer Screenin

Indicate Differential Deductible Amount for Colorectal Screening:

Indicate Differential Deductible Amount for Bone Mass Measurement:

Indicate Differential Deductible Amount for Mammography Screening:

Indicate Differential Deductible Amount for Diabetes Monitoring:

Indicate Differential Deductible Amount for Nutrition Therapy for Diabetes and Renal Disease:

Indicate Differential Deductible Amount for Medicare Part B Rx Drugs

Indicate Differential Deductible Amount for Preventive Dental:

Indicate Differential Deductible Amount for Comprehensive Dental:

Indicate Differential Deductible Amount for Eye Exams:

Indicate Differential Deductible Amount for Eye Wear:

Indicate Differential Deductible Amount for Hearing Exams:

Indicate Differential Deductible Amount for Hearing Aids:

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** Plan Deductible (Out-of-Network)

Is there an Out-of-Network (OON) Plan Deductible?

- Yes
- No

Do you charge the Medicare-defined Part B Deductible amount?

- Yes
- No

Indicate Out-of-Network Plan Deductible Amount:

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

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

Does the Out-of-Network Deductible apply to all Out-of Network Medicare-covered plan services?

- Yes
- No

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

- 1a: Inpatient Hospital Acute:
- 1b: Inpatient Psych Hospital:
- 2: Skilled Nursing Facility (SNF)
- 3: Comprehensive Outpatient Rehabilitation Facility (CORF):
- 4b: Urgently Needed Care:
- 5: Partial Hospitalization:
- 6: Home Health Services:
- 7a: Primary Care Physician:

Does the Out-of-Network Deductible apply to all Out-of Network Non-Medicare-covered plan services?

- Yes
- No

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

- 10b: Transportation:
- 13b: Acupuncture:
- 13c: Over The Counter (OTC) Items:
- 13d: Meal Benefit:
- 13e: Other 1:
- 13e: Other 2:
- 14a: Health Ed/Wellness:
- 16a: Preventive Dental:
- 16b: Comprehensive Dental:
- 17a: Eye Exams:
- 17b: Eye Wear:
- 18a: Hearing Exams:
- 18b: Hearing Aids:

SECTION D – PLAN DEDUCTIBLE (NON-NETWORK) SCREEN

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate)

Go To: Plan Deductible (Non-Network)

Is there a Plan Deductible?
- Yes
- No

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

Indicate Plan Deductible Amount:

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

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

Select all of the Medicare-covered Service Categories to which the Plan Deductible applies:
- 1a: Inpatient Hospital Acute:
- 1b: Inpatient Psych Hospital:
- 2: Skilled Nursing Facility (SNF):
- 3: Comprehensive Outpatient Rehabilitation Facility (CORF):
- 5: Partial Hospitalization:
- 6: Home Health Services:
- 7a: Primary Care Physician:
- 7b: Chiropractic Services:

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

Select all of the Non-Medicare-covered Service Categories to which the Deductible applies:
- 10b: Transportation:
- 13b: Acupuncture:
- 13c: Over The Counter (OTC) Items:
- 13d: Meal Benefit:
- 13e: Other 1:
- 13f: Other 2:
- 14a: Health Ed/Wellness:
- 16a: Preventive Dental:
- 16b: Comprehensive Dental:
- 17a: Eye Exams:
- 17b: Eye Wear:
- 18a: Hearing Exams:
- 18b: Hearing Aids:

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** Max Enrollee Cost Limit (Combined) - Base 1

Is there a Combined (In-Network and Out-of-Network) Maximum Enrollee Out-of-Pocket Cost?

- Yes
- No

CMS' recommended out-of-pocket maximum for Medicare A/B covered services for CY2011 is $3400.

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

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

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

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

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

- Yes
- No

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

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

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

- Yes
- No

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

- 10b: Transportation:
- 13b: Acupuncture:
- 13c: Over The Counter (OTC) Items:
- 13d: Meal Benefit:
- 13e: Other 1:
- 13f: Other 2:
- 14a: Health Ed/Wellness:
- 16a: Preventive Dental:
- 16b: Comprehensive Dental:
- 17a: Eye Exams:
- 17b: Eye Wear:
- 18a: Hearing Exams:

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Max Enrollee Cost Limit (Combined) - Base 2

CMS' recommended out-of-pocket maximum for Medicare A/B covered services for CY2011 is $3400.

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

- Yes
- No

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

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

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

- Yes
- No

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

- 10b: Transportation:
- 13b: Acupuncture:
- 13c: Over The Counter (OTC) Items:
- 13d: Meal Benefit:
- 13e: Other 1:
- 13f: Other 2:
- 14a: Health Ed/Wellness:
- 16a: Preventive Dental:
- 16b: Comprehensive Dental:
- 17a: Eye Exams:
- 17b: Eye Wear:
- 18a: Hearing Exams:
- 18b: Hearing Aids:

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Max Enrollee Cost Limit (In-Network)

Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?

- Yes
- No

CMS' recommended out-of-pocket maximum for Medicare A/B covered services for CY2011 is $3400.

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

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

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

- In-Network Medicare-covered benefits
- In-Network Non-Medicare-covered benefits

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

- Yes
- No

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

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

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

- Yes
- No

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

- 10b: Transportation:
- 13b: Acupuncture:
- 13c: Over The Counter (OTC) Items:
- 13d: Meal Benefit:
- 13e: Other 1:
- 13f: Other 2:
- 14a: Health Ed/Wellness:
- 16a: Preventive Dental:
- 16b: Comprehensive Dental:
- 17a: Eye Exams:
- 17b: Eye Wear:

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** Max Enrollee Cost Limit (Out-of-Network)

Is there an Out-of-Network Maximum Enrollee Out-of-Pocket Cost?

- Yes
- No

CMS' recommended out-of-pocket maximum for Medicare A/B covered services for CY2011 is $3400.

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

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

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

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

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

- Yes
- No

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

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

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

- Yes
- No

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

- 10b: Transportation:
- 13b: Acupuncture:
- 13c: Over The Counter (OTC) Items:
- 13d: Meal Benefit:
- 13e: Other 1:
- 13f: Other 2:
- 14a: Health Ed/Wellness:
- 16a: Preventive Dental:
- 16b: Comprehensive Dental:
- 17a: Eye Exams:
- 17b: Eye Wear:
- 18a: Hearing Exams:

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Max Enrollee Cost Limit (Non-Network)

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

- Yes
- No

CMS' recommended out-of-pocket maximum for Medicare A/B covered services for CY2011 is $3400.

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

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

- Medicare-covered benefits
- Non-Medicare-covered benefits

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

- Yes
- No

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

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

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

- Yes
- No

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

10b: Transportation:
13b: Acupuncture:
13c: Over The Counter (OTC) Items:
13d: Meal Benefit:
13e: Other 1:
13f: Other 2:
14a: Health Ed/Wellness:
16a: Preventive Dental:
16b: Comprehensive Dental:
17a: Eye Exams:
17b: Eye Wear:
18a: Hearing Exams:

SECTION D – MAX PLAN BENEFIT COVERAGE SCREEN

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** Max Plan Benefit Coverage

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

Is there a Maximum Plan Benefit Coverage Amount?

- Yes
- No

Indicate Maximum Plan Benefit Coverage Amount:

Select Maximum Plan Benefit Coverage Amount Periodicity:

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

Select the benefits that apply to the Maximum Plan Benefit Coverage Amount:

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

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

- Yes
- No

Select all of the In-Network Non-Medicare-covered Service Categories to which the Maximum Plan Benefit Coverage Amount applies:

- 10b: Transportation:
- 13b: Acupuncture:
- 13c: Over The Counter (OTC) Items:
- 13d: Meal Benefit:
- 13e: Other 1:
- 13f: Other 2:

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

- Yes
- No

Select all of the Out-of-Network Non-Medicare-covered Service Categories to which the Maximum Plan Benefit Coverage Amount applies:

- 10b: Transportation:
- 13b: Acupuncture:
- 13c: Over The Counter (OTC) Items:
- 13d: Meal Benefit:
- 13e: Other 1:
- 13f: Other 2:
- 14a: Health Ed/Wellness:
- 16a: Preventive Dental:
- 16b: Comprehensive Dental:

SECTION D – MAX PLAN BENEFIT COVERAGE (NON-NETWORK) SCREEN

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** Max Plan Benefit Coverage (Non-Network)

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

Is there a Maximum Plan Benefit Coverage Amount?

- Yes
- No

Indicate Maximum Plan Benefit Coverage Amount:

Select Maximum Plan Benefit Coverage Amount Periodicity:

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

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

- Yes
- No

Select all of the Non-Medicare-covered Service Categories to which the Maximum Plan Benefit Coverage Amount applies:

- 10b: Transportation:
- 13b: Acupuncture:
- 13c: Over The Counter (OTC) Items:
- 13d: Meal Benefit:
- 13e: Other 1:
- 13f: Other 2:

SECTION D –PLAN PREMIUM/ REBATE REDUCTION SCREEN

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** Plan Premium/Rebate Reduction

Indicate Plan Premium Amount (Part A/B):

Indicate Plan Premium Amount (B Only):

Are you using any of your plan's MA rebates to reduce the Part B Premium?

- Yes
- No

Indicate the Part B Premium reduction amount:

SECTION D – PFFS BALANCE BILLING SCREEN

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: PFFS Balance Billing

Do you permit balance billing?

- Yes
- No

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

What category of providers do you permit to balance bill?

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

Enter Minimum percentage for balance billing:

Enter Maximum percentage for balance billing:

SECTION D –MSA ANNUAL DEDUCTIBLE/DEPOSIT SCREEN

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** MSA Annual Deductible/Deposit

Indicate Annual MSA Deductible amount:

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

SECTION D – MSA DEMO PLANS SCREEN

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** MSA Demo plans ONLY

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

- Yes
- No

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

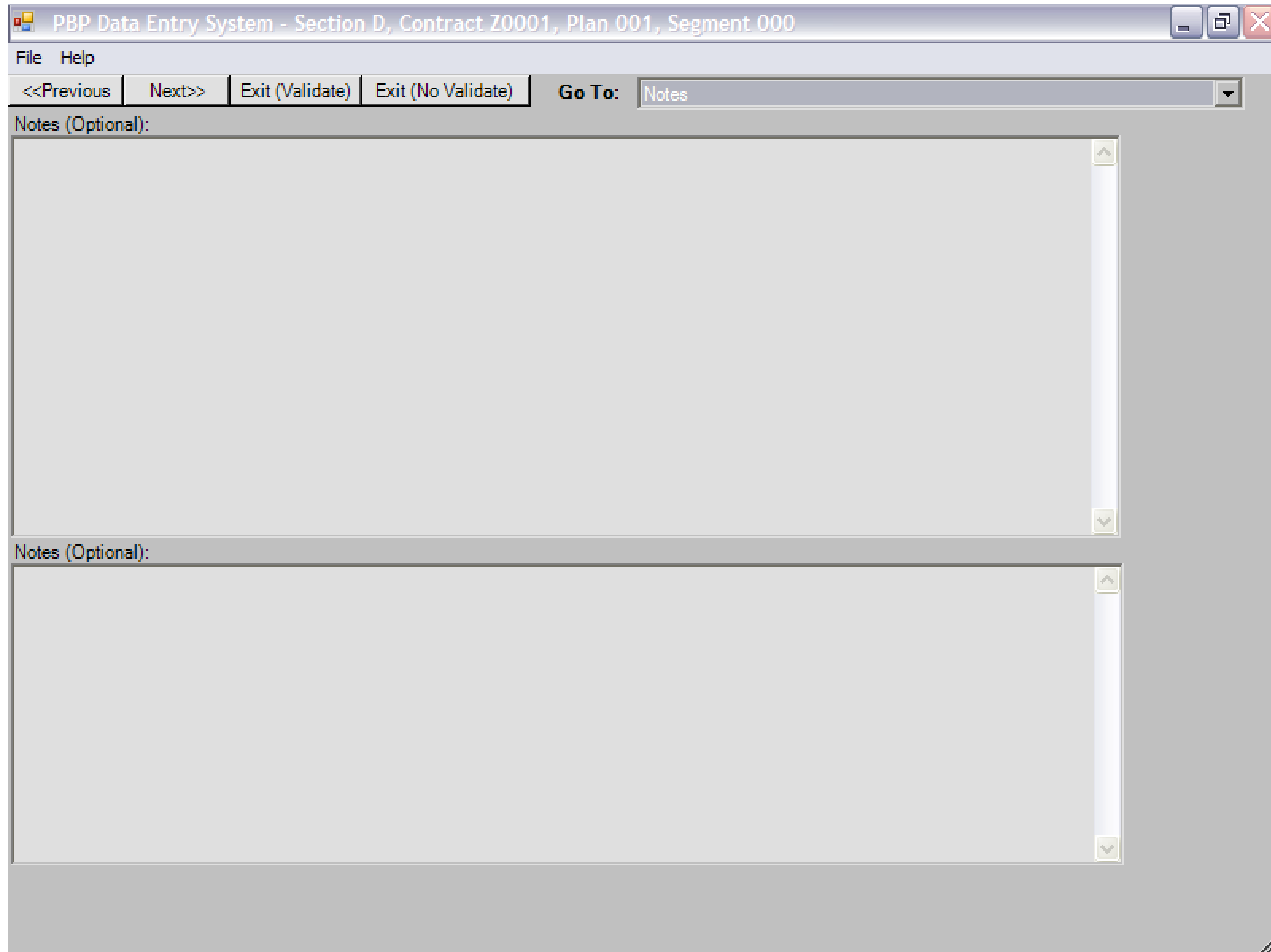
- Bone Mass Measurement
- Cardiovascular Screenings
- Colorectal Cancer Screenings
- Diabetes Screenings
- Immunizations
- Glaucoma Tests
- Screening Mammograms
- Pap Test and Pelvic Exam
- Physical Exam
- Prostate Cancer Screening
- Additional Smoking Cessation

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

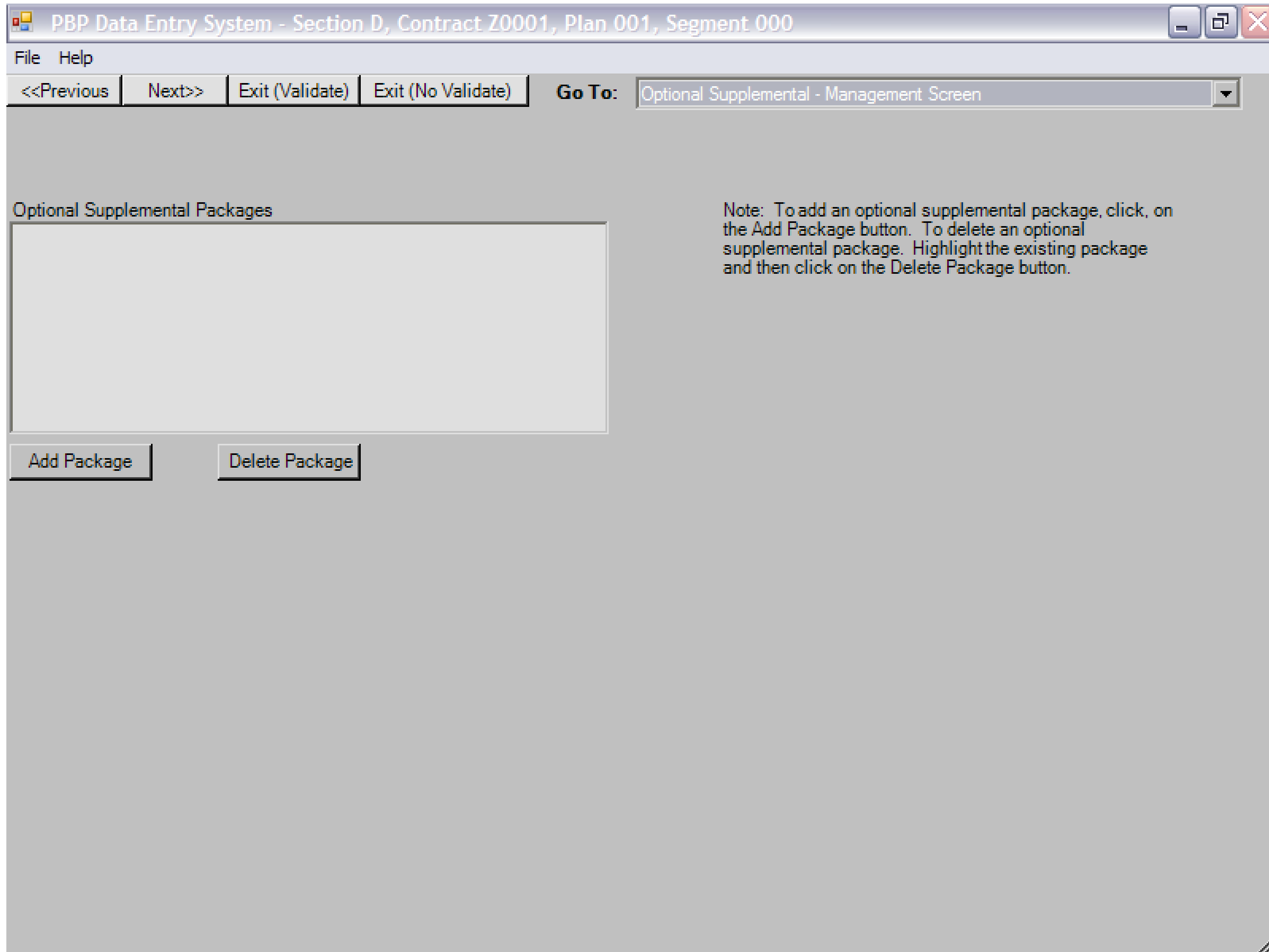
- Yes
- No, describe

Notes (Describe Cost Sharing Differences):

SECTION D – NOTES SCREEN



SECTION D – OPTIONAL SUPPLEMENTAL PACKAGE MANAGEMENT SCREEN



SECTION D – OPTIONAL SUPPLEMENTAL – LABEL AND PREMIUM SCREEN

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Optional Supplemental - Label and Premium

Optional Supplemental Benefits ID:

Optional Supplemental Package Description:

Indicate Optional Supplemental Premium Amount:

Is there a Maximum Plan Benefit Coverage Amount for this package?

- Yes
- No

Indicate Maximum Plan Benefit Coverage Amount for this package:

Select the Maximum Plan Benefit Coverage periodicity:

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

Notes:

SECTION D – OPTIONAL SUPPLEMENTAL – SERVICE CATEGORIES SCREEN

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** Optional Supplemental - Service Categories

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

1a: Inpatient Hospital Acute:
1b: Inpatient Psych Hospital:
2: Skilled Nursing Facility (SNF):
3: Comprehensive Outpatient Rehabilitation Facility (COF
4a: Emergency Care:
4b: Urgently Needed Care:
5: Partial Hospitalization:
6: Home Health Services:
7a: Primary Care Physician:
7b: Chiropractic Services:
7c: Occupational Therapy Services:
7d: Physician Specialist excl Psychiatric:
7e: Mental Health Specialty Services:
7f: Podiatry Services:
7g: Other Health Care Professional:
7h: Psychiatric:
7i: PT and SP Services:
8a: Diagnostic Procedures/Test/Lab Benefits:
8b: Diagnostic/Therapeutic Radiological Services:
9a: Outpatient Hospital Services:
9b: ASC Services:
9c: Outpatient Substance Abuse:
9d: Cardiac Rehabilitation Services:
10a: Ambulance Services:
10b: Transportation:
11a: DME:
11b: Prosthetics/Medical Supplies:
11c: Diabetes Monitoring Supplies:
12: End-Stage Renal Disease:
13a: Blood:

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

1a: Inpatient Hospital Acute:
1b: Inpatient Psych Hospital:
2: Skilled Nursing Facility (SNF):
3: Comprehensive Outpatient Rehabilitation Facility (CC
4a: Emergency Care:
4b: Urgently Needed Care:
5: Partial Hospitalization:
6: Home Health Services:
7a: Primary Care Physician:
7b: Chiropractic Services*:
7c: Occupational Therapy Services:
7d: Physician Specialist excl Psychiatric:
7e: Mental Health Specialty Services:
7f: Podiatry Services*:
7g: Other Health Care Professional:
7h: Psychiatric:
7i: PT and SP Services:
8a: Diagnostic Procedures/Test/Lab Benefits:
8b: Diagnostic/Therapeutic Radiological Services:
9a: Outpatient Hospital Services:
9b: ASC Services:
9c: Outpatient Substance Abuse:
9d: Cardiac Rehabilitation Services:
10a: Ambulance Services:
10b: Transportation*:
11a: DME:
11b: Prosthetics/Medical Supplies:
11c: Diabetes Monitoring Supplies:
12: End-Stage Renal Disease:
13a: Blood:

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

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

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

SECTION D – OON-STEP-UP

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Optional Supplemental - OON Stepup

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

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

Is there an OON Coinsurance?
- Yes
- No

Enter Minimum Coinsurance Percentage:

Enter Maximum Coinsurance Percentage:

Is there an OON Copayment?
- Yes
- No

Enter Minimum Copayment Amount:

Enter Maximum Copayment Amount:

Notes:

SECTION D – OPTIONAL SUPPLEMENTAL -OON-OPTIONAL

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Optional Supplemental - OON Optional

Does this category include Out-of-Network benefits?

- Yes
- No

Are the OON cost shares the same as the In-Network cost shares?

- Yes
- No

Is there an OON Coinsurance?

- Yes
- No

Enter Minimum Coinsurance Percentage:

Enter Maximum Coinsurance Percentage:

Is there an OON Copayment?

- Yes
- No

Enter Minimum Copayment Amount:

Enter Maximum Copayment Amount:

Notes:

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #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 D – STEP-UP – 7B – CHIROPRACTIC SERVICES – BASE 2 SCREEN

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #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 D – STEP-UP – 7B – CHIROPRACTIC SERVICES – BASE 3 SCREEN

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #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:

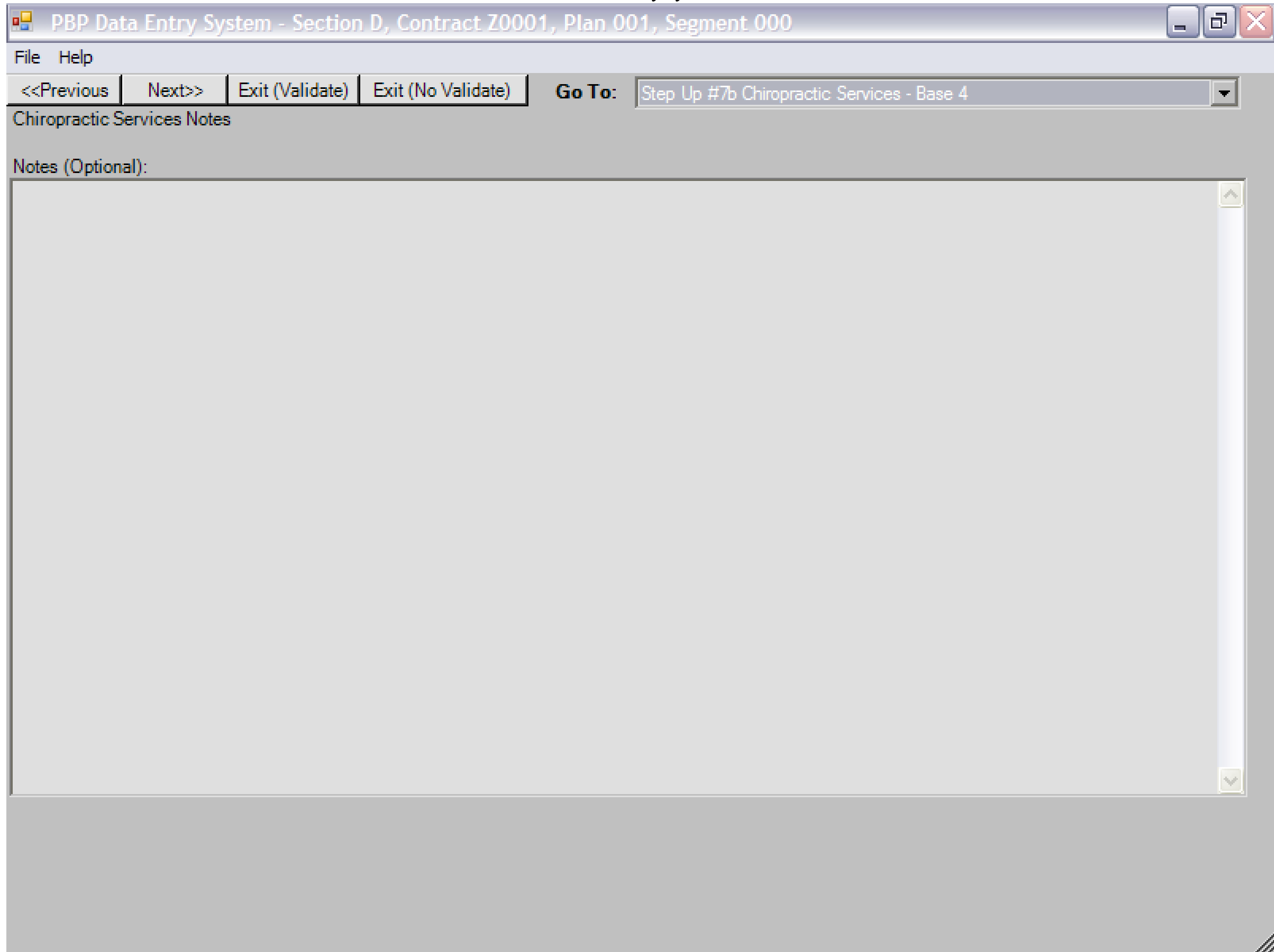
Enrollee must receive Authorization from one or more of the following:

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


PBP Data Entry System - Section D, Contract Z0001, Plan 001, Segment 000
File
Help
<<Previous
Next>>
Exit (Validate)
Exit (No Validate)
Go To:
Step Up #7b Chiropractic Services - Base 4
Chiropractic Services Notes
Notes (Optional):

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #7f Podiatry Services - Base 1

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #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 D – STEP-UP – 7F – PODIATRY SERVICES – BASE 3 SCREEN

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** Step Up #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 D – STEP-UP – 10B – TRANSPORTATION – BASE 1 SCREEN

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #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 D – STEP-UP – 10B – TRANSPORTATION – BASE 2 SCREEN

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #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 D – STEP-UP – 10B – TRANSPORTATION – BASE 3 SCREEN

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #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 D – STEP-UP – 16A – PREVENTIVE DENTAL – BASE 1 SCREEN

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #16a Preventive Dental - Base 1

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** Step Up #16a Preventive Dental - Base 2

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate)

Go To: Step Up #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 D – STEP-UP – 16A – PREVENTIVE DENTAL – BASE 4 SCREEN

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #16a Preventive Dental - Base 4

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate)

Go To: Step Up #16a Preventive Dental - Base 5

Is there an enrollee Copayment?

- Yes
- No

Is there a combination of services included in a single cost per Office Visit?

- Yes
- No

Select which combination of services are included in a single cost per Office Visit:

- Oral Exams
- Prophylaxis (Cleaning)
- Fluoride Treatment
- Dental X-Rays

Indicate Copayment amount for Office Visit:

Indicate Minimum Copayment amount for Oral Exams:

Indicate Maximum Copayment amount for Oral Exams:

Indicate Minimum Copayment amount for Prophylaxis (Cleaning):

Indicate Maximum Copayment amount for Prophylaxis (Cleaning):

Indicate Minimum Copayment amount for Fluoride Treatment:

Indicate Maximum Copayment amount for Fluoride Treatment:

Indicate Minimum Copayment amount for Dental X-Rays:

Indicate Maximum Copayment amount for Dental X-Rays:

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #16a Preventive Dental - Base 6

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #16b Comp Dental - 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:
- 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 D – STEP-UP – 16B – COMPREHENSIVE DENTAL – BASE 2 SCREEN

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #16b Comp Dental - Base 2

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** Step Up #16b Comp Dental - Base 3

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #16b Comp Dental - Base 4

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #16b Comp Dental - Base 5

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** Step Up #16b Comp Dental - Base 6

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #17a Eye Exams - Base 1

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate)

Go To: Step Up #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 D – STEP-UP – 17A – EYE EXAMS – BASE 3 SCREEN

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** Step Up #17a Eye Exams - Base 3

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #17b Eye Wear - 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:
- Contact Lenses
- Eye Glasses (Lenses and Frames)
- Eye Glass Lenses
- Eye Glass Frames
- Upgrades

Select type of benefit for Contact Lenses:
- Mandatory
- Optional

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

Indicate quantity (number of pairs) for Contact Lenses:

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

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

Is this benefit unlimited for Eye Glasses (Lenses and Frames)?
- Yes
- No, indicate number

Indicate quantity for Eye Glasses (Lenses and Frames):

Select Eye Glasses (Lenses and Frames) periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #17b Eye Wear - Base 2

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #17b Eye Wear - Base 3

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #17b Eye Wear - Base 4

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

- Yes
- No

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

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

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:

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

Is there an enrollee Coinsurance?

- Yes
- No

Indicate Coinsurance percentage for Medicare-covered Benefits:

Indicate Coinsurance percentage for Contact Lenses:

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

Indicate Coinsurance percentage for Eye Glass Lenses:

Indicate Coinsurance percentage for Eye Glass Frames:

Indicate Coinsurance percentage for Upgrades:

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

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

File Help

<<Previous Next>> Exit (Validate) Exit (No Validate)

Go To: Step Up #17b Eye Wear - Base 5

Is there an enrollee Deductible?

- Yes
- No

Indicate Deductible Amount:

Is there an enrollee Copayment?

- Yes
- No

Indicate Copayment amount for Medicare-covered Benefits:

Indicate Copayment amount for Contact Lenses:

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

Indicate Copayment amount for Eye Glass Lenses:

Indicate Copayment amount for Eye Glass Frames:

Indicate Copayment amount for Upgrades:

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

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

Is a referral required for Eye Wear?

- Yes
- No

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #17b Eye Wear - Base 6

Eye Wear Notes

Notes (Optional):

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate)

Go To: Step Up #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 D – STEP-UP – 18A – HEARING EXAMS – BASE 2 SCREEN

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #18a Hearing Exams - Base 2

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate)

Go To: Step Up #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 D – STEP-UP – 18A – HEARING EXAMS – BASE 4 SCREEN

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** Step Up #18a Hearing Exams - Base 4

Hearing Exams Notes

Notes (Optional):

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #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 D – STEP-UP – 18B – HEARING AIDS – BASE 2 SCREEN

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** Step Up #18b Hearing Aids - Base 2

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #18b Hearing Aids - Base 3

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | Go To: Step Up #18b Hearing Aids - Base 4

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

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

File Help

<<Previous | Next>> | Exit (Validate) | Exit (No Validate) | **Go To:** Step Up #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):